Evaluation of the Advanced Training for Community Pharmacists in the Assessment and Management of Urgent Cases

Final report

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Health Education North West funded CPPE to provide an intensive two-day training course in the assessment and management of urgent cases for community pharmacists. This training was delivered to ten cohorts of community pharmacists during 2015-16.

To investigate the impact of this training (see Appendix for the training agenda) on community pharmacists’ practice, a team from Manchester and Bath universities completed an evaluation of it. The evaluation team worked with CPPE to design the overall approach taken in the evaluation, but then worked independently when carrying out the study.

The evaluation investigated change in a number of psychological factors that influence whether people are able to modify their behaviours and to see whether the training had been effective in supporting community pharmacists to change their day-to-day behaviours in practice. The behaviours the training was intended to have an impact on include medical history-taking, clinical examination, and appropriate onward referral.

**Key findings**

Community pharmacists report that the training had been successful in extending the scope of their day-to-day practice in relation to many behaviours (in particular those associated with history-taking and referral), and that this change in behaviour had been sustained over time, suggesting patient and NHS benefits from this training.

Change in the psychological factors influencing behaviours were also sustained after training. For example, participant’s perceptions of their ability, in terms of their knowledge, skills and competency to carry out urgent care assessments increased; and their motivation to implement the intended changes in their day-to-day practice also increased following training.

Many were motivated to seek out ways to integrate community pharmacy more within the primary healthcare team by establishing closer working relationships, especially with GPs.

Barriers to changing behaviours related to lacking opportunities (because of a lack of time, workload, lack of resources, lack of a commissioned service). Some participants also felt that they needed more training to be competent in treating and managing patients requiring urgent care.

**Recommendations**

Based on the findings from our evaluation the training is effective at changing community pharmacists’ behaviours. To provide patient benefit and efficiency savings for the NHS it would be of value to continue to develop the community pharmacy workforce by providing advanced training in clinical skills such as those needed to effectively manage and treat patients needing urgent care.

Commissioners should consider ways for community pharmacists to deliver new services that can alleviate NHS pressures.
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1 INTRODUCTION
Community pharmacists play a key role in the management of minor ailments and supply of over-the-counter (OTC) medicines. In the United Kingdom, a number of community pharmacy Minor Ailment Schemes (MAS) have been established in the past two decades. Such schemes involve community pharmacists supplying medicines from a limited formulary, allowing for improved access to GPs for patients with more complex conditions. Such schemes provide benefit to both patients – through increased access to care – and to the NHS in terms of improved efficiency in resource allocation (reduced GP workload related to minor ailments consultations), demonstrating that community pharmacy-based MAS are effective and cost-effective for managing patients. As well as reducing GP workload, there is also evidence to suggest that 8% of adults attending A&E departments could be managed within community pharmacy, and that treating minor ailments such as coughs and sore throats in community pharmacy rather than in A&E or GP surgeries could save the NHS £1.1 billion / year.

To further promote community pharmacy as the most appropriate, accessible, healthcare provider for the management of self-limiting minor ailments, the existing competence of the workforce needs to be built on to expand the conditions that can be managed, treated and supported by community pharmacists. The purpose of the two-day training course being evaluated here, then, was to extend the range of conditions that community pharmacists could manage, ensure effective safety netting and follow-up, and rational onward referral to the most appropriate care provider. Learning outcomes for the training included: taking a structured medical history; performing a clinical examination (respiratory, eyes, ENT, skin, lymph) in order to manage a wider range of conditions; using clinical guidelines; and appropriate referral.

However, for community pharmacists to then use this learning in practice – and hence for the training to have an impact on those taking part outside of the training setting – community pharmacists must change several aspects of the way they carry out their day-to-day practice. Changing day-to-day practice is difficult; previous research suggests that healthcare professionals experience many barriers when trying to implement new practices, services or guidelines into their day-to-day work.

To investigate whether those taking part in the training have been able to change their day-to-day practice we used the learning outcomes for the training to describe the implementation of ‘target behaviours’ the training was specifically designed to influence (by changing community pharmacists’ practice behaviours). In this report we refer to the training as an ‘intervention’, and we use an evaluation framework based on the theory of planned behaviour to investigate the effects of the intervention on pharmacists’ behaviours.
1.1 Aims and objectives
The aim and objectives for the evaluation were:

Aim: To evaluate the perceived impact of a training intervention on community pharmacists’ assessment and management of patients requiring urgent care

Objectives:
- To establish the impact of the intervention using data collected at three time points (pre-training, referred to as ‘Time point one’ or T1 and post training [one week after the training referred to as ‘Time point two’ or T2] and two months after the training, referred to as ‘Time point three’ or T3]) measuring domains of behavioural determinants which describe the barriers and enablers to behaviour change that pharmacists may encounter (where change in the domains indicates that participants feel they are more capable [in terms of their knowledge, skills and competencies], motivated and likely to carry out the target behaviours in their practice);

- To establish the extent to which implementation of target behaviours were reported amongst participants post training [T2 and T3]

1.2 Overview of this report
This report provides a summary of analysis of quantitative data collected at the three time points; following this analysis examples of planned changes in behaviour are presented as qualitative quotations based on responses given to free text questions included in our evaluation.

A short summary and discussion of the findings is provided at the end of the report.
2 METHODS
A different online questionnaire was developed by the evaluation team for each of the three data collection time points.

A weblink to the first questionnaire, administered at T1 (Time point 1), was emailed to registered participants one week prior to attending the training (i.e. one week pre-intervention). This questionnaire used validated items\(^2\) that measure six domains of the Theoretical Domains Framework (TDF).\(^3,4\) The six domains were: knowledge; skills; professional role; beliefs about capabilities; intentions; and goals. The TDF has been used extensively to study and find solutions for the factors that affect the implementation of new guidelines, practices and services in health care, and to identify solutions where problems with implementation are identified.

A link to an initial follow-up questionnaire was sent to participants one week post-training (at T2) and a further follow-up was sent 2 months post-training (at T3) (i.e. T2 and T3 questionnaires collected data post-intervention).

The T2 and T3 questionnaires included the same validated items for capturing the six domains of behavioural determinants, (knowledge; skills; professional role; beliefs about capabilities; intentions; goals) plus additional validated items related to a further two domains of behavioural determinants: (memory, attention and decision making; and behavioural regulation).

To determine the impact of the training (intervention) on participants’ behaviours the scores recorded by each domain were compared pre and post training (T1 and T2); in addition, to determine whether any behaviour change in the domains was sustained, domain scores at T2 were compared those at T3. For all domains, an increased post intervention score is interpreted as the intervention having had a positive impact on psychological factors that influence behaviour. Post hoc statistical tests are provided where relevant to indicate whether any change in domain score is statistically significant.

As well as items related to domains mediating behaviour change, at T2 and T3 a number of additional questions were included to investigate transfer of learning to practice. These questions were designed to capture data related to whether the implementation of target behaviours had occurred.

In addition, a free text question related to implementation goals for the intended behaviour change of the intervention was included where respondents were asked to include a timescale for completing this goal; and a question exploring what participants intended to do the next time a patient presented in their pharmacy requiring urgent care was included. The rationale for including these questions related to goals and intentions is that, within the TDF, it is important for participants to set an intention (a self-instruction) for a particular behaviors as it increases the likelihood that the behaviour will occur – that is, in the TDF intentions play a key role in the prediction of future behaviours.
3 RESULTS

3.1 Participation rates

In total, 185 participants attended the Urgent Care course at ten locations within the North West region.

Table 1 shows completion rates for each cohort of participants for the three questionnaires by location of each course. The rate of completion for all three questionnaires was 35.7%. For a study of this type that uses repeated measures and where attrition is to be expected, this is an acceptable response rate. To set into context, the longitudinal response rate for a cohort study of early career pharmacists conducted by members of the research team was 26.3%.

<table>
<thead>
<tr>
<th>Location</th>
<th>Attended</th>
<th>T1 completed</th>
<th>T2 completed</th>
<th>T3 completed</th>
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<td>18</td>
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<td>7</td>
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<tr>
<td>TOTAL (%)</td>
<td>185</td>
<td>169 (91.4%)</td>
<td>129 (69.7%)</td>
<td>81 (43.7%)</td>
<td>66 (35.7%)</td>
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</table>

3.2 Characteristics of participants

Sixty-three per cent of those for whom demographic data were available were female (n=128). More than a third of participants (35.5%, n=48) worked for a large multiple pharmacy (≥25 stores), with a further 18.8% (n=24) working for an independent pharmacy.

Forty-two per cent (n=70) of those who participated and for whom data were available worked as a pharmacist manager, with a further 26.2% (n=44) working as a locum. Over a third (36.7%, n=47)

*Note on statistical tests*

The term ‘statistically significant’ is used in the report to indicate where the data have been tested using statistical techniques to determine whether the null hypothesis should be rejected or retained, with the significance level set at 5% (i.e. the probability [p] of an observed effect being not due to chance alone is p≤0.05). In other words, a result is statistically significant not because it is considered meaningful by the research team but because there is a 95% probability that the result would not have occurred by chance alone.
worked in a pharmacy located in a high street or parade of shops, with 17.2% (n=22) worked in a pharmacy co-located within a GP surgery, walk-in centre or health centre. Participants had been qualified a mean of 12.86 years (SD±10.503) and the majority (62.5%, n=80) worked full time (33 or more hours per week).

When comparing those who completed all the surveys with all attendees, the only significant difference in terms of personal or work characteristics was gender, with female participants significantly more likely to have completed all three surveys than their male counterparts (51.25 vs. 29.2%, χ²=5.103, p=0.05).

### 3.3 Change in behavioural domains

The mean scores for the domains measured in the questionnaires are shown for each of the three time points in the table below (Table 2). An analysis of the changes in domain scores across the three time points using a repeated measures analysis indicated that the change in scores were statistically significant for six of the eight domains, with the non-significant domains being ‘Intentions’ and ‘Behavioural regulation’. Post-hoc tests indicated that the significant differences were between the mean score at T1 and those at T2 and T3. There were no significant differences for the domain scores between T2 and T3.

<table>
<thead>
<tr>
<th>Domain name</th>
<th>Mean scores</th>
<th>F</th>
<th>P-value</th>
</tr>
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<tr>
<td>Knowledge</td>
<td>6.97</td>
<td>11.61</td>
<td>11.26</td>
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<tr>
<td>Skills</td>
<td>8.48</td>
<td>16.61</td>
<td>16.42</td>
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<tr>
<td>Professional role</td>
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<td>Beliefs about capabilities</td>
<td>16.48</td>
<td>25.29</td>
<td>25.59</td>
</tr>
<tr>
<td>Intentions</td>
<td>17.75</td>
<td>19.16</td>
<td>18.77</td>
</tr>
<tr>
<td>Goals</td>
<td>13.31</td>
<td>24.65</td>
<td>24.85</td>
</tr>
<tr>
<td>Memory, attention and decision processes</td>
<td>n/a</td>
<td>16.55</td>
<td>17.71</td>
</tr>
<tr>
<td>Behavioural regulation</td>
<td>n/a</td>
<td>20.43</td>
<td>19.44</td>
</tr>
</tbody>
</table>

*Significant at the 5% level.

### 3.4 Reported implementation of target behaviours

Between T2 and T3, the proportion of participants reporting that they had implemented one of the target behaviours increased (see Table 3). Two months after completing the training, around a half of participants had practised the skills they had learned (45.4%), had changed their onward referral behaviours (51.5%), and referred fewer patients to their GP (47%).
At T2, participants were also asked to set a goal for their future practice; when followed up at T3, around a third (30.3%) had achieved their goal to refer to clinical guidelines more frequently, a quarter had increased the number of urgent care cases they assessed (25.8%) and one fifth had increased the number of clinical reviews (21.2%) (see Table 4).

Finally, at T3 participants were asked about the extent to which they had performed two of the target implementation behaviours; The histograms in Fig 1 and 2 show the frequencies with which they were reported, on a 7-point scale ranging from ‘Not at all’ to ‘Very much so’. From these charts it can be seen that pharmacists have had less success applying the clinical examination techniques in their practice compared to the taking of a structured history.
Fig 1: Having completed the training in assessing and managing patients requiring urgent care, to what extent have you been able to take a structured history from patients requiring urgent care?

Scored on a scale from 1 to 7, where 1=not at all and 7=very much so

Fig 2: Having completed the training in assessing and managing patients requiring urgent care, to what extent have you been able to take apply the clinical examination techniques to patients requiring urgent care?

Scored on a scale from 1 to 7, where 1=not at all and 7=very much so
3.5 Implementation goal

When participants were followed up at T2 they were asked to set a goal for their immediate development or learning needs, or an implementation intention (something they intended to do related to the assessment and management of patients requiring urgent care). Analysis of the goals set is presented next (in section 3.5.1).

In addition to setting a goal, those completing the survey were asked to set a deadline for this goal. Analysis of these data are presented in section 3.5.2.

3.5.1 Goal

Participants set a range of goals; the most frequently reported goals were related to undertaking further training, practising the clinical examination and communication skills learned, and to improving integration within the primary care workforce. Examples of education and training goals included reviewing the course materials, familiarising themselves with clinical guidelines, learning to recognise red-flags and completing other courses:

[I intend to] review my learning from the pre-workshop tasks and practical course, re-enforce using on-line resources, practice the practical on family.

My main focus will be to gain enough knowledge about red flag symptoms by which I can improve my consultation and assessment skills in less time. Physical examination skills like hearing the chest sounds etc...and having a complete understanding of what is wrong with a patient are also my priority and I have requested one of the GP's near my pharmacy to provide me with the basic training of physical assessment.

Read more about red flag symptoms so I am completely familiar with them...I need more practice at looking at 'normal' patients before knowing what is abnormal (breath sounds, ear drums etc.). So...I will ask certain patients who know me well if I can have a look at their ear.

I intend to do extra research around clinical guidelines and clinical examination by reading Macleod's Clinical Examination book and NICE/CKS guidelines, as well as revising the information from the Urgent Care CPPE course.

Complete pharmacist prescribing qualification.

Many set a goal to apply their skills in day-to-day practice, rather than to refer patients on, demonstrating an intention to extend their scope of practice.

Apply skills in day to day practice and make sure I practise the techniques to keep up to speed.

Ensure I practice what I have learnt by applying skills and knowledge from the training

Be more willing to assess and manage patients, rather than referring them to their GP.

I intend to complete 10 otoscope checks and 10 opthalmoscope checks by end August 2016
I intend to use the 7Cs whenever taking a history from patients

A clear theme amongst the goals related to improving access to care for patients:

I intend...to decrease the referrals to the doctors because I think that it is the best for the patient, the pharmacy, the surgeries and the NHS.

Some participants planned to work more closely with other primary health care professionals:

I aim to sit in with an experienced GP and gain experience of examining chest infections and furthering my role as part of the healthcare team

Work with local GPs and try to create a Urgent care plan for the pharmacy outside of GP hours

Discuss with the local practice a mechanism for referral from pharmacy when the case requires further investigation.

I intend to meet with the senior doctors in the medical centre to which we are attached to draw up plan and protocol to ensure all healthcare professionals are confident with our change of practice and respond in a co-operative manner. I am also engaging in further competency courses. We are also building a new, larger, better equipped consultation room.

A number of the goals related to finding out more about how a service could be implemented if it were to be commissioned, such as by PGD; participants intended to write an SOP, speak to commissioners, the PDA or their employer:

Write an SOP to use these skills within work and acquire the equipment to carry out the assessments by February 2016

Check with my contractor about insurance cover before physically examining patients whom have given consent.

To explore the corporate stance within my organisation on developing UC service and to influence them to provide equipment.

3.5.2 Timescale for achieving goal
Of those who set a deadline for their learning or development goal (n=102), the majority (60.8%, n=62) were planning to achieve their goal within three months. A small number of participants (7.8%, n=8) were planning on achieving their goal immediately. Overall, 96.1% of the participants who responded were planning to achieve their goal within 12 months. The respondent quoted below had set a number of different goals, with different timescales for each one:
I want to learn the history-taking format by heart by 31st December. I want to know and be able to take a competent respiratory/ENT history and complete the exam by 31st December. I want to know and be able to take a competent medical history and exam by the end of Jan 2016

Other participants struggled to put a specific timescale on their goals, because of perceived barriers to implementation:

Work out how & when I could assess patients coming in for urgent care as well as patients already waiting for meds.

3.5.3 Implementation intention (Behaviour)
Participants were also asked what they intended to do the next time a patient requiring urgent care presented in the pharmacy where they were working. The majority planned to use the skills they had learned to manage the patient, and to record any interventions.

Take a more detailed history to determine if a referral is required and ask the patient to come back and tell me how they got on. Record the intervention.

Take a full history, examine if appropriate, give the best advice I possibly can to self treat/manage the condition and only signpost/refer if necessary to a GP

In the past I have looked and discussed but never physically examined a patient with their permission. I will record the outcome on the PMR, look for red flag symptoms and refer or treat as appropriate. I intend to reduce the overall need for referral of simple ENT problems.

The next time ENT / skin or respiratory issues** (** not sure since the facilities in consultation rooms aren't great) requiring urgent care presents I will examine thoroughly and make sure that they do or do not need referring and make sure get treated appropriately at the pharmacy

Assess the patient asking specific questions following the I.C.E. and S.O.C.R.A.T.E.S and I will look at his medicine record and I will ask about other part of the body, I will look at his finger, hands, eyes, lymph nodes, check blood pressure, check hear rate, etc. I will ask about his social background and I will be able to refer the patient if necessary to the right service. I can fax or give to the patient a letter for the doctor using the right terminology. I will try to see if I can solve the problem without referring the patient first.

I will complete consultation and assessment of patient using my knowledge and skills. I’ll make notes and keep a record of it and if needed direct patient to appropriate health practitioner and complete follow up with patient

Take a more detailed history to determine if a referral is required and as the patient to come back and tell me how they got on. Record the intervention

One participant provided a detailed plan:
I will take them to the pharmacy private consultation room. I will introduce myself and ensure they are comfortable to talk to me with confidentiality/shared care/chaperoning policies in mind. I will use the ICE and SOCRATES memory aids to work through the patients problem whilst maintaining flow of information. I will record information on the patients PMR with their permission and in a discreet and non-invasive way. I will take a holistic approach in my consultation into the patients background, family ad lifestyle as possible contributing factors affecting the patient. I will attempt to educate patients with regard to their concerns and beliefs which may contribute to fear about their symptoms. If the fear needs further reassurance or possible investigation I will refer them to their GP for further discussion. I will assess within my ability any symptoms which [sic] may be red flags and I will refer any such red flags to the best healthcare provider suitable within an appropriate time frame… whether that be +E, walk-in centre or GP. I will examine the patient with their permission/chaperone for ENT problems (currently chest examination not possible c/o space/time/steth). I will more confidently NOT REFER simple cases and supply products on minor ailment scheme or advise patient to purchase product. I will liaise with the local walk-in centre as to my referrals and ensure we are both following the same set of guidelines and I will try to get more feedback from the patient as to the outcome of their condition ad their referral.

Barriers to implementing urgent care behaviours related to lacking opportunities (because of a lack of time, workload, lack of resources) and to lacking capabilities (because the training was not enough for participants to perceive themselves as competent in treating and managing patients requiring urgent care).

I will invite them into the consultation room. I will listen to their concerns and assess the situation. I will not examine them because I do not have the equipment to do this or sufficient expertise. The course was vey much a taster rather than the finished article.

I will refer back to my notes and attempt to engage the patient in effective consultation in order to get a full and accurate history of the presenting complaint. I will then carry out observations of the patient but would probably not carry out a full examination due to insurance / liability restrictions at the present time.

I will carry out more patient centred consultations, looking at the social side more and getting a more comprehensive patient medical history. At the moment I feel trapped by the constraints of...what I can offer due to lack of PGD’s and resources to buy equipment and training to use properly.

Barriers to implementation were of particular concern for locum pharmacists:

As a locum pharmacist, I am limited in the range of urgent care services I can provide within pharmacies I do not regularly work in or have regular rapport with clinical governance leads. I will incorporate any urgent care techniques that have been learnt where possible, maybe within minor ailment services such as with those presenting with ear ailments. However, without valid company standard operating procedures/consent paperwork already in place, I will be limited in the service I could provide.

One participant reported how they had used the skills learnt:
I have already been able to use my new skills on a gentleman with history of angina who presented with pain on inhalation. I felt more confident in taking a good history of the problem, I felt the problem was more muscular and felt confident enough to auscultate (mainly to reassure the patient that his lungs were ok and it was a good opportunity for me to practice on a real patient.) I explained that I had done some extra training in urgent care and gained consent to listen to his chest. Normal bilateral breath sounds were heard and I was able to reassure the patient. We discussed red flag issues and what to do if any developed. A record was made on his PMR.

For this participant, the experience of attending the course had been a valuable one, which they felt had led to them being able to provide better care to the patients visiting their pharmacy:

I am enjoying the challenge of demonstrating the role of the pharmacist and what I can do to ease their workload. I use the ICE technique and am much more aware of gaining consent and explaining what I am about to do. Overall I found this course to be massively beneficial in allowing me to give better patient care and is has been very rewarding.

3.5.4 Summary
Based on the free text comments, many planned to implement their learning although not all of the participants felt that they would be able to provide a comprehensive urgent care service to patients, due to a number of barriers, including lack of equipment, unsuitable facilities, concerns about insurance liability or workload. Despite these barriers most reported being keen to extend their scope of practice and many were looking for opportunities to integrate community pharmacy more within the primary healthcare team.
DISCUSSION
The aim of this evaluation was to investigate the impact of the training for community pharmacists in the assessment and management of urgent cases. We conclude this report by reflecting on the findings and considering the implications of the results.

By collecting data using a repeated measures design we have been able to explore whether taking part in a training intervention had an impact on the implementation of a number of target urgent care behaviours (taking a structured medical history; performing a clinical examination (respiratory, eyes, ENT, skin, lymph) in order to manage a wider range of conditions; using clinical guidelines; and appropriate referral). Based on pharmacists’ self-reports of their performance of the target behaviours, the results indicate that the training did have a measurable effect on the performance of the target behaviours, and over time the frequency with which they performed these behaviours increased. This result is promising, as it has shown that according to pharmacists’ self-report, behaviour change has occurred and that this change has been sustained over time. This training had the greatest impact on pharmacists’ thresholds for referral to other healthcare professionals, with pharmacists setting goals at follow-up to increase their use of clinical guidelines, and the numbers of clinical reviews they undertook and urgent cases they assessed.

In line with these findings, our evaluation also found that participant’s perceptions of their ability, in terms of their knowledge, skills and competency to carry out urgent care assessments increased following training and that this was again sustained at the second follow-up (T3). Participant’s motivation (goals and intentions) to implement the target behaviours in their practice also increased following training. Many reported having implemented the target behaviours. Although this was only up to a third of those who responded, this is consistent with other studies investigating rates of behaviour change, where intention to perform a behaviour usually only translates into 20-30% of individuals actually carrying out their intentions.

Applying a psychological theory of behaviour change we have therefore demonstrated that community pharmacists are able to extend their scope of practice in relation to some behaviours (in particular those associated with referral). Notwithstanding attrition affecting response rates at follow-up, findings suggest likely patient and NHS benefits from this training.

As the evaluation was relatively small-scale there are a number of limitations associated with our approach. First of all, a lack of control group makes it difficult to attribute the changes to the training. Secondly, we experienced difficulty in following up participants for the repeated measures so it is possible that those who responded to the T2 and T3 questionnaires were different to the rest of the cohort who took part in the training. To address these limitations it would be worth investigating the impact of the intervention with a larger sample. This would allow for subgroup analysis to be undertaken that could identify differences within the three groups – for example, analysis could compare between job role, gender etc.

4.1 Recommendations
Based on the findings from our evaluation the training is effective at changing community pharmacists’ behaviours. To provide patient benefit and efficiency savings for the NHS it would be
of value to continue to develop the community pharmacy workforce by providing advanced training in clinical skills such as those needed to effectively manage and treat patients needing urgent care.

Commissioners should consider ways for community pharmacists to deliver new services that can alleviate NHS pressures.

5 Acknowledgements
The authors would like to thank the following for contributing to the development of the training and its evaluation:
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John Miller
Louise Smith
Sarah Gough
Thanks also to the community pharmacists who completed the questionnaires for this evaluation,

6 References
## Agenda: day one

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</tr>
<tr>
<td>10.00am</td>
<td>Welcome</td>
<td>Samantha</td>
</tr>
<tr>
<td>10.15am</td>
<td>Introduction: the course programme</td>
<td>Samantha</td>
</tr>
<tr>
<td>10:30am</td>
<td>Consultation skills for pharmacy practice</td>
<td>Simon</td>
</tr>
<tr>
<td>11.05am</td>
<td>The consultation (theory)</td>
<td>John</td>
</tr>
<tr>
<td>11.45am</td>
<td>Break</td>
<td></td>
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<tr>
<td>11.55am</td>
<td>Taking a history (demonstration)</td>
<td>John</td>
</tr>
<tr>
<td>12.10pm</td>
<td>Taking a history (practice)</td>
<td>John and Louise</td>
</tr>
<tr>
<td>1.10pm</td>
<td>Lunch</td>
<td>John and Louise</td>
</tr>
<tr>
<td>1.40pm</td>
<td>Taking a history, including note keeping (practice)</td>
<td>John and Louise</td>
</tr>
<tr>
<td>3.10pm</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>3.25pm</td>
<td>The examination (theory)</td>
<td>John</td>
</tr>
<tr>
<td>4.40pm</td>
<td>Reflection and review</td>
<td>All</td>
</tr>
<tr>
<td>5.15pm</td>
<td>Break before dinner</td>
<td></td>
</tr>
<tr>
<td>6.15pm</td>
<td>Dinner and networking</td>
<td></td>
</tr>
<tr>
<td>7.15pm</td>
<td>Ear, nose and throat (theory and examination)</td>
<td>John and Louise</td>
</tr>
<tr>
<td>8.45pm</td>
<td>Close</td>
<td></td>
</tr>
</tbody>
</table>

**NB** Since this is a pilot course timings are flexible. However, we will start and end on time.
Agenda: day two

8.30am  Welcome and introduction

8.35am  A major examination … respiratory system (demonstration)

9.25am  Respiratory system examination (practice)  John and Louise

10.45am How can we do this differently?  Samantha

11.15am Break

11.25am Minor system examination … eyes, skin and lymph nodes (demonstration)  John and Louise

12.30pm Lunch

1.15pm Minor system examination … eyes, skin and lymph nodes (practice)  John and Louise

2.15pm How can we do this differently? Part 2  Simon

3.15pm Break

3.30pm Barriers, solutions and next steps  Simon and Samantha

4.30pm Close

NB Since this is a pilot course timings are flexible. However, we will start and end on time