NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 6th February 2018 at 2.00 pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
February 2018

TITLE OF REPORT:	Service for Out of Area Patients
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	A gap in commissioning has been identified, NHS England Guidance is not currently being fulfilled for patients living in the Wolverhampton area but live outside of their practice boundary and therefore termed out of area.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public meeting in order to discuss the need for commissioning a new service in line with NHS England Guidance.
KEY POINTS:	• NHS England originally commissioned this service for CCGs, these arrangements end on 31 March 2017. • The requirement for the CCG to commission such a service was not identified during the 'Preparing for Full Delegation' process. • The CCG became aware of a gap in provision summer 2017 & following liaison with a range of colleagues identified that draft guidance dated January 2017 existed. • Based on NHSE's guidance a local service specification has been developed for consideration in order to address the current gap in commissioning.
RECOMMENDATION:	This report and accompanying draft service specification should be considered & discussed by the Committee. In order to address the current gap in commissioning the committee are asked to grant approval for expressions of interest from practices/groups & other local providers to be obtained.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of the services we commission 2 Reducing health inequalities in Wolverhampton 3 System effectiveness delivered within our financial envelope

BACKGROUND AND CURRENT SITUATION

1.1. In December 2014 NHS England published guidance for GP Practices & CCGs confirming arrangements for patients registered with practices and who live outside of their practice boundary. The guidance seeks to ensure that patients who choose to register out of area without home visits can continue to access primary medical services should they have an urgent care need during core hours and if they cannot reasonably be expected to attend their registered practice.

2. NHS ENGLAND

2.1. NHS England introduced contractual changes within GMS, PMS & APMS contracts in 2014 that came into force from 5 January 2015. Patients were able to register with their practice of choice, beyond the areas in which they lived. Out of area patients are entitled to a full range of primary medical services however, should the service they require involve any of the following the practice is not obliged to provide these:-

- A home visit
- Immediately necessary treatment following accident or emergency wheent the patient is at home (outside the practice boundary)
- Access to out of hours service when the patient is at home or
- There are other clinical or practical reasons for the provision of service to be delivered near the patient's home (eg follow care following hospital discharge)

Therefore, at the point of registering the patient should be reminded that the above would not usually be fulfilled by the practice they have chosen to register with.

2.2. Once fully delegated from 1 April 2017 NHS England responsibilities for the provision of primary medical services in hours for out of area patients became the responsibility of the CCG. Area Teams are required to work with CCGs to make these service available as it is unlikely that other locally commissioned services would provide a home visiting service ie walk-in centres or minor injuries units.

2.3. The CCG are responsible for considering opportunities for extending existing or establishing new co-operative home visiting arrangements that can provide the service quickly, effectively and efficiently.

3. OPTIONS FOR SERVICE DELIVERY

3.1. In the absence of such a service currently & following discussion with colleagues in neighbouring CCGs provision is achieved elsewhere through enhanced commissioning with either a practice/federation or urgent care provider. The demand in other areas is advised to be negligible although in line with NHS England Guidance the payment of £60 per home visit or £15.87 per face to face consultation with a GP or other healthcare professional should be noted.

3.2. One other Black Country CCG commissions one practice from each locality offering a £500 retainer payment to set up the service and any patient contact is claimed in addition ie £60 or £15.87 per home visit/consultation respectively.

3.3. Likely demand for this service is not clear other 2 neighbouring CCGs have a service in place but they have never been accessed however, there have been two occasions since April 2017 when Wolverhampton CCG have become aware of patients attempting to identify who the Wolverhampton provider is for patients requiring a home visit (in hours). Should a patient seek assistance from NHS 111 they have been advised that there isn't a home visiting service available in Wolverhampton and signposted to attend the Urgent Care Centre.

4. CLINICAL VIEW

4.1. The view of clinicians will be sought through discussion at the Committee Meeting, particularly from clinical colleagues & lay members on behalf of the public.

5. PATIENT AND PUBLIC VIEW

5.1. Whilst the CCG has not yet entered into any engagement activity in Wolverhampton regarding this service there have not been any complaints regarding the gap in service. The view of lay members will be welcomed during discussion at the Committee Meeting.

6. KEY RISKS AND MITIGATIONS

6.1. There are a series of risks attached to the current gap in commissioning continuing. A continued gap in commissioning gives rise to complaint(s) from patients who may need to access such a service & also confusion that may exist/arise as a result of non-provision of such a service at this time. These risks may culminate in reputational to the CCG should a clinical incident arise resulting in a patient not receiving the right care, in the right place at the right time.

6.2. A new risk was entered onto the Risk Register on 29 January in line with this gap in commissioning detailing the options to mitigate the risk by seeking approval for the service to be commissioned for the contract year 2018/19.

7. IMPACT ASSESSMENT

7.1 Financial and Resource Implications

Whilst this service is not currently funded nor were any obvious specific funds transferred to the CCG at the point of full delegation. The cost of this service referred to in the attached service specification is based on NHS England guidance. The guidance advocates a payment of £60 per home visit or £15.87 per GP consultation in the practice and whilst the number of out of area patients residing in the city is unknown versus the number of queries raised directly the CCG it recommended that

a discrete allocation of funds be made available from within Primary Care Budgets on a recurring basis in the sum of £5,000.

7.2 Quality & Safety Implications

The quality of care patients may experience in the absence of a home visiting service (in hours) gives rise to a shortfall in patient experience and potential for a patient safety incident to arise. To date there haven't been any incidents reported.

7.3 Equality Implications

At this stage a full equality analysis has not been undertaken, however, if the committee support the intention to seek expressions of interest from local providers a full equality analysis will be completed in conjunction with the CCGs Equality & Diversity Lead.

7.4 Legal & Policy Implications

Name	Sarah Southall
Job Title	Head of Service
Date	29 January 2018
Enclosure(s)	Out of Area Home Visiting Service Specification (draft)

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**Dr S Reehana**	**Requested 31.01.18**
Public/ Patient View	**Sue McKie**	**31.01.18**
Finance Implications discussed with Finance Team	**Lesley Sawrey**	**30.1.18**
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service	**NA**	
Information Governance implications discussed with IG Support Officer	**NA**	
Legal/ Policy implications discussed with Corporate Operations Manager	**NA**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**Mike Hastings**	**30.01.18**
Any relevant data requirements discussed with CSU Business Intelligence	**NA**	
Signed off by Report Owner (Must be completed)	**Mike Hastings signed off on behalf of Steven Marshall**	**30.01.18**

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WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
February 2018

TITLE OF REPORT:	Pharmacy First Scheme for all patients
AUTHOR(s) OF REPORT:	Hemant Patel/ Sarah Southall
MANAGEMENT LEAD:	Steven Marshall
PURPOSE OF REPORT:	Seek approval for funding of this service.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The CCG already commissions a service for over 16s • The service for under 16s will be decommissioned by NHSE on 31st March 2018. • CCG members have requested that a service covering all ages should be continued and commissioned by the CCG • The CCG will need to finance consultation and drug costs in addition to the service management fees to the CSU in 2018/19.
RECOMMENDATION:	That the CCG commission this service until March 2019.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Continuation of existing service

2. Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton. Withdrawal of this service would put increased demand on GP practices
3. System effectiveness delivered within our financial envelope	The service makes best use of community pharmacist's skills and helps develop and maintain a modern up skilled workforce across Wolverhampton.

1. BACKGROUND AND CURRENT SITUATION

1.1. Reports suggest that 20% of GP consultations can be dealt with by self-care and support from community pharmacy.

1.2. In areas of high deprivation, Pharmacy First schemes that allow access to a limited range of NHS- funded over the counter medicines for low income and deprived families to support self-care have been shown to be cost-effective in reducing demand on GPs, walk-in-centres and Accident and Emergency.

1.3. Many pharmacies are now open 100 hours a week with a qualified pharmacist on hand to advise on minor illnesses, medication queries and other problems

1.4. Community pharmacy can support self-care for long term conditions, coughs and colds and other complaints and support better health through provision of healthy lifestyle advice. Many Wolverhampton pharmacies are now designated as healthy living pharmacies

1.5. Over the last 3 years local GP practices have worked closely with community pharmacies to encourage patients to self-treat ailments, rather than going to their general practitioner particularly when it comes to asking for antibiotics which will be ineffective for symptoms of viral infections.

1.6. Community pharmacy teams have resources in place to help them provide messages to patients on self-care about the normal self-limited duration of ailments and the red flags (warning symptoms) where patients are referred to their GP.

1.7. In 2013 the PCT transferred funds for the minor ailment service to NHSE. This was invested in the Pharmacy First service.

1.8. NHSE has decided to de-commission the service for patients under 16 years of age. The CCG is not aware that any consultation has taken place to inform this decision.

1.9. No funding has been transferred or offered to the CCG to continue to commission this service. Originally 66K was transferred to NHSE for the minor ailment service to be continued by the area team

2. PROPOSAL

2.1. The CCG takes over the commissioning of the under 16 service from April 2018 to complement the service already commissioned for over 16s. This would therefore be a continuation of an existing service.

2.2. The activity for patients over the age of 16 for 2016/17 was 2,750 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £13,750. In addition the drug costs were £7,999. Total cost of the service in the last financial year was £21,749.

2.3. The activity for patients under the age of 16 for 2016/17 were 3,852 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £19,260. In addition the drug costs were £10,991. The total costs for under 16s therefore were: £30,251.

2.4. Patients will be made aware of this service by GP practice staff using the proposed care navigation system and community pharmacists and their staff.

2.5. The Pharmacy First Service is administered by the PharmOutcomes system which is managed by the Midlands and Lancs CSU under the current service level agreement with NHSE. A service charge of £5,727 has been made by the CSU for this work to be undertaken in 2018/19. The service charge covers :-

- Procurement, contract and implementation of PharmOutcomes® IT Software System
- Service design, development and management
- Payments Management function
- Reporting Function
- Helpdesk Function

2.6. Payments due to pharmacy contractors for this service will be generated by the CSU who will provide schedules with back up data for CCG budget holders to sign off. On receipt NHSE will make arrangements to pay pharmacy contractors via their normal payment process.

2.7. Other Key Points to bear in mind:-

- NHS Clinical Commissioners are running a consultation on the proposed commissioning policy which may restrict NHS funding for over the counter and self-care medicines.

- For this reason a 12 month non-recurring contract is advised to enable this service to continue until 31 March 2019.

3. CLINICAL VIEW

3.1. Dr Reehana the Interim Deputy Chair of the CCG is the clinical champion for this service.

4. PATIENT AND PUBLIC VIEW

4.1. None. It is assumed the patients and public would wish to keep this service active until a national decision is made on using NHS funding for self-care treatments.

5. KEY RISKS AND MITIGATIONS

5.1. Withdrawal of this service could place greater demand on GP practice, Urgent Care, Walk in Centres and A and E department.
5.2. As this is a 1 year contract only this would require non re-current funding.
5.3. Demand could increase with uptake of Care Navigation

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. A total budget of £60K will be required. This will need to be split between the Primary Care Budget and the Prescribing Budget. Primary care will fund the consultation costs and the drug costs will be funded from prescribing. Pragmatically it was decided the costs would be split 70/30 between primary care and the prescribing budget, with Primary Care funding 70% of the total cost. Costs will be absorbed within existing budgets.

Quality and Safety Implications

6.2. None. This will be a continuation of an existing service with a different commissioner

Equality Implications

6.3. None. This will be a continuation of an existing service with a different commissioner

Legal and Policy Implications

6.4. None. This will be a continuation of an existing service with a different commissioner

Other Implications

6.5. None

Name Hemant Patel & Sarah Southall
Job Title Head of Medicines Optimisation/ Head of Primary Care
Date: 02/2/18

ATTACHED:

Service Specification 17/18 attached
Service Offer from Midlands & Lancs CSU

RELEVANT BACKGROUND PAPERS
Nil

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	Dr Reehana	**02.02.2018**
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**Lesley Sawrey**	**02.02.2018**
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Hemant Patel & Sarah Southall**	**02.2.18**

Condition	Proposed Formulary Items for NEW SLA
Acute Pain /Earache /Headache /Temperature	Paracetamol 500mg tablets Ibuprofen 200mg tablets
Athlete's foot	Clotrimazole cream 1%
Bites and Stings	Crotamiton 10% cream Certirizine 10mg OD Hydrocortisone 1% cream Chlorphenamine 4mg tabs
Colds/Flu-like symptoms/Nasal Congestion	Paracetamol 500mg tablets Ibuprofen 200mg tablets Menthol and Eucalyptus inhalation Xylometazole 0.1% nasal spray
Cold Sores	Aciclovir 5% cream
Conjunctivitis (acute bacterial)	Chloramphenicol 0.5% eye drops Chloramphenicol 1.0% eye ointment
Constipation (acute)	Ispaghula 3.5g sachets Senna 7.5mg tabs Lactulose solution Glycerol suppositories 4g
Cough	Simple Linctus S.F

	Pholcodine 5mg/5ml SF
Cystitis	**Potassium Citrate sachets** **Sodium Citrate sachets**
Dermatitis/Dry Skin/Allergic Type Skin Rash	**Emulsifying ointment** **Hydrocortisone cream 1%** **Crotamiton 10% cream** **Chlorphenamine 4mg tablets** **Cetirizine 10mg tablets**
Diarrhoea	**Electrolade sachets**
Hay Fever (Seasonal Allergic Rhinitis)	**Chlorphenamine 4mg tabs** **Cetirizine 10mg tabs** **Beclometasone nasal spray** **Sodium cromoglycate 2% eye drops**
Haemorrhoids	**Anusol ointment** **Anusol suppositories** **Anusol Plus HC ointment** **Anusol Plus HC suppositories**
Heartburn/Indigestion	**Gaviscon Advance tabs** **Gaviscon Advance liquid** **Ranitidine 75mg**
Mouth Ulcers	**Bonjela gel** **Chlorhexidine 0.2% mouthwash**
Oral Thrush	**Miconazole oral gel**
Scabies	**Permethrin 5% dermal cream** **Chlorphenamine 4mg tab**

	Crotamiton 10% cream
Sore Throat	**Paracetamol tablets 500mg** **Ibuprofen 200mg tablets** **Difflam Throat spray**
Sprains and Strains	**Paracetamol 500mg tab** **Ibuprofen 400mg tab** **Ibuprofen gel 10%**
Threadworms	**Mebendazole 100mg chewtab**
Vaginal Thrush	**Clotrimazole 2% cream** **Clotrimazole 500mg pessary** **Fluconazole 150mg oral cap**

Midlands and Lancashire Commissioning Support Unit

Midlands & Lancashire CSU

Service Offer to Wolverhampton CCG

Pharmacy First Service Development

01st April 2018 – 31st March 2019

In commercial confidence

Midlands & Lancashire Commissioning Support Unit (MLCSU) has been providing Pharmacy First (minor ailments) service support since its commencement in April 2014. MLCSU developed the existing Pharmacy First Scheme currently used by community pharmacies in Wolverhampton and across the wider NHSE footprint (Birmingham, Black Country, Arden, Hereford and Worcester) on behalf of NHS England in 2017. NHSE are transferring the responsibility of community pharmacy commissioned services to CCGs. The current NHSE Pharmacy First scheme is due to expire at the end of March 2017, leaving a short timescale to confirm continued provision by local CCGs.

Pharmacy First is an important gateway service for patients presenting with minor ailment conditions that could be treated in primary care without the need for a patient to access their GP, Urgent Care Centre or A&E. MLCSU have had feedback confirmed by activity data that suggests our approach delivers an efficient and effective method to the supply of minor ailment medication. MLCSU is committed to supporting the continuity of this service and have developed this service offer for local CCGs to help implement the self-care agenda.

MLCSU has a proven track record of providing high quality locally commissioned services and a full range of Medicines Management and Optimisation services to a number of local organisations including: Clinical Commissioning Groups, Local Authorities and NHS England. Since 2013, MLCSU have successfully delivered and transitioned locally commissioned pharmacy services from paper-based schemes to fully auditable on-line services. Implementation of a bespoke IT software package PharmOutcomes® is essential for the implementation of robust and resilient community pharmacy commissioned services across any NHSE or CCG area nationally. MLCSU will procure and contract the PharmOutcomes® IT Software System for the forthcoming financial year to achieve the best value solution.

Schemes successfully set-up, managed and administered by MLCSU include the Wolverhampton CCG *Minor Eye Conditions scheme (MECS)*, the West Cheshire CCG commissioned *Pharmacy First (PF) scheme* and the *Specialist Palliative Care Drugs Supply (SPCD) service* jointly commissioned by six local CCGs. MLCSU is instrumental in working collaboratively to ensure this crucial SPCD service continued to be offered to patients. MLCSU brings a wealth of experience of developing and managing services on behalf of commissioners, other schemes managed by MLCSU include the NHSE *Dermatology* and the *Assisted Medication Scheme.*

Pharmacy First Service Development Overview

- Procure, contract and implement PharmOutcomes® IT Software System
- Service design, development and management
- Payments Management function
- Reporting Function
- Helpdesk Function

Procure, contract and implement PharmOutcomes® IT Software System

- MLCSU to procure IT software system licenses in line with NHSE SFIs and processes.
- Implementation of IT software system across existing pharmacies and for any new providers.

***Please note MLCSU is not responsible for individual license costs. This may be an additional charge.**

Service design, development and management

- Service Funding Form for CCGs set up to cover consultation costs and medication fees within the service.
- Develop updated Service Level Agreement (SLA) incorporating; service aims, outcomes, remuneration, service provider duties, commissioner duties, exclusions & exceptions, confidentiality & data protection and on-line enrolment phase thus allowing contractors to sign up to the service on-line as part of a binding agreement.
- Development and enhancement of on-line service platform corresponding to updated service specification.
- Communications Function to allow commissioners to communicate key messages to service providers (limited to one communication per quarter).
- Annual contractor evaluation survey to assess provider feedback.

Payments Management Function

- Monthly Individual contractor Invoices for service claims will be generated on PharmOutcomes and paid monthly
- Invoices paid via the NHSE local payments application directly to providers
- NHSE will re-charge CCG quarterly via the recently established re-charge process

***Please note MLCSU fees to provide commissioning support do not include provider drug costs and consultation costs. The CCG is responsible for these pharmacy service level payments.**

Reporting Function

- Delivery of monthly reports based on variables captured on the PharmOutcomes Platform including activity, conditions, and treatments.
- Reports delivered in a pdf and/or csv format containing service analysis and raw service data.
- Ad hoc reports available (limited to one per quarter)

***Does not include third party reporting at the request of the commissioner**

Helpdesk Service:

- Resolve service issues including: IT queries, payments, stock, contractual issues and provide information on a range of queries.
- Queries to be submitted via email as the preferred route of communication. Response times of 5 working days to be made known to enquirers and linked to availability of lead in the service.

Service Quotes

This offer is to deliver commissioning support, administration, evaluation and development of the Pharmacy First service. The fee is based on:

- Proposed contract period: 1st April 2018 until 31st March 2018.
- Our quote does not include the procurement and administration of contracting with Pinnacle Health Ltd to cover individual license costs

***VAT is not charged to CCGs for our services.**
***Our fee includes all set up costs, travel and staffing oncosts.**
***As a service provider we will cover the service delivery even if staff sickness or absence occurs for leads as required in our contract.**

The annual total cost for our service is: £5,727

*Please note MLCSU fees for commissioning support do not include provider drug costs and consultation costs relating to the above mentioned service. Wolverhampton CCG is responsible for these pharmacy service level payments.

Why choose Midlands & Lancashire CSU?

Our experience

Our team has many years of experience in both the commissioning role, and in providing the clinical services. We have a high level of knowledge, experience and understanding about the commissioning of Community Pharmacy services. We have established relations with a range of local organisations that impact on the commissioning of community pharmacy services including CCGs and City Councils.

Service resilience

We have a range of staff medicines skills in this area of commissioning with access to a range of other expert advice in the CSU to support the service delivery including communications, contracting and procurement.

Service Lead Contacts

Gurjinder Samra
Senior Prescribing Adviser
Tel: 0121 612 3814
E-mail: Gurjinder.Samra@nhs.net

Ravinder Kalkat
Head of Medicines Optimisation
Mob: 07552002497
Email: ravi.kalkat@nhs.net

NHS Midlands and Lancashire CSU, 438-450 High Street, West Bromwich, B70 9LD www.midlandsandlancashirecsu.nhs.uk

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West Midlands

Pharmacy First Local Enhanced Service (V1)

Service Specification

Service	**Pharmacy First 15 and under – West Midlands**
Commissioner Lead	Brian Wallis
Provider Lead	Local Pharmaceutical Committee
Period	1st June 2017 – 31st March 2018

1. Population Needs

National/local context and evidence base

The general population experiences the symptoms of minor ailments almost every day and the vast majority of people are very responsible about what they do to deal with them including the sensible practice of self-care and self-medication. However, people who turn to their doctor as the first port of call for these ailments cost the NHS some £2billion and generate 57million consultations taking up valuable GP time, and using up finite resources of the NHS. Of these consultations 51.4million are for minor ailments alone at a cost of £1.5billion just for GPs' time. If these consultations could be handled by a pharmacist time could be released for GPs to see patients with more complex needs.

This service follows learning from the Pharmacy First scheme commissioned during 2015 – 2017 across a limited number of Clinical Commissioning Groups (CCG) areas and will now provide a service across parts of the West Midlands area for patients aged 15 years and under.

2. Outcomes

The service supports practices improving access to GP services, an improvement area of 'Ensuring that people have a positive experience of care' of the NHS Outcomes Framework Domain 4 by the release and building of capacity in general practice allowing for increased consultation times & access to the GP when more complex consultations are required and thereby also supporting the NHS Outcomes Framework Domain 2 'Enhancing quality of life for people with long-term Conditions' and finally the service also supports Domain 3 of the framework- 'Helping people to recover from episodes of ill health or following injury'.

Locally defined outcomes

- ✓ Improve patient capability to Self-Care and thereby reduce reliance on medical services as well as other clinical services.
- ✓ Improve primary care capacity by reducing medical practice workload related to minor ailments and to ease pressures on their local A&E department and primary care urgent services.

- ✓ Promote the role and greater contribution of pharmacies in primary health care
- ✓ Improve working relationships between GPs and Pharmacists

3. Scope

3.1 Aims and objectives of service

Patients aged 15 years and under can access self-care advice for the treatment of minor ailments and, where appropriate, can be supplied with over the counter (OTC) and Pharmacy (P) medicines without the requirement to attend their GP practice for an appointment. The scheme is offered as a quicker alternative for 2017/18. Patients are at liberty to refuse the service and continue to access healthcare in the same way as they have done previously.

The overall aim of the scheme is to ensure that patients can access self-care advice for the treatment of common ailments and, where appropriate, can be supplied with medicines, at NHS expense, to treat their ailment. This provides an alternative location from which patients can seek advice and treatment, rather than seeking treatment via a prescription from their GP or out of hours (OOH) provider, or via a walk-in centre or accident and emergency. This will:

- Improve patients' access to advice and appropriate treatment for common ailments
- Reduce GP workload for common ailments allowing greater focus on more complex and urgent medical condition
- Promote the role of the Pharmacist and self-care
- Improve working relationships between Doctors and Pharmacists
- Allow GPs to focus on more complex and urgent medical conditions.

Patients may choose to refuse this service and continue to access treatments in the same way as they have done previously. The service is only available for the ailments listed in Appendix 1 and in those Pharmacies who have enrolled on to the service. Only medicines specified in these protocols may be supplied for the ailments specified.

3.2 Service description/care pathway and patient eligibility

This scheme is available to patients who are registered with participating GPs in parts of Birmingham, Sandwell, Dudley, Walsall, Wolverhampton. Patient consent must be sought in writing by the "registering" Pharmacy before any intervention under this scheme. The declaration form must be completed at each intervention under the scheme, signed by the parent or legal guardian.

The PharmOutcomes platform has printable versions of the consent and declaration forms. The consent and declaration forms must be printed and completed in full. Each patient is only required to register once with an accredited pharmacy up until the 31st March 2018. Once registered patients are able to access the scheme from any accredited pharmacies of their choice. Patients are not restricted to using one pharmacy only. Patients are able to access the scheme up to a maximum of 3 times in a 12 month period, although this may be reviewed. Recording of NHS Number is mandatory.

The pharmacy will provide advice and support to eligible patients on the management of minor ailments, including where necessary, the supply of medicines as per the formulary summary at appendix 1, and treatment protocols in appendix 2 for those patients who would have otherwise accessed GP services. At every intervention, the Pharmacy must promote the self-care advice and

resources available at **www.selfcareforum.org**

The pharmacy will operate a referral system to GPs, A&E and other health and social care professionals, where appropriate.

The service is only available for the minor ailments included within appendix 1 of this specification. Management of these conditions is set out in the treatment protocols (see Appendix 2). The formulary and/or list of minor ailments covered by the scheme may be amended by NHS England (in agreement with the relevant CCG where appropriate) by way of an update to all participating pharmacies.

3.3 Service Outline: Registration of patients to the Pharmacy First service at Community Pharmacy

A patient registered with a participating GP practice may register at an accredited Community Pharmacy. Patients presenting with identified symptoms, covered by the Pharmacy First Conditions, at a pharmacy will be offered the option of using the Pharmacy First service.

For those patients who consent to join the scheme a consent form must be completed. For a child under 16, the parent or legal guardian must sign the consent form. For each intervention under the scheme, the patient declaration form must be completed. The **NHS number must be captured** at the time of the patient consultation and preferably the patient demographics as well. Pharmacies will not be eligible for payment where the NHS number is not captured. The only exception to this will be during Bank Holidays when it may be difficult to confirm NHS number in a timely manner. The community pharmacy staff will need to verify the patient address, via either:

- Evidence produced by patient of registration by e.g. producing a repeat prescription tear-off slip, NHS card

  or

- PMR records showing evidence of prescriptions dispensed in the last three months

  or

- Confirmation of registration with a surgery by phone if patient has not produced suitable identification. Permission from patient must be sought first.

As part of the registration process, the community pharmacy will advise of the maximum usage of the Pharmacy First scheme.

3.4 What The Scheme is Not

The scheme is not available to patients requesting medications included within the formulary to maintain or stock pile “just in case.” Pharmacies are expected to advise patients accordingly and remind them of the declaration they signed on registration. Pharmacies must also maintain a log of patients refused the scheme and the reason for and date of refusal on PharmOutcomes. This will be used to inform decisions on future levels of provision and design of the scheme.

Patients who have already attended a GP appointment or intend to take up a GP appointment for the same symptoms are not eligible for the Pharmacy First service.

3.5 Responsibilities of Participating General Practices

1. Patients requesting appointments (either immediately or on a future appointment basis) for symptoms matching criteria identified in this service specification will be offered transfer to the service. This can be immediate if this would enable the person to be seen quicker or in the future if they present with one of the conditions listed. Please note, patients who have already attended a GP appointment or intend to take up a GP appointment for the same symptoms are not eligible for the Pharmacy First service.
2. Co-operate and liaise with Community Pharmacists and to agree a local process for patients requiring immediate consultation.
3. Display official posters promoting the service where provided by NHS England or Public Health
4. Patients under the age of one year old can be referred into the scheme but are treated at the Pharmacist's discretion. Medicine can be provided it is licensed for a child less than one year of age.
5. GPs to ensure their staff are fully aware of and understand the Pharmacy First service and limitations of what can be referred into the scheme
6. GP staff are to advise patients of a choice of local pharmacies operating the scheme and are reminded that directing patients to a specific pharmacy is not permitted under Regulation and Standards of Professional Conduct.
7. GP Practices are asked to support initiatives to involve their Patient Participation Group in cascading information to raise awareness of the scheme/self-care.

3.6 Responsibilities of Participating Accredited Community Pharmacists

1. The Contractor will ensure that the service is managed by an accredited pharmacist, working in the community pharmacy. In the absence of the accredited pharmacist due to holiday or sick leave, the service may be provided by the covering pharmacist provided there is a standard operating procedure (SOP) in place.
2. Patients presenting with identified symptoms at a pharmacy will be offered the option of using this service and an eligibility check and consent to the scheme will be undertaken at first registration. Subsequent visits will require confirmation of their identity and continued eligibility where the latter may have changed. Patients are able to access the scheme at any number of accredited pharmacies up to their maximum entitlement to interventions (up until 31st March 2018). Failure to check patient details on PharmOutcomes and record relevant details at the time of consultation may result in claims not being authorised for payment.
3. Provide a professional consultation service: communicate with, counsel and advise people appropriately and effectively on minor ailments and self –care; sign-posting all patients to self-care resources including **www.selfcareforum.org**
4. **Patients must attend the pharmacy in person; non face-to-face consultations** are not permitted. The only exception to this includes circumstances where an infant may be suffering from diarrhoea or a contagious condition and in the professional opinion of the pharmacist face-to-face consultation is not essential. Children under 5 years of age suffering from fever ***must attend*** the pharmacy in order to be assessed in line with NICE guidance. If this is not possible then they must be referred back to their GP.
5. The appropriate pharmacy staff will assess the patient's condition and the pharmacist is responsible for approving the advice. The consultation will consist of:
    - Patient assessment to determine the relevant person that needs to continue to support the patient where the necessary pre-requisites have been satisfied as per this specification (such as fully completed, signed consent and declaration of exemption).

- Provision of advice (as per Pharmacy First protocols included in this scheme) and sign-post to self-care resources including **www.selfcareforum.org**
- Check that the maximum usage of the Pharmacy First service has not been exceeded, invalidating access to the service
- Provision of a medication, **only if necessary**, from the agreed formulary appropriate to the patient's condition (as per Pharmacy First protocols included in this scheme). The professional fee can still be claimed for advice where there is no supply of medications provided all other criteria within the specification are met.
- Advise patient if they have exceeded the maximum usage of the scheme, and provide Self Care advice, recording "refusal" on PharmOutcomes.
- Rules of patient confidentiality apply.

6. Record the intervention or "refusal" on PharmOutcomes at the time of consultation and optionally in the Pharmacy's PMR system; maintaining and retaining good quality records (including copies of signed patient consent forms) as per relevant professional and information governance standards.
7. Implement the referral process if symptoms meet agreed criteria.
8. If the pharmacist suspects that the patient and/or parent is abusing the scheme they should add an alert to PharmOutcomes which will automatically notify the appropriate person.
9. Contact the surgery if there are concerns regarding patient referrals e.g. inappropriate referrals to this scheme.
10. **Referral Procedure-** Referral for urgent appointment - If the patient presents with symptoms indicating the need for a consultation with the GP, the pharmacist should (within surgery hours) contact the patient's GP by phone to arrange an appointment or if outside surgery hours to contact the on-call doctor, or advise the patient to attend A & E immediately.
11. Document referrals made to the GP and state the reason for the referral on the PharmOutcomes platform.
12. Explain the provision, range of conditions covered and features of the service to the public and other appropriate professionals; encouraging patients to self-care in the future.
13. An annual patient satisfaction survey will be undertaken as directed by NHS England, the number of returns will be based on activity and will be confirmed by NHS England on an annual basis.
14. Accredited pharmacists are expected to attend an annual training event as organised by NHS England.
15. Any adverse incident that has happened in relation to this scheme must be reported to NHS England via **england.medsreporting@nhs.net** within 72 hours of occurrence:
16. Inform locum pharmacist of local paperwork and SOP to provide service.

3.7 Population Covered

Patients aged 15 years and under, registered to a participating GP with any of the symptoms or conditions covered under this scheme may access the service.

3.8 Exclusion Criteria

Patients who have a) already attended a GP appointment or intend to take up a GP appointment for the same symptoms or b) accessed the maximum number of interventions in a 12 month period permitted under the scheme are not eligible for the scheme.

4. Quality Indicators

4.1 Scheme Evaluation

- Number of minor illness conditions dealt with by the pharmacies and uptake by postcode, day of week and time of intervention (as well as patient demographics) – Analysis of the percentage of total pharmacy consultations dealing with minor illnesses and patient demographics of "frequent flyers"
- Number of patients accessing the scheme who would otherwise have a) booked an appointment to see their GP or b) accessed an urgent out of hours or emergency A&E appointment - i.e. Analysis of impact of capacity liberation
- Number of patients referred back to/subsequently seeking appointment with the GP after seeing the Pharmacist (including by condition) – Analysis of effectiveness of intervention
- Number of inappropriate referrals (including self-referrals) into the scheme and refusals – Analysis of potential "misunderstanding or abuse" of the scheme and adequacy of level of provision
- Number of patients registered with the Pharmacy First scheme – The total number of patients registered with the scheme will be monitored on a regular basis to analyse uptake of the scheme
- Number of patients dealt with by the Pharmacists for each condition – Analysis of the total consultations with the Pharmacists for each condition using the returns supplied by the Pharmacists to identify trends
- Number of items, quantities and costs of medications supplied under Pharmacy First – Analysis by Pharmacy, GP, CCG and NHS England
- Analysis of patient satisfaction and number of patients feeling more empowered to self-care
- Analysis of GP/staff and Pharmacy/Staff satisfaction with the scheme

5. Applicable Service Standards & Accreditation

5.1 Applicable national standards

The pharmacy must have demonstrated best practice in meeting or working towards achieving the standards as set out in the Community Pharmacy Assurance Framework (CPAF) by way of timely e-submission of a fully completed CPAF self-assessment to the NHS Business Services Authority and implementation of improvements as required.

5.2 Applicable standards set out in Guidance

General Pharmaceutical Council standards:

- Standards of conduct, ethics and performance
- Standards for registered pharmacies
- Standards for continuing professional development (CPD)

5.3 Applicable local standards Any adverse incidents reportable under this scheme must be notified within 72 hours of occurrence to **England.medsreporting@nhs.net**

5.4 Accreditation

- The Pharmacy must be approved as included on the relevant Health and Well-Being Board Pharmaceutical List and be located within one of the participating CCG areas.
- The Contractor must ensure that they keep the NHS Choices website accurately updated of

their opening hours and provision of the Pharmacy First LES.

- The Contractor must have demonstrated best practice in meeting or working towards achieving the standards as set out in the Community Pharmacy Assurance Framework (CPAF) by way of timely e-submission of a fully completed CPAF self-assessment template to the NHS Business Services Authority.
- There must be suitable access to a confidential patient consultation room on site to undertake the intervention should this be requested by the patient.
- There are no significant concerns in regards to the way the Contractor has operated previous iterations of the Minor Ailments/Pharmacy First schemes.
- The Responsible Pharmacist in a community pharmacy must have completed CPPE Minor Ailments training. The Contractor must maintain accurate and up-to-date training logs for each member of staff and ensure that a tailored SOP is available and understood by locum pharmacists.
- There are two **optional** CPPE distance learning programmes relating to Minor Ailments Services:
  -Minor Ailments Services: A starting point for pharmacists

  -Minor Ailments Services: Pharmacy technicians leading the way
- Local accreditation will take the form of the Responsible Pharmacist attending an annual training event. The Contractor must also self-certify that they have read and understood this document issued by NHS England as per the sign up process for providing the scheme. It is a mandatory requirement for the Responsible Pharmacist to attend the local training.

The Contractor must ensure that staff members, who are involved in the delivery of the service, receive appropriate training and fully understand how the scheme is to be operated.

6. Service funding and payment mechanism

6.1 The Pharmacy will be paid according to the following components:

1. Consultation fee: £5.00
2. Drug costs: As per Appendix One.

Provided the Pharmacy/Contractor has ensured that PharmOutcomes is maintained and updated at the time of each patient intervention, the system will automatically extract the required information to generate the payment. **Handwritten or separate claims are no longer required and will not be accepted. Pharmoutcomes must be updated by the 1st of every month for upload on the 2nd.** Payments will be made to the participating pharmacy via the Prescription Pricing Authority, itemising the payment made for that month and the bank account. Contractors are advised to retain a copy of the reimbursement form.

6.2 Claims will be processed and paid on a monthly basis. Where Contractors fail to deliver the scheme in line with this specification or fail to ensure that PharmOutcomes is kept updated, they risk not being paid for those interventions.

6.3 Activity under the scheme will be monitored. Any activity deemed at odds with the LES or expected level of dispensing by the pharmacy may result in withholding of payment or ultimately (subject to investigation outcomes) termination of this agreement with immediate effect.

7. Period of Service and Termination

7.1 This Local Enhanced Service will run up until 31st March 2018. No further notice period will be required unless the scheme is terminated before the 31st March 2018 in which case the notice period will be 30 calendar days.

7.2 The exception to the above is where a Contractor fails to meet any of the obligations in this contract. In such circumstances they will be notified in writing of the nature of the breach. Where the breach is not remedied within appropriate time-frames or NHS England deems it is not capable of remedy, NHS England will be entitled to terminate this agreement with immediate effect.

The agreement between the Pharmacy contractor and NHS England in respect to provision of the Pharmacy First Scheme for patients aged 15 and under for the period 1st June 2017 to 31st March 2018 will be made online at the first point of access to the scheme.

The contractor will be required to declare they have read the Pharmacy First Local Enhanced Service Specification (including accreditation requirements as set out in section 5) and agree to provide the service in accordance with this.

Appendix ONE

Formulary Medicine	DT Price
Acute Cough	
Simple Linctus BP s/f (200mls) For Acute Cough	£0.80
Simple Linctus paediatric s/f (200ml pack) For Acute Cough	£1.25
Acute Fever	
Ibuprofen 100mg/5ml s/f suspension (100ml pack) For Acute Fever / Earache	£1.25
Ibuprofen 200mg tabs (24 pack) For Acute Fever / Earache	£0.92
Paracetamol 500mg tablets (32 pack) For Acute Fever / Cold and Flu	£0.70
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu	£1.12
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething	£1.29
Athletes Foot	
Clotrimazole 1% cream (20g pack) for Athletes Foot/ Infected Nappy Rash	£1.12
Acute Bacterial Conjunctivitis	
Chloramphenicol 0.5% Eye Drops (10ml pack) for Acute Bacterial Conjunctivitis	£3.75
Bites and Stings and Allergies	
Hydrocortisone 1% cream (15g pack) For Bites and Stings	£0.90
Mepyramine maleate 2% cream 20g (Antisan)	£2.13
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever	£2.62
Chlorphenamine 4mg tabs (28 pack) for hayfever	£0.76
Cold and Flu	
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething	£1.29
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu	£1.12
Paracetamol 500mg 32 tablets	£0.70
Pseudoephedrine linctus 30mg/5ml 100ml (Sudafed decongestant liquid)	£2.60
Constipation	
Lactulose Liquid (300ml pack) For Constipation	£2.61
Diarrhoea	
Electrolade oral powder multiflavour sachets blackcurrant 6	£1.32
Dry Skin (Simple Eczema)	
Zerobase (500g pack) For Dry Skin / Simple Eczema	£5.26
Zerobase (50g pack) For Dry Skin / Simple Eczema	£1.04
Zeroderm (125g pack) for Dry Skin / Simple Eczema	£2.41
Zeroderm (500g pack) For Dry Skin / Simple Eczema	£4.10
Earache	
Ibuprofen 100mg/5ml s/f suspension (100ml pack) For Acute Fever / Earache	£1.25
Ibuprofen 200mg tabs (24 pack) For Acute Fever / Earache	£0.92
Paracetamol 500mg tablets (32 pack) For Acute Fever / Cold and Flu	£0.70
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu	£1.12
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething	£1.29
Earwax	

Olive Oil Ear Drops (10ml pack) For Ear Wax	£1.40
Hay Fever	
Cetirizine liquid (70ml pack) For Hay Fever	£2.46
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever	£2.62
Cetirizine 10mg tabs (30 pack)	£0.73
Chlorphenamine 4mg tabs (28 pack) for hayfever	£0.76
Loratadine 5mg/5ml syrup 100ml	£1.86
Loratadine 10mg tablets 30	£0.82
Sodium cromoglicate 2% eye drops 5ml (Opticrom Aqueous 2% eye drops 5ml)	£2.35
Infant Decongestant	
Normal Saline Nose Drops 0.9% (10ml pack) For Infant Decongestant	£0.99
Mouth Ulcers and Teething	
Anbesol Teething Gel	£1.33
Paracetamol 120mg/5ml s/f susp100ml	£1.29
Nappy Rash	
Clotrimazole 1% cream (20g pack) for Athletes Foot/ Infected Nappy Rash	£1.12
Conotrane 100g cream	£0.88
Scabies	
Permethrin 5% Dermal Cream (30g pack) For Scabies	£7.46
Chlorphenamine 4mg tabs (28 pack) for hayfever	£0.76
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever	£2.62
Sunburn	
Calamine cream (aqueous) (100g pack) For Sunburn	£1.38
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething	£1.29
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu	£1.12
Paracetamol 500mg 32 tablets	£0.70
Threadworm	
Mebendazole 100mg tablet (1 pack) For Threadworm	£2.03
Oral Thrush	
Miconazole 2% Oromucosal Gel (15g pack) For Oral Trush	£3.23
Warts and Verruca's	
Salactol Topical Paint (10ml pack) For Warts and Verrucas	£1.71

ACUTE COUGH

Definition	**Coughing arising from a defensive reflex mechanism. The cough may be productive (chesty) where phlegm is produced or non-productive (dry), with no phlegm.**		
Criteria for Inclusion	Child presenting with onset of cough within the last seven days. Children under 1 year can be treated at the pharmacist's discretion.		
Exclusion Criteria	Severe pain when coughing - including chest or shoulder pain		
	Presence of blood in phlegm		
	Presence of green/rusty phlegm		
	Asthmatic patients reporting wheeze or shortness of breath or those with severe disease. Check for worsening symptoms of asthma.		
	If cough symptoms have persisted beyond 7 days, No sign of improvement after 3 - 4 weeks or continual worsening of symptoms		
	Breathing difficulty		
	Pain related to exertion		
	Moderate to severe hepatic or renal impairment.		
	Unexplained weight loss – Presenting over the previous 6 weeks		
	Voice changes – Hoarseness lasting from more than 3 weeks or continuing after the cough has settled		
	New lumps or swellings – Located anywhere in the neck or above the collarbone		
	Wheezing		
	Recurrent night time cough		
Action for Excluded patients:	Refer to GP		
Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage			
Drug	**Route**	**Class**	**Dose**
Simple linctus s/f paediatric (200ml) 1-5 years	**PO**	**GSL**	**5-10ml three times daily when required**
Simple linctus BP (200ml) 6-16 years	**PO**	**GSL**	**5mls three times daily when required**
Follow Up and Advice		**Side effects and Management**	
Maintain good fluid intake		-	
Try simple home remedies, such as 'honey and lemon'			
Avoid a smoky atmosphere.			
Rest			
Take paracetamol for associated symptoms e.g. temperature, aches and pains			
Supply patient information leaflet			
Advise on likely course of cough			
No need for antibiotics- antibiotics do not work against viral infections			
When to refer			
Conditional referral			
General aches and pain , sore throat, sneezing or runny nose – probably a viral infection			
If cough persists beyond two weeks			
Tender swellings around the jaw and neck – probably swollen glands (analgesic and plenty of cool drinks)			
Fever (refer to acute fever protocol)			
If the cough does not improve over a few days, gets worse, or they develop warning symptoms			
Rapid Referral			
Severe shortness of breath or a blue tinge to the lips or severe pain in the chest – Dial 999			
Toxic fumes such as ammonia or industrial chemicals have recently been breathed in – call NHS 111 or contact the GP			
Very high temperature or shortness of breath along with a cough should be referred to rule out a diagnosis of pneumonia			
Fit of coughing due to obstruction of the airways (e.g. after swallowing food) – call NHS 111 or contact the GP			

ACUTE FEVER

Definition	**Feeling of hotness in the body and temperature in excess of the normal (over 38°C /100.4F). Symptoms may include flushing and feeling sweaty.**
Criteria for Inclusion	Child presenting with feeling of hotness, flushing or feeling sweaty. Children under 1 year can be treated at the pharmacist's discretion.
	Children under 5 years – refer to NICE guidance
	SEE BELOW FOR FURTHER GUIDANCE FOR FEVER IN CHILDREN
Exclusion Criteria:	Shortness of breath or difficulty in breathing
	Concomitant rash that does fade on pressing with glass
	Severe headache or continuous vomiting
	Ibuprofen contra-indicated in patients with hypersensitivity to NSAIDs
	Worsening of asthma symptoms with NSAID previously
	A body temperature over 38°C in children age 0-3 months or over 39°C in children age 3-6 months.
	A child brings up dark-green vomit.
	If a child looks pale, ashen, mottled or blue.
	Premature child - Child born prematurely and less than 3 months of age
	Response - Child does not respond normally and wakes only with difficulty, appears ill or does not smile
	Unusual crying - Cries in an unusual way – weak, high pitched or continuous cry
	Breathing - Breathing much faster than usual, flared nostrils, skin between the ribs or the area just below the rib cage moves abnormally during breaths
	Abnormal grunting
	Hydration - Child does not eat or drink much and does not pass much urine, nappies remain dry, fontanelle is bulging or sunken
	Non-blanching rash – rash that does not fade on pressure
	Other signs - Neck stiffness (not being able to touch chin to chest), cold limbs or fitting, other unexplained or unusual symptoms
	As per NICE guidelines enclosed for children under 5 years
Action for Excluded patients:	**Refer to GP or NHS 111**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months			**60mg four times a day when required**
6-24 months			**120mg four times a day when required**
2-4 years			**180mg four times a day when required**
4-6 years			**240mg four times a day when required**
Paracetamol suspension s/f 250mg/5ml	**PO**	**P**	
6-8 years			**250mg four times a day when required**
8-10 years			**375mg four times a day when required**
10-15 years			**500mg four times a day when required**
Paracetamol tablets 500mg (32 tabs)	**PO**	**GSL**	
12-15 years			**500mg four times a day when required**
Ibuprofen oral suspension s/f 100mg/5ml (100ml)	**PO**	**P**	
1-3 years			**100mg three times daily**
4-6 years			**150mg three times daily**
7-9 years			**200mg three times daily**
10-12 years			**300mg three times daily**
Ibuprofen tabs 200mg (32)	**PO**	**P**	
12-16 years			**200-400mg three times daily**
Follow Up and Advice		**Side effects and Management**	

Use regular analgesic to reduce the temperature Increase fluid intake Wear light clothing	Very rare with paracetamol but rashes and blood disorders reported. If affected patients should stop paracetamol immediately and contact their GP.
Make sure that the room temperature is not too warm Check your child at night for signs of serious illness	Ibuprofen – Side effects include GI irritation, hypersensitivity reactions (rashes, bronchospasm or angiooedema), and fluid retention. If side effects occur advise patient to stop ibuprofen and contact their GP or pharmacist.
When to refer	
Conditional referral	
General aches and pain, sore throat, sneezing or runny nose – probably a viral infection	
Earache (refer to management of earache protocol)	
Diarrhoea (refer to management of acute diarrhoea protocol)	
Tender swellings around jaw and neck – probably swollen glands (analgesic + plenty of cool drinks)	
Consider supply, but patient should be advised to make an appointment to see a GP if:	
Patient is difficult to wake, not keeping fluids down or light hurts the eyes	
Fever has lasted more than 5 days	
Difficulty in breathing	
Patient has recently travelled abroad	
Severe headache or continuous vomiting	
New symptoms develop or existing symptoms worsen	
Rapid Referral	
Concomitant rash that does not fade on pressing with glass.	
Feverish illness in children	
Drug interventions to reduce body temperature	
Consider using either paracetamol or ibuprofen in children with fever who appear distressed.	
Do not use antipyretic agents with the sole aim of reducing body temperature in children with fever.	
When using paracetamol or ibuprofen in children with fever: continue only as long as the child appears distressed consider changing to the other agent if the child's distress is not alleviated.	
Do not give both agents simultaneously, only consider alternating these agents if the distress persists or recurs before the next dose is due.	
Advise parents or carers looking after a feverish child at home:	
Check the child's temperature In children aged between four weeks and five years, use either an electronic or chemical dot thermometer in the child's arm pit, or an infra-red tympanic thermometer in the ear canal.	
To offer the child regular fluids (where a baby or child is breastfed the most appropriate fluid is breast milk)	
How to detect signs of dehydration by looking for the following features:	
sunken fontanelle	
dry mouth	
sunken eyes	
absence of tears	
poor overall appearance	
to encourage their child to drink more fluids and consider seeking further advice if	
they detect signs of dehydration	
How to identify a non-blanching rash	
To check their child during the night for signs of serious illness	
To keep their child away from nursery or school while the child's fever persists but to notify the school or nursery of the illness.	
Following contact with a healthcare professional, parents and carers who are looking after their feverish child at home should seek further advice if:	
The child has a fit	
The child develops a non-blanching rash	
The parent or carer feels that the child is less well than when they previously sought advice	
The parent or carer is more worried than when they previously sought advice	
The fever lasts longer than 5 days	
The parent or carer is distressed, or concerned that they are unable to look after their child.	

A summary of prescribing recommendations from NICE guidance

Feverish illness in children

NICE CG160: 2013

This guideline covers the assessment and initial management of children <5 years old with feverish illness.

Definition of terms

Fever	a rise in body temperature above the normal daily variation
BP	blood pressure
RR	respiratory rate

Detection of fever

- Do **NOT** routinely use oral and rectal routes to measure body temperature in children aged 0 to 5 years.
- To measure body temperature in children:
  - < 4 weeks old: use an electronic thermometer in the axilla (armpit),
  - aged 4 weeks to 5 years: use an electronic or chemical dot thermometer in the axilla **OR** an infra-red tympanic thermometer.
- Parental reports of fever should be considered valid and taken seriously by health professionals.

Clinical assessment

- Assessment should consist of three stages:
  - first check for any immediately life-threatening features (compromised Airways, Breathing or Circulation, and Decreased level of consciousness).
  - use the traffic light system to assess the presence or absence of any signs/symptoms of serious illness,
  - look for a source of fever and check for symptoms and signs that are associated with specific diseases – see NICE pathway.
- Measure and record temperature, heart rate, respiratory rate and capillary refill time as part of routine assessment.
- Recognise that a capillary refill time of ≥3 seconds is an intermediate-risk marker for serious illness ('amber').
- Measure BP if the heart rate or capillary refill time are abnormal and facilities to measure BP are available.
- Do **NOT** use height of body temperature alone to identify those with serious illness in children >6 months old.
- Do **NOT** use duration of fever to predict the likelihood of serious illness. Children with a fever lasting >5 days should be assessed for Kawasaki disease.
- Recognise that children:
  - <3 months old with a temperature of ≥38°C are at high-risk for serious illness,
  - aged 3 to 6 months with a temperature of ≥39°C are at least at intermediate-risk for serious illness,
  - with tachycardia are at least at intermediate-risk for serious illness.
- Assess for signs of dehydration – see Box 1 (over page)

Traffic light system – see Table 1

- **High risk**: children with fever and any of the signs or symptoms in the **RED** column.
- **Intermediate risk**: children with fever and any of the signs or symptoms in the **AMBER** column and **NONE** in the **RED** column.
- **Low risk**: children with fever and any of the signs or symptoms in the **GREEN** column and **NONE** in the **AMBER/RED** column.

See NICE pathway: Feverish illness in children

Table 1: Traffic light system

	GREEN Low-risk	AMBER Intermediate risk	RED High risk
Colour	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: RR >50 breaths/minute age 6 to 12 months, RR >40 breaths/minute age >12 months • Oxygen saturation ≤95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR >60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: >160 beats/minute age <12 months,>150 beats/minute age 12 to 24 months, >140 beats/minute age 2 to 5 years, • Capillary refill time ≥3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3 to 6 months, temperature ≥39°C • Fever for ≥5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age <3 months, temperature ≥38°C • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

Athlete's Foot

Definition	**Athlete's foot is a cutaneous fungal infection caused by Tinea Pedis on the skin. It is characterized by itching, flaking and fissuring of the skin, often between the toes**
Criteria for Inclusion	A suspected symptomatic fungal infection of the foot which is characterised by macerated skin between the toes. Often this is associated with itchiness. Children aged under 1 year can be treated at the Pharmacists discretion.
Criteria for Exclusion	If toenails are black and discoloured If fungal infection has spread under the nails If the fungal infection has spread to other parts of the body If unsure if it is athlete's foot (e.g. possibility of eczema, psoriasis etc.) Diabetes
Action for Excluded patients:	Patients may be referred to a to a GP practice if considered necessary by the pharmacist.

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	**Route**	**Class**	**Dose**
Clotrimazole 1% cream 20g	**Topical**	**P**	Apply twice daily and continue for 2 weeks after infection clears

Follow Up and Advice	**Side effects and Management**
Make an appointment to visit the GP Practice if symptoms do not resolve within 7 days	Redness, itching and scaling. Rarely allergic reaction. If this occurs discontinue treatment
Cream may sting on application	
To be applied thinly	
Advise patient to use dusting powder in shoes and socks as an additional measure	
Wash and dry feet thoroughly, especially between the toes.	
Wearing clean wool or cotton socks allows the skin to breathe and can reduce the moisture that is kept in contact with the skin.	

When to refer:
Conditional referral:
On 3rd occurrence
Consider supply, but advise patient to make an appointment with the GP if the patient has or is suspected of having any of the following:
Eczema/Psoriasis
Diabetes
Candidiasis
Bacterial Infection
Rapid referral:
Signs of generalised infection especially if immunocompromised
Toenails becoming black or discoloured
If fungal infections start to spread under the nails or to other areas of the body

Bacterial Conjunctivitis (Acute)

Definition	Acute inflammation of the conjunctiva. An infectious condition usually affecting both eyes.
	Patients with bacterial conjunctivitis may present with the following symptoms; Creamy white or yellow discharge, swelling, redness, watering eyes, irritated and/or a gritty feeling.
Criteria for Inclusion	Patients presenting with symptoms of bacterial conjunctivitis.
Criteria for Exclusion	Children under 2 years old.
	Patients presenting with symptoms of conjunctivitis, which are accompanied by pain, and/or disturbance of vision and patients with allergic conjunctivitis.
	Patients with glaucoma, dry eye syndrome or those patients who have had eye surgery or laser treatment in the past six months.
	Foreign body in the eye, pupil looks unusual, associated pain, swelling or redness around the eye
	Patients with contact lenses are prone to infections and should be referred to an optometrist or doctor. Contact lenses should not be worn during an eye infection and soft contact lenses should not be worn for 24 hours after the course of chloramphenicol drops is complete.
	Known hypersensitivity to chloramphenicol
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist.

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Chloramphenicol 0.5% eye drops	**Topical**	**P**	**Child over 2 years** - One drop to be instilled every two hours for the first 48 hours, then one drop every four hours for a further three days. **USED DURING WAKING HOURS ONLY** - Total of 5 days

Follow Up and Advice	**Side effects and Management**
Inform the patient about how to instil the eye drops. Provide a PIL.	Serious side effects include hypersensitivity reactions, and treatment must be discontinued in such cases.
The importance of good hygiene should be stressed including the following; washing the hands before and after touching an infected eye, not to share towels, facecloths or make-up as this will help to minimise the spread of this infectious condition.	sensitivity reactions such as irritation, burning, stinging, itching or dermatitis
Discard the remaining chloramphenicol after the 5-day treatment course.	the medicine may become less effective or cause sensitisation during prolonged use
If the symptoms do not improve within two days of treatment, the patient should be referred to an optometrist or doctor.	
The patient should be advised to wash their hands before and after administration of the eye drops.	

When to refer

Conditional referral

If the symptoms do not improve within two days of treatment, the patient should be referred to an optometrist or doctor

Rapid referral

If the symptoms do not improve within two days of treatment, the patient should be referred to an optometrist or doctor

Patients with associated vesicular rash which may indicate herpes zoster infection
Patients with affected vision or severe pain in the eye
Patients with glaucoma or dry eye syndrome
Patients who have had eye surgery or laser treatment in the past 6 months
Features of a serious cause of “Red eye” e.g. photophobia, irregular pupil shape, severe pain
Copious discharge (that re-accumulates after being wiped away), which may indicate hyper-acute conjunctivitis

Bites and Stings

Definition	Irritation and inflammation where the skin has been bitten, small extremely itchy popular lesions usually seen
Criteria for Inclusion	Patients bitten or stung by small insects, displaying localised minor irritation to the skin
Criteria for Exclusion	Children under 2 years old
	Bites or stings around the eyes or on the face
	Bites or stings which have become infected
	Pregnancy
	Patients exhibiting systemic effects, e.g. wheezing, shortness of breath, major swelling & redness
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Hydrocortisone 1% cream (15g)	Topical	P	**Children over 10 years**- apply sparingly twice a day for seven days
Chlorphenamine 4mg tabs (x28)	PO	P	**Children over 12 years old**: One tablet four times a day
Chlorphenamine syrup 2mg/5mls s/f 150mls	PO	P	**Child 1 –2 years:** 1 mg twice daily
			Child 2–6 years: 1 mg four times daily
			Child 6–12 years 2 mg four times daily
Mepyramine maleate 2% cream (20g)	Topical	GSL	**Children over 2 years**: Apply three times a day for 3 days

Follow Up and Advice	**Side effects and Management**
A cold compress can reduce pain and swelling Repeated application of mepyramine cream 2% to the same area for longer than three days is not recommended Wash the affected area frequently with soapy water to prevent infection Avoid insect bites by wearing loose clothing with long arms and legs Educate children to avoid unknown insects For bee stings, scrape out the sting	Hydrocortisone cream should not be applied to the face, ano-genital region, broken or infected skin. Sensitivity to hydrocortisone cream - discontinue treatment

When to refer

If symptoms persist for more than 7 days

Patients exhibiting systemic reactions.

Patients experiencing severe allergic reactions must be referred to A&E.

Patients should be advised to seek further assistance from NHS 111 or GP if symptoms worsen

COLD AND FLU

Definition	**Nasal congestion, sneezing, mild temperature, sore throat, general aches and pains are associated with the common cold. Refer to other relevant protocols as appropriate.**
Criteria for Inclusion	Children presenting with cold or flu-like symptoms. Children under 1 yr can be treated at the pharmacist's discretion.
Criteria for Exclusion	Concomitant rash that does not fade under pressing e.g. with glass Patient is breathless, Light hurts the eyes It is painful to bend the neck Raised temperature - Persistent raised temperature - (39°C and above) for longer than 3 days Severe headache with vomiting or severe earache Hearing - Problems develop with hearing Confusion - Experiencing confusion or is disorientated Coughing blood - Coughing up blood/blood stained mucus on more than one occasion Chest pain Severe difficulty swallowing or breathing difficulties Swelling of lymph nodes in neck and/or armpits Particular care should be taken in those who have diabetes, heart disease, respiratory problems including COPD, kidney disease, and those with a compromised immune system
Action if Excluded	**Refer to GP**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Paracetamol suspension s/f 120mg/5ml (100ml)	**po**	**P**	
3 months – 6 months			**60mg four times daily when required**
6-24 months			**120mg four times daily when required**
2-4 years			**180mg four times daily when required**
4-6 years			**240mg four times daily when required**
Paracetamol suspension s/f 250mg/5ml	**po**	**P**	
6-8 years			**250mg four times daily when required**
8-10 years			**375mg four times daily when required**
10-15 years			**500mg four times daily when required**
Pseudoephedrine Linctus 30mg/5ml (100ml)	**po**	**P**	
6-12 years			**5ml three -four times daily when required**
12 - 15 years			**10ml three-four times daily when required**
Paracetamol tablets	**po**	**GSL**	
12-15 years			**500mg four times daily when required**

Follow Up and Advice	**Side effects and Management**
Simple analgesics to bring temperature down Maintain a good fluid intake Encourage rest (if possible) Warm soothing drinks Common cold does not require antibiotics for effective treatment Remind high risk patients of influenza vaccination programmes Protect yourself and others against cold and flu by taking the following actions: Wash your hands regularly and properly especially after touching your nose or mouth and before handling food Always sneeze and cough into tissues, use disposable paper towels to dry your hands and face rather than shared towels Clean surfaces regularly Drink – Drink plenty of fluids and get plenty of rest	Very rare with paracetamol but rashes and blood disorders reported. If affected patient should stop paracetamol immediately and contact their GP.
When to refer	

Conditional referral
If symptoms worsen or sinus pain develops
Patient becoming breathless
Painful to bend the neck or light hurts the eyes
Rapid Referral
Development of a rash that does not fade when you press a glass tumbler against the rash

Constipation

Definition	**A reduced frequency of stools compared to the patient's normal bowel habits/ difficulty in passing stools or a sense of incomplete emptying after a bowel movement and abdominal discomfort**
Criteria for Inclusion	Significant variation from normal bowel evacuation which has not improved following adjustments to diet and other lifestyle activities (see below)
Criteria for Exclusion	New or worsening constipation with no explanation Nausea/vomiting Children under 1 year of age Rectal bleeding with change in bowel habit Severe abdominal pain Unintentional weight loss Co-existing diarrhoea Tenesmus (cramping rectal pain, giving the feeling that you need to have a bowel movement) Patients currently taking regular laxatives. Failure of previous medicines
Action for Excluded patients:	**Refer to GP**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

If constipation is confirmed, and underlying conditions are reasonably excluded, the first step in the management of constipation should be appropriate dietary and lifestyle changes. If this is ineffective or impractical, a short course of laxatives may relieve symptoms and restore normal bowel function.

Drug	**Route**	**Class**	**Dose**
Lactulose (300ml)	**PO**	**P**	
1 year - 6 years			**2.5ml – 10ml twice daily**
7 years - 14 years			**10ml - 15ml twice daily**

Follow Up and Advice	**Side effects and Management**
Drink plenty of water	Advise patient that Lactulose may take up to 48hrs to work
Eat food rich in fibre e.g. fruit, vegetables	Flatulence may occur initially
Take regular exercise	

When to refer
Pregnancy and breastfeeding
Laxative dependence
Non responsive to treatment
Conditional referral
If constipation persists beyond one week, consult the GP
If more than one request per month
Rapid Referral
New or worsening constipation without explanation
Symptoms of blood in the stools, unexplained weight loss and nausea and vomiting, severe abdominal pain

DIARRHOEA

Definition	**Loose and/or watery motions occurring more than three times over 24 hours with or without fever or abdominal pain**
Criteria for Inclusion	Children presenting with signs and symptoms of diarrhoea. Children under 1 yr can be treated at the pharmacist's discretion.
Criteria for Exclusion	Dehydration drowsiness or confusion passing little urine dry mouth and tongue sunken eyes weakness cool hands or feet sunken fontanelle in babies/young infants Child appears very poorly with or without high fever Bloody diarrhoea with or without mucus Recent travel Frequent episodes of diarrhoea
Action for Excluded patients:	Refer to GP or NHS 111 Where applicable, continue breast feeding Continue to offer as much fluids or oral rehydration fluids as possible For older children, avoid solid foods until appetite returns Avoid cows milk until diarrhoea settles down Refer to GP where new medicines have been started in last two weeks and are suspected to be causing diarrhoea

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Electrolade sachets	PO	GSL	
1 month to under 2 years	PO	GSL	1 sachet in 200mls boiled and cooled water - give 1- 1.5 times usual feed volume of solution
2 years - under 12 years	PO	GSL	1 sachet in 200mls boiled and cooled water every loose motion. Max 12 in 24 hours.
12 years - 16 years	PO	GSL	1- 2 sachets in 200 mls boiled and cooled water after every loose motion. Max 16 in 24 hours.

Follow Up and Advice	**Side effects and Management**
Simple analgesics to bring temperature down	
Maintain a good fluid intake	
Encourage rest (if possible)	
If a high temperature develops and persists, or there is dehydration, or the condition deteriorates then refer to GP or contact NHS 111	
Avoid cows milk until diarrhoea settles down	
Eat as normally as possible. Ideally include fruit juices and soups, which will provide sugar and salt, and also foods that are high in carbohydrate, such as bread, pasta, potatoes, or rice. There is little evidence to support the advice which used to be the given to avoid solid food for 24 hours.	
Always wash your hands after going to the toilet (or changing nappies).	

When to refer
Conditional referral
Bloody diarrhoea with or without mucus
Poorly child
Consider supply, but patient should be advised to make an appointment to see a GP if:
Where patient is becoming dehydrated, showing high temperature, provide Electrolade sachets and advise on additional fluids and rest If diarrhoea has lasted over 48 hours and appears to be getting worse Poorly child Recent travel Frequent episodes of diarrhoea
Rapid Referral
If child is very ill then refer to GP or Paediatric Assessment Unit

DRY SKIN / SIMPLE ECZEMA

Definition	Common dry skin conditions include simple eczema (dermatitis). Eczema is used to describe an inflammation of the skin, which causes dry, flaky skin. There is often itching which causes scratching leading to redness, breaking of the skin and soreness. Severe eczema may begin to weep where the epidermis is severely damaged. Emollients reduce water loss from the epidermis and make the skin softer and suppler. Regular use of emollients may reduce flare-ups of eczema and the need for topical cortisosteroids.
Criteria for Inclusion	Children presenting with symptoms of dry skin or simple eczema. Children under 1 yr can be treated at the pharmacist's discretion.
Criteria for Exclusion	Cracking, weeping and painful skin may suggest infection.
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Zerobase 50g,500g	**topical**	**GSL**	The cream should be applied to the dry skin areas as often as is required.
Zeroderm 125g,500g	**topical**	**GSL**	As an emollient: Apply to the affected area as often as required. Smooth gently into the skin, following the direction of the hair growth. As a bath additive: Melt about 4g in hot water in a suitable container then add to the bath. As a soap substitute: Take a small amount of the ointment and lather it under warm water and use as required when washing or in the shower. Pat skin dry.

Follow Up and Advice	**Side effects and Management**
Emollients should be applied as liberally and as frequently as possible Emphasise regular emollient use after skin washing and instead of soap Avoid or minimise the use of soap and detergents as they remove lipids from the skin and may exacerbate dry skin conditions Advise patients to avoid irritants if possible - common irritants include water (e.g. wet work), soaps, detergents, solvents, metal-working fluids, dust and friction. Advise patients to avoid allergens if possible - common allergens include metal (e.g. nickel, chromate), perfumes, rubber, latex and preservatives. Advise patients to keep nails short and avoid scratching Avoid excessive heat Further information can be obtained from the National Eczema Society(www.eczema.org) Also see NICE guidance on Atopic Eczema in Children (www.nice.org.uk)	Certain ingredients found in emollients can rarely cause problems for individual patients – see BNF for list. Preservatives are more likely to be present in creams than in ointments. The actual preservative used may differ If allergy to an excipient is suspected advise the patient to stop using the emollient concerned and contact their GP. Patients should be made aware of the potential dangers of slipping in the bath if emulsifying ointment is used as a bath emollient – the use of a bath mat may reduce this risk.

When to refer

Conditional referral

Patients with physical signs of infection such as sore pus spots (Staph. Aureus may trigger or complicate eczema flare-up and may require a short course or oral antibiotics e.g. flucloxacillin)
Exacerbations of eczema – may require topical corticosteroids on an acute basis (3-7 days for acute eczema and up to 2-3 weeks to gain remission in chronic eczema)
If eczema is causing severe psychological or social problems e.g. school absenteeism

Consider supply, but patient should be advised to make an appointment to see a GP if:

Dry skin or simple eczema is not responding to emollients or condition is worsening. Investigate and encourage regular use of emollients.

Rapid Referral

The development and rapid spread of vesicles, blisters and erosions- suggests eczema herpeticum (caused by dissemination of herpes virus in the skin) and requires treatment with a systemic antiviral agent.

EARACHE

Definition	Common problem particularly in children caused by a viral or bacterial infection of the middle ear. Children can become irritable, experience pain or pressure in the ear and have problems sleeping, feeding and hearing. Other symptoms similar to those of a cold or runny nose may also occur.
Criteria for Inclusion	Children presenting with symptoms of earache. Children under 1 year can be treated at the pharmacist's discretion.
Criteria for Exclusion	Pain in the teeth or jaw. Pain after attempt to clean wax with finger or similar object Discharge from the ear. Pain not helped by analgesics such as paracetamol when taken for 1-2 days Children under the age of 3 months
Action for Excluded patients:	Refer to GP or NHS 111

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months			**60mg four times daily when required**
6-24 months			**120mg four times daily when required**
2-4 years			**180mg four times daily when required**
4-6 years			**240mg four times daily when required**
Paracetamol suspension s/f 250mg/5ml	**PO**	**P**	
6-8 years			**250mg four times daily when required**
8-10 years			**375mg four times daily when required**
10-15 years			**500mg four times daily when required**
Paracetamol tablets 500mg (32 tabs)	**PO**	**GSL**	
12-15 years			**500mg four times daily when required**
Ibuprofen oral suspension s/f 100mg/5ml (100ml)	**PO**	**P**	
1-3 years			**100mg three times daily**
4-6 years			**150mg three times daily**
7-9 years			**200mg three times daily**
10-12 years			**300mg three times daily**
Ibuprofen tabs 200mg (32)	**PO**	**P**	
12-16 years			**200-400mg three times daily**

Follow Up and Advice	**Side effects and Management**
Maintain good fluid intake. Continue to encourage children to eat adequately. Give doses after food. Rest (if possible). Dress children in light clothes (avoid overheating) Keep children away from smoky environments. Encourage simple hygiene measures – wash hands regularly, use tissues and dispose of them after use. **Avoid sticking anything into the ear -** Do not 'clean' the ear out by sticking anything in it, i.e. cotton buds, pencils, fingers etc. as this may damage the ear further Antibiotics only help in a few patients and overuse leads to build up of resistance. Recent evidence suggests that children with high temperature or vomiting were more likely to benefit from antibiotics, although it is still reasonable to wait 24-48 hours as many children will settle anyway (BMJ 2002;325:22)	Very rare with paracetamol but rashes and blood disorders reported. If affected patient should stop paracetamol immediately and contact their GP.

When to refer

Conditional referral

Children with symptoms not responding to analgesics – within 1-2 days for children over 2 years
Children or adults with worsening symptoms. Neck stiffness
Children with high temperature or vomiting after 48 hours of symptomatic relief
Tinnitus (ringing) or vertigo (disrupted sense of movement**)**

Consider supply, but patient should be advised to make an appointment to see a GP if:

New symptoms develop (could also contact pharmacist or NHS 111)
Hearing becomes dull

Rapid Referral

Pain in teeth or jaw – could be dental abscess or a bad tooth
Pain after attempt to clean ear – may have damaged lining of ear or possibly the eardrum
Very severe pain, vomiting or yellow discharge – could be middle ear infection

Earwax

Definition	Build up of the natural protective oily/waxy substance in the ear causing hearing loss		
Criteria for Inclusion	Child presenting with Blocked ears and hearing loss.		
Criteria for Exclusion	Patients with a temperature and/or severe pain		
	Otitis Externa		
	Foreign bodies within ear canal		
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist.		
Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage			
Drug	**Route**	**Class**	**Dose**
Olive Oil ear drops + Dropper – 10mL	**Aural**	**GSL**	Fill your ear with (room temperature) oil and stay in that position for 5-10 minutes. Do not put any cotton wool in your ear, as this will absorb the oil and stop it from working into the wax. After 5-10 minutes, sit up, holding a tissue to your ear to catch the oil as it runs out of your ear

Follow-up and Advice	**Side effects and Management**
Use at room temperature	
If ears are still blocked, ear irrigation (syringing) may be needed.	
Advise that earwax is normal but sometimes builds up causing symptoms	
Advise not to poke or clean ears with cotton buds or similar objects (using cotton buds to clean the ear canal can force wax further down the canal to form a plug against the ear drum)	
Syringing may be necessary if treatment fails to break up wax	
When to refer	
Consider supply, but patient should be advised to make an appointment to see their GP if:	
Symptoms are severe	
Rapid referral:	
Foreign body in the ear canal	

HAY FEVER

Definition	Seasonal allergic rhinitis characterised by nasal congestion, excessive sneezing, watery and itchy eyes. Itching can also occur in the nose, throat, mouth and ears. Congestion may interfere with sleep.
Criteria for Inclusion	Children over 1 years or adults presenting with symptoms of hay fever requiring symptomatic treatment
Criteria for Exclusion	Children under 1 years
	If symptoms occur in a particular place e.g. workplace or near animals (consider allergy to dust, animal droppings, plants, etc)
	If symptoms develop when patient is at home (consider allergy to house dust mites
Action for Excluded patients:	**Refer to GP**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Chlorphenamine s/f syrup 2mg/5ml (150ml)	**PO**	**P**	**1-2 years –** 1mg twice daily
			2-5 years 1mg every 4-6 hours – Maximum 6mg daily
			6-12 years 2mg every 4-6 hours – Maximum 12mg daily
Chlorpheniramine tablets 4mg (30 tabs)	**PO**	**P**	**12 years and over** 4mg every 4-6 hours – Maximum 24mg daily
Cetirizine tablets 10mg	**PO**	**P**	**Over 6 years** 10mg daily or 5mg bd
Cetirizine s/f liquid 5mg/5ml	**PO**	**P**	**2-6 years** 5mg daily or 2.5 mg bd
Loratidine tablets 10mg	**PO**	**P**	**Over 6 years** 10mg daily or 5mg bd
Loratidine liquid 5mg/5mls	**PO**	**P**	**2-6 years** 5mg daily or 2.5 mg bd
Sodium Cromoglycate 2% eye drops	**Gutte**	**P**	**Over 2 years -** 1-2 drop(s) four times a day

Follow Up and Advice	**Side effects and Management**
Not to exceed maximum doses Pollen avoidance measures – watch out for pollen counts e.g. newspapers, TV weather reports Possible drug interactions – check for any concomitant medication Advise patient not to exceed recommended dose.	Drowsiness. More so with chlorphenamine – Drowsiness may diminish after a few days of treatment. Other side-effects include antimuscarinic effects (urinary retention, dry mouth, blurred vision and GI disturbance) If patients experience side-effects, discontinue treatment immediately and contact their GP Side -effects can be reduced by dividing the dose.

When to refer

Conditional referral

If treatment is ineffective or persists after the end of September (please note that hay fever can sometimes persist beyond September)

Consider supply, but patient should be advised to make an appointment to see a GP if:

If new symptoms develop (could also contact NHS 111 or their pharmacist) that are worrying to the patient, e.g. epistaxis

Rapid Referral

If the patient has difficulty in breathing

Infant Congestion

Definition	Blocked stuffy nose with difficulty breathing through the nose
Criteria for Inclusion	Child presenting with blocked nose
Criteria for Exclusion	Saline solutions can be used safely by anyone
Action for Excluded patients:	Refer to GP if problem persists

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Normal saline Nose drops 0.9% 10ml	**nasal**	**GSL**	1 or 2 drops in each nostril

Follow Up and Advice	Side effects and Management
Saline nasal drops may help thin and clear nasal secretions in infants who are having difficulty with feeding and should be administered immediately before feeding	

When to refer

If symptoms worsen or sinus pain develops, consult GP

Mouth Ulcers & Teething

Definition	A mouth ulcer is any ulcerative lesion affecting the oral mucosa, mostly occur on the inner cheek, inner lip, tongue, soft palate, floor of the mouth, and sometimes the throat. They are usually about 3-5mm in diameter. Teething is a normal physiological process in which deciduous teeth (milk teeth or baby teeth) emerge through the gums starting around 6 months of age (although the onset of teething may be earlier or later, usually between 4 and 12 months). A full set of milk teeth is usually present by the time the child reaches 2–3 years of age.
Criteria for Inclusion	Patients requiring symptomatic relief
Criteria for Exclusion	Ulceration that has persisted for more than 3 weeks or is very red, painful and swollen.
	Immunocompromised patients
	Temperature above 38^0C
	Oral Candiastasis
	Recurrent or multiple ulcers
	Any sore that bleeds easily
	Consider referral to GP for babies/children with oral problems
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	**Route**	**Class**	**Dose**
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months			**60mg four times daily when required**
6-24 months			**120mg four times daily when required**
2-4 years			**180mg four times daily when required**
4-6 years			**240mg four times daily when required**
Anbsesol teething gel (10g)	**Topical**	**P**	**Apply a small amount to the affected area with a clean fingertip. Two applications immediately will normally be sufficient to obtain pain relief. Use up to four times a day.**

Follow Up and Advice	**Side effects and Management**
Suggest the patient limits the use of sharp foods (e.g. crisps), spicy foods, hot fluids and carbonated drinks	
Try not to touch the oral mucosa with the nozzles of topically applied products as this may cause contamination	
Advise patients to wash hands before and after each application	
Good oral hygiene may help in the prevention of some types of mouth ulcers or complications from mouth ulcers.	
Avoid precipitating factors, for example, by use of a softer toothbrush.	

When to refer
If ulcer persists for more than 3 weeks then the patient should be referred to their doctor or dentist for further investigation.
Difficulty in swallowing or chewing not associated with a sore lesion
Any sore that bleeds easily

Nappy Rash

Definition	Nappy rash is an irritant contact dermatitis confined to the nappy area. A painful and raw area of skin around the anus and buttocks due to contact with frequent irritant stools, or reddening over the genitals and napkin area due to urine soaked napkins.
Criteria for Inclusion	Mild to moderate red rash or sore skin confined to the nappy area
Criteria for Exclusion	Infants with a fungal infection (characterised by a bright red rash which extends into the folds of the skin). Infants with a bacterial infection of the skin – may be accompanied by fever. Broken skin. Severe, prolonged or recurrent fungal infection Nappy rash accompanied by oral thrush Ulceration of affected area Nappy rash that is causing discomfort
Action for Excluded patients:	**Refer to GP**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Conotrane 100g	**Topical**	**GSL**	**Apply after nappy change**
Clotrimazole 1% cream 20g	**Topical**	**P**	**Apply thinly twice daily and continue for 2 weeks after infection clears for children aged 1 year and over. At Pharmacist discretion to treat if candida infection is suspected, refer to GP.**

Follow Up and Advice	**Side effects and Management**
If candida infection: not to use a barrier cream until after infection has settled	Sensitivity to Imidazole's - discontinue use and refer to GP
Increase frequency of nappy changes	
Expose skin to fresh air	

When to refer GP
Signs of infection
Infant with rash and satellite lesions
Nappy rash that is a bright shade of red, very warm or swollen
Baby has a high temperature or seems distressed, in addition to the nappy rash.

Scabies

Definition	Contagious and intensely itchy skin infestation caused by a mite. Sites usually affected include; finger webs, wrists and palms of hands, soles of feet and external genitalia in both sexes which can lead to severe itching
Criteria for Inclusion	Intense itching and/or rash, generally symmetrical on the body.
	The skin develops thick crusts which are highly contagious
	Patients infested with scabies and symptomatic close contacts
Criteria for Exclusion	Immunocompromised patients. Infants and children below two years old.
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Permethrin 5% dermal cream	**Topical**	**P**	**Children aged 2 and over:** apply to the whole body and wash off after 8-12 hours; if hands are washed with soap within 24 hours, they should be retreated. Larger patients may need 2 x 30g packs
Chlorphenamine s/f syrup 2mg/5ml (150ml)	**PO**	**P**	**2-5 years:** 1mg every 4-6 hours – Maximum 6mg daily
			6-12 years: 2mg every 4-6 hours – Maximum 12mg daily
Chlorpheniramine tablets 4mg (30 tabs)	**PO**	**P**	**12 years and over:** 4mg every 4-6 hours – Maximum 24mg daily

Follow Up and Advice	Side effects and Management
All members of the affected household should be treated simultaneously. **Family members aged 16 and over to be treated outside of this NHSE U16s Pharmacy First scheme**	Discontinue if hypersensitivity occurs
Particular attention should be paid to the webs of the fingers and toes and lotion brushed under the ends of nails.	Drowsiness. More so with chlorphenamine – Drowsiness may diminish after a few days of treatment. Other side-effects include antimuscarinic effects (urinary retention, dry mouth, blurred vision and GI disturbance)
It is now recommended that permethrin should be applied twice, one week apart	
Washing clothing and bed linen in hot water is not essential.	
Infected patients should be warned about the mite's contagious nature	
Pruritis may continue for days after successful scabies eradication.	
Consider symptomatic treatment for itching.	
Incubation is usually 4-6 weeks in patients without previous exposure	
The patient should be referred to GP if treatment fails after two courses	

When to refer
Signs of bacterial infection
Previous treatment failures

Sunburn

Definition	After exposure to too much UV light, skin becomes red and painful and may later peel or blister
Criteria for Exclusion	Severe sunburn in children and babies
Action for Excluded patients:	**Refer to GP**

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Calamine aqueous cream 100g	**Topical**	**GSL**	**Apply as necessary**
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months			**60mg four times daily when required**
6-24 months			**120mg four times daily when required**
2-4 years			**180mg four times daily when required**
4-6 years			**240mg four times daily when required**
Paracetamol suspension s/f 250mg/5ml	**PO**	**P**	
6-8 years			**250mg four times daily when required**
8-10 years			**375mg four times daily when required**
10-15 years			**500mg four times daily when required**
Paracetamol tablets 500mg (32 tabs)	**PO**	**GSL**	
12-15 years			**500mg four times daily when required**

When to refer
Severe burns/ sunburn in babies and children
Suspected melanomas

Threadworm

Definition	Infestation by the threadworm parasite resulting in symptoms of peri-anal itching, especially at night. Confirmed by presence of cotton-like threadworms in the faeces or around the anus
Criteria for Inclusion	Sore, itchy bottom (anus) which is worse at night
	Worms may be visible (about 10mm long) in stools and/or around anus.
	Re-infection following treatment within the previous 2-3 weeks
	Close family contacts of the patient presenting with the infestation
Criteria for Exclusion	Children under 2 years old
	Pregnant or breastfeeding women
	Consult GP if signs of bacterial infection (mucus discharge, red and inflamed skin around the anus)
	Patients who have recently returned from tropical travel
	Loss of appetite, weight loss, insomnia
Action for Excluded patients	Patients may be referred to their GP if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Mebendazole (Ovex) 100mg – 1 tablet	**Oral**	**P**	**Patients over 2 years old:** Take 1 single tablet. (If re-infection occurs, a second dose can be taken after 14 days via a follow up consultation).

Follow Up and Advice	Side effects and Management
All members of the family over 2 years old, should be treated at the same time to obtain maximum benefit even if they are asymptomatic. Family members aged over 16 to be treated outside of this NHSE Pharmacy First scheme.	Rarely abdominal pain, diarrhoea, hypersensitivity reactions. Re-assure patient
Treatment needs to include hygiene measures to prevent ova being transferred from anus to mouth and re-infection for 14 days after treatment.	
Wash hands and scrub nails before meals and after going the toilet	
Bathing immediately after rising will remove the eggs laid during the night	
Wash bed-linen and towels frequently and change night and under wear daily	

When to refer
Recent tropical travel
Other type of worm infection
Rapid referral:
Heavy cases or persistent cases.

Oral Thrush

Definition	Oral thrush is an infection of yeast fungus, Candida albicans, in the mucous membranes of the mouth.		
Criteria for Inclusion	Child presenting with associated symptoms ranging from asymptomatic infection to a sore and painful mouth with a burning tongue and altered taste. White patches on an erythematous background are usually seen on the buccal mucosa, tongue or gums.		
Criteria for Exclusion	Children under 4 months		
	Children under 6 months that were born pre-term		
	Immunocompromised patients		
	Patients looking ill		
	History of recurrent infection		
Action for Excluded patients:	Patients may be referred to a dentist, GP or midwife as appropriate if considered necessary by the pharmacist		
Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage			
Drug	**Route**	**Class**	**Dose**
Miconazole (Daktarin) oral gel 15g	**Oral**	**P**	**Children over 4 months:** Apply miconazole gel four times a day, after meals. Space your doses out evenly throughout the day.
Follow Up and Advice			**Side effects and Management**
Treatment with miconazole gel should continue for 48 hrs after clearance			Occasional exacerbation of local infection
Oral thrush can be a sign of a serious underlying systemic disease			Strange taste in mouth
Recommend registration with an NHS dentist if the child is not already registered			
Highlight the potential for drug induced oral thrush, broad spectrum antibiotics are the most common cause			
Breastfeeding mothers may apply miconazole to their nipples to prevent re-infection			
When to refer			
Consider supply, but patient should be advised to make an appointment to see the GP:			
Suspected differential diagnosis			
If symptoms persist beyond one week			
Rapid referral:			
Suspected oral neoplasia			
Suspected systemic condition			

Warts and Verrucas

Definition	**Warts** are small (often hard) benign growth on the skin caused by a virus, usually occurring on the face, hands, fingers, elbows and knees. **Verrucas** (plantar warts) occur on the sole of the foot, usually painful and may be covered by a thick callus.
Criteria for Inclusion	Symptoms and signs suggestive of a wart or verruca.
Criteria for Exclusion	Warts on face, ano-genital region or large areas Diabetes mellitus Impaired peripheral blood circulation Broken skin or redness around area of wart / verruca
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Salactol topical paint 10ml	**Topical**	**P**	Apply topically daily, usually in the evening until area is clear. Soak the affected area in warm water for few minutes, then dry. Scrape away loose skin using emery board then apply few drops of paint onto area.

Follow Up and Advice	Side effects and Management
Plantar warts should be covered with an adhesive plaster Before applying the treatment to your wart, use an emery board or pumice stone to file it down a little (avoid sharing the board or pumice stone with others). Repeat this about once a week while you are treating your warts. Each time you treat your wart, soak it in water for about five minutes first to soften it, and then follow the instructions that come with the medication. You may need to apply the treatment every day for 12 weeks or longer. You should stop the treatment if your skin becomes sore.	Stinging, dryness and peeling

When to refer

See exclusion criteria