An evaluation of the Pharmacy First Pilot Service for the treatment of Shingles

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List of Abbreviations

Acronym	Full term
BAD	British Association of Dermatologists
CPNI	Community Pharmacy Northern Ireland
DH	Department of Health
ECHO	Extension of Community Healthcare Outcomes
LCG	Local Commissioning Group
MOIC	Medicines Optimisation Innovation Centre
NICE	National Institute for Health and Care Excellence
OOH	Out of Hours
PGD	Patient Group Direction
SPPG	Strategic Performance and Planning Group

1. Introduction

1.1 Overview of Pharmacy First Pilot Service for the treatment of shingles

The introduction of a Pharmacy First Pilot Service for the treatment of shingles was proposed in 50 community pharmacies as part of the Department of Health's (DH) 2024/25 Winter Preparedness Plan for Northern Ireland's health and social care system. The purpose of the pilot was highlighted as enabling assessment of the capability of the community pharmacy network to displace activity from other areas of urgent care for this condition.

Shingles (herpes zoster) is a viral infection of an individual nerve and the skin surface served by the nerve (dermatome). It is caused by the reactivation of the varicella-zoster virus, the same virus that causes chickenpox.

A Pharmacy First Service is a service whereby patients are encouraged to consult with a participating community pharmacy rather than their GP for a defined list of common conditions. The pharmacist will give advice and (if appropriate) supply medication from an agreed formulary or refer the patient to another healthcare setting if necessary. Medicines, when deemed necessary, are supplied free of charge.

This Pharmacy First Pilot Service for the treatment of shingles aims to facilitate the assessment and treatment of patients aged 18 years and over in the community pharmacy in line with NI Antimicrobial Guidelines[1] and NICE shingles guidelines[2].

1.2 Service aims and objectives

The aims of the Pharmacy First Pilot Service[3] for the treatment of shingles are to:

[1] NI Antimicrobial Guidelines. https://app.eolasmedical.com/organisation/Northern%20Ireland%20Primary%20Care%20Antimicrobial%20Guidelines
[2] NICE shingles webpage. Shingles | Health topics A to Z | CKS | NICE
[3] Pharmacy First Pilot Service for Treatment of Shingles in patients aged 18 years and over - Service Specification and Guidance. https://bso.hscni.net/wp-content/uploads/2026/03/PharmacyFirst_Shingles_Service_SpecificationGuidanceVersion3_March2026_FINAL.pdf

- Provide a more accessible, efficient and high-quality clinical pathway for patients with shingles.
- Better use pharmacist skills and free up GP time for more complex and urgent medical issues.

The objectives of the service are to:

- Provide a timely and appropriate service for patients in the treatment of their condition and to identify patients who need onward referral to another healthcare professional.
- Provide a service which is acceptable to patients and community pharmacists and which is supported by GP practices.
- Support the cost-effective use of medicines and health service resources in Primary Care in line with the NI formulary.
- Promote the role of the community pharmacist as the first port of call for the treatment of shingles in patients aged 18 years and over.

2. Evaluation

As part of an agreed business plan with the DH, the regional Medicines Optimisation Innovation Centre (MOIC) was asked to complete an evaluation of the Pharmacy First Pilot Service for the treatment of shingles.

2.1 Evaluation methodology

The following outcome measurement and analysis was undertaken:

- *Pharmacy First Consultation Form*

During consultations for the Pharmacy First Pilot Service for the treatment of shingles, community pharmacists complete a consultation form (Appendix 1). The Strategic Performance and Planning Group (SPPG) requested all completed consultation forms from participating community pharmacies for the first six months of the pilot service, from commencement on the 6th January 2025 to 6th July 2025.

The process for data sharing detailed below was then followed:

1. Consultation forms called in from all participating community pharmacies were shared with SPPG.
2. SPPG retrieved the selected consultation forms from the community pharmacies.
3. Staff at SPPG redacted the consultation forms to remove patient identifiable data and each consultation form was assigned a unique identifier. Redacted information linked to the unique identifier was stored on an electronic database held by SPPG.
4. Redacted consultation forms were shared with MOIC via Egress or as paper copies.
5. Data from the consultation forms were inputted into an electronic database for analysis by MOIC staff.

Analysis of consultation form data was completed using Microsoft Excel.

- *Stakeholder feedback*

Stakeholder feedback was obtained from participating community pharmacies, GP practices and Out of Hours (OOH) services using questionnaires co-designed by MOIC, SPPG and Community Pharmacy Northern Ireland (CPNI). The questionnaires were launched as online surveys via MS forms and links distributed via email by SPPG. Stakeholder questionnaires are included in Appendix 2.

Data was exported from MS forms to Microsoft Excel and descriptive statistics were used to summarise responses.

3. Results

3.1 Consultation form data

Within the results section figures have been rounded to one decimal place so may not sum precisely to 100.0% in some tables.

3.1.1 Sampling of consultation forms

SPPG requested all consultation forms completed by participating pharmacies during the period 6th January 2025 to 6th July 2025 of the pilot. In total, 439 consultation forms were returned. Of these, 47 consultation forms were excluded because it had not been recorded or could not be determined when the patient presented for consultation.

A final sample of 391 consultation forms were included for analysis.

3.1.2 Local Commissioning Group (LCG) area of participating pharmacies

Table 1: LCG area of participating pharmacies

	No. consultation forms returned	% of consultation forms returned
Belfast	61	15.6%
Northern	76	19.4%
South Eastern	83	21.2%
Southern	84	21.5%
Western	87	22.3%
Total	**391**	**100.0%**

Consultation forms were returned from all LCG areas. The distribution of consultation forms by pharmacy LCG was broadly even, with each area contributing between 15.6% and 22.3% of the sample. This supports the regional nature of the pilot.

3.1.3 Patient age range

Table 2: Patient age range

	No. of patients	% of patients
Under 18	1	0.3%
18-24	25	6.4%
25-34	43	11.0%
35-44	61	15.6%

45-54	66	16.9%
55-64	103	26.3%
65-74	64	16.4%
75-84	21	5.4%
85-94	7	1.8%
Total	**391**	**100.0%**

Most patients availing of the Pharmacy First Pilot Service for the treatment of shingles were middle-aged or older adults, with the largest group aged 55–64 years. Presentations in younger adults were less common and only one individual was recorded as under 18 years of age, which represents an ineligible presentation under the service specification.

3.1.4 Referral route into service

Table 3: Referral route into service

Referral route	No. of patients	% of patients
Self-referral	197	50.4%
Pharmacist	87	22.3%
GP practice	75	19.2%
OOHs	8	2.1%
Other*	6	1.5%
Unknown	18	4.6%
Total	**391**	**100.0%**

Self-referral was the main route into the service, accounting for half of all consultations. Referral from pharmacists and GP practices also contributed substantially, while OOH and other routes were used infrequently. Other routes into the service included: from another pharmacy or through word of mouth.

3.1.5 Consultations outside of usual community pharmacy hours.

Just over one fifth of consultations took place at weekends (n=84/391, 21.5%). This indicates that the service added access outside the traditional working week for a meaningful minority of patients.

A small proportion of consultations occurred after 6pm (n=20/391, 5.1%). This demonstrates the potential for the service to provide OOH access to care which may prevent patients having to access OOH services.

3.1.6 Assessment of signs/symptoms of shingles

Patients presenting within 72 hours of rash onset

The majority of patients (n=315/391; 80.6%) were assessed within 72 hours of rash onset. This is clinically important because antiviral treatment is most effective when started early and demonstrates the accessibility of community pharmacists in providing timely patient care.

Table 4 below show details of the cohort (n=315/391) presenting within 72 hours of rash onset.

Table 4: Cohort presenting within 72 hours of rash onset

		No. of patients	% of patients
Aged 50 or over	Yes	188	59.7%
	No	127	40.3%
Immunocompromised	Yes	8	2.5%
	No	307	97.5%
Non-truncal involvement	Yes	108	34.3%
	No	207	65.7%
Moderate or severe pain	Yes	224	71.1%
	No	91	28.9%
Moderate or severe rash	Yes	157	49.8%
	No	158	50.2%
Total		**315**	**100.0%**

Among patients presenting within 72 hours, a substantial proportion were aged 50 years or over (n=188/315, 59.7%) and only a small number were recorded as immunocompromised (n=8/315, 2.5%). The most common symptom identified was “moderate or severe pain” with over 70% of the cohort presenting with this issue. This was followed by a “moderate or severe rash” identified in half of the cohort (n=157/315, 49.8%), with non-truncal involvement seen in approximately one third of patients presenting within 72 hours of rash onset (n=108/315, 34.3%).

There were no signs/symptoms ticked on the consultation form for a small number of patients who presented within 72 hours of rash onset (n=6/315; 1.9%).

Patients presenting within more than 72 hours and up to one week after rash onset

A smaller subgroup of patients presented more than 72 hours after rash onset but within one week (n=62/391; 15.9%) which is still within a clinically useful period. There are different eligibility criteria for individuals presenting more than 72 hours after rash onset but within one week and these are shown in Table 5 below

Table 5: Cohort presenting more than 72 hours after rash onset but within one week

		No. of patients	% of patients
Aged 70 and over	Yes	11	17.7%
	No	51	82.3%
Immunocompromised	Yes	3	4.8%
	No	59	95.2%
Continued vesicle formation	Yes	41	66.1%
	No	21	33.9%
Severe pain	Yes	28	45.2%
	No	34	54.8%
High risk of severe shingles	Yes	0	0.0%
	No	62	100.0%
Total		**62**	**100.0%**

Only a minority of patients in the 72 hours to one week window were aged 70 years or over (n=11/62, 17.7%), with only three patients in the subgroup recorded as being immunocompromised (n=3/62, 4.8%). Continued vesicle formation was recorded in approximately two thirds of this cohort (n=41/62, 66.1%) and severe pain was documented in almost half (n=28/62, 45.2%). A high risk of severe shingles was not documented in any patients presenting more than 72 hours but within one week of rash onset.

As with patients presenting within 72 hours, for the subgroup presenting more than 72 hours but within one week of rash onset there were a small number of patients where no signs/symptoms had been ticked on the consultation form (n=3/62; 4.8%).

Patients presenting more than a week after rash onset

Only a small minority of patients presented more than one week after rash onset (n=15/391; 3.8%). This indicates that most patients accessing the service did so within a clinically useful timeframe. Of these 15 patients, most had documentation that advice and written information was supplied (n=11/15; 73.3%).

3.1.7 Medicines supplied

Table 6: Medicine supplied

	No. of patients	% of patients
Aciclovir	342	87.5%
Valaciclovir	5	1.3%
No medicine supply recorded	44	11.2%
Total	**391**	**100.0%**

Aciclovir was by far the most frequently supplied medicine, with valaciclovir used only occasionally. Approximately 10% of consultation forms had no medicine supply recorded (n=44/391; 11.2%). Of the 44 cases where no medicine supply was recorded,

14 patients are accounted for by those who were presenting after one week (n=14/44, 31.8%). In the other 30 cases (n=30/44, 68.2%) reason for no supply was recorded in 16 cases and no reason was detailed on the other 14 consultation forms. Reason for non-supply included: Suspected shingles rash on head/face/neck (n=7), valaciclovir out of stock (n=3), differential diagnosis suspected (n=2), severely immunocompromised (n=1), patient with severe kidney disease (n=1); patient in between vaccine doses and pharmacist unsure of eligibility (n=1), and medication interaction (n=1). Some of these recorded reasons i.e. shingles rash on the head/face/neck and patient being severely immunocompromised; are reasons for exclusion from the service.

Aciclovir was supplied to three patients (n=3/391; 0.8%) who were identified on consultation forms as being immunocompromised. These would appear to be cases of inappropriate supply as according to the service specification these individuals should have been supplied valaciclovir.

Valaciclovir was only supplied in five cases (n=5/391; 1.3%). In four out of the five cases the reason was due to the patient being immunocompromised (n=4/5; 80.0%) with the reason being recorded as “aciclovir is unsuitable” in the remaining case.

Was medicine supplied in line with service formulary?

Aciclovir

Table 7: Strength of aciclovir supplied

Strength	No. of patients	% of patients
800mg	334	97.7%
400mg	4	1.2%
500mg	1	0.3%
Unclear	1	0.3%
Unknown	2	0.6%
Total	**342**	**100.0%**

In all but a few instances the strength of aciclovir supplied was recorded as 800mg. This is in line with the formulary, which states that 800mg tablets should be supplied in the first instance where available.

Table 8: Quantity of aciclovir supplied

Quantity	No. of patients	% of patients
35	264	77.19%
70	4	1.17%
25	1	0.29%
Unknown	73	21.35%
Total	**342**	**100.0%**

The most common recorded quantity for aciclovir was 35 tablets (n=264/342, 77.2%) which is consistent with a seven-day course of 800mg taken five times daily. In over a fifth of cases where aciclovir was supplied, no information was recorded on the quantity supplied.

Aciclovir was usually recorded simply as tablets or tabs, although formulation was missing in a large proportion of records (n=147/342, 43.0%).

Valaciclovir

Due to the very small numbers of valaciclovir supplied and variable documentation in these cases (shown in Table 9), conclusions cannot be made as to whether supply was in line with service formulary.

Table 9: Strength, quantity and formulation of valaciclovir supplied

		No. of patients	% of patients
Valaciclovir strength	1g	2	40.0%
	500mg	2	40.0%

	800mg	1	20.0%
Valaciclovir quantity	42	1	20.0%
	Unclear	1	20.0%
	Unknown	3	60.0%
Valaciclovir formulation	Tablets	2	40.0%
	Unknown	3	60.0%
Total		**5**	**100.0%**

Paracetamol

Paracetamol was supplied in a small number of consultations (n=32/391; 8.2%). In these cases, details on strength and quantity were fully completed and show consistent application of the service specification. Paracetamol formulation was usually recorded as tablets, although some entries were not completed (n=9/32; 28.1%).

Ibuprofen

Ibuprofen was supplied less often than paracetamol (n=20/391; 5.1%). As with paracetamol, details on the strength and quantity of ibuprofen supplied was well recorded and in line with service formulary. However, there was incomplete recording regarding formulation (Unknown: n=13/20; 65.0%).

3.1.8 Advice

Advice to immunosuppressed patients

Eleven patients were identified as being immunocompromised on the consultation forms (n=11/391; 2.8%). Records showed that all had been provided with advice but only half (n=5/11; 45.5%) were identified as being referred on to GP/OOHs for review as directed in the service specification.

Advice to all patients

Most consultation forms indicated that patients were advised to attend GP or OOH services if symptoms worsened rapidly or significantly (n=336/391; 85.9%). A similarly high proportion of patients were advised to contact GP or OOH services if symptoms had not improved after seven days (n=318/391, 81.3%). This is consistent with the service specification and reinforces appropriate follow-up advice.

The British Association of Dermatologists (BAD) shingles leaflet was supplied in most consultations (n=279/391; 71.4%) indicating generally good provision of written advice, although there remains scope to improve.

Advice about vaccination after recovery was recorded in a minority of consultations (n=86/391, 22.0%). The current HSC vaccination service is for over 65s (and under 80) and severely immunosuppressed, further analysis shows n=21/85 (24.7%) of those in the 65-84 ages range were recorded as receiving advice about vaccination. This may suggest a missed opportunity to reinforce public health messaging.

3.1.9 Referral to another healthcare professional

Table 10: Was patient referred to another healthcare professional?

	No. of patients	% of patients
No	242	61.9%
Yes	26	6.6%
Unknown	123	31.5%
Total	**391**	**100.0%**

As shown in Table 10 only a small proportion of consultations resulted in referral to another healthcare professional. This could suggest that most patients were appropriately managed within the community pharmacy pathway, with referral reserved for more complex or excluded cases.

Where onward referral occurred, GP practices (n=17/26, 65.4%) and OOH (n=7/26, 26.9%) were the most common destinations. The recorded reasons for onward referral appeared to be appropriate and were predominantly linked to exclusion criteria or red flag symptoms and included: head/face/neck or ophthalmic involvement; immunosuppression; chronic kidney disease; vaccine timing queries; stock or medicine suitability issues; and diagnostic uncertainty.

3.2 Stakeholder feedback

3.2.1 Community pharmacy service provider

The community pharmacy feedback questionnaire was issued to all participating community pharmacies (n=50) on 6th March 2026 with responses requested by 10th April 2026. Twenty-five pharmacies participated resulting in a response rate of 50%.

LCG area of participating community pharmacies

Table 11: LCG area of participating community pharmacies

	No. of responses	% of responses
South Eastern LCG	6	24.0%
Southern LCG	6	24.0%
Belfast LCG	5	20.0%
Western LCG	4	16.0%
Northern LCG	4	16.0%
Total	25	100.0%

Pharmacist feedback was obtained from all LCG areas, with responses broadly distributed across the region.

Impact on practice

Pharmacists were asked a number of questions to explore how the Pharmacy First Pilot Service for the treatment of shingles had impacted their practice.

When asked how much time they spent per patient for assessment and provision of advice/treatment through the Pharmacy First Pilot Service for the treatment of shingles, most pharmacists reported spending 10–15 minutes per patient (n=15/25, 60.0%). Six pharmacists stated they spent 15-30 minutes per patient (24.0%) and four said they spent 20-30 minutes (16.0%).

Just under half of pharmacists (n=11/25, 44.0%) reported that the Pharmacy First Pilot Service for the treatment of shingles had affected patient flow elsewhere in the pharmacy. When asked to provide further detail the key theme, from pharmacists who had reported an impact on patient flow, was disruption to dispensary workflow when a single pharmacist was on duty. This was illustrated by the comment below:

> *As with any Pharmacy First service, it takes the pharmacist out of the dispensary for the duration of the consultation. As we usually operate with only one pharmacist, other tasks build up when the pharmacist is conducting a Pharmacy First consultation. These tasks mostly consist of waiting prescriptions, other Pharmacy First queries, Stop Smoking consultations, medicine queries, RTS queries and anything else that must be completed exclusively by a pharmacist.*

In contrast, those who felt there wasn't an impact on patient flow highlighted that as presentations numbers were low the service impact was manageable.

When asked to rate the acceptability of the admin/paperwork involved in providing the Pharmacy First Pilot Service for the treatment of shingles most respondents considered the administration and paperwork to be acceptable or completely acceptable (n=21, 84.0%).

Table 12: Acceptability of admin/paperwork

	No. of responses	% of responses
Completely acceptable	3	12.0%
Acceptable	18	72.0%
Unacceptable	2	8.0%
Completely unacceptable	1	4.0%
No opinion	1	4.0%
Total	**25**	**100.0%**

Respondents were asked to explain their answers. Feedback suggested that the consultation form was considered understandable, however, duplication and administrative burden were recurring concerns. Respondents suggested that a single streamlined or digital form would improve efficiency. For example, one respondent stated:

> *As with all Pharmacy First services, I think the administration is excessive. It should be sufficient to complete one form, preferably online which can be used to inform the GP, BSO and SPPG. We currently have to; 1) complete a consultation form, 2) email this to the GP (if we have an email), 3) fill in the claim form for SPPG, 4) fill in a PV1 and claim for payment from BSO, 5) label and dispense any required items. It should be possible for the first 4 steps to be completed in one bit of administrative work.*

Table 13: Acceptability of service workload

	No. of responses	% of responses
Completely acceptable	9	36.0%
Acceptable	11	44.0%
Completely unacceptable	1	4.0%
No opinion	4	16.0%
Total	**25**	**100.0%**

When asked to rate the acceptability of the service in terms of overall workload, the Pharmacy First Pilot Service for the treatment of shingles was most frequently rated as acceptable or completely acceptable (n=20/25; 80.0%).

From additional information offered by respondents it could be determined that workload was usually perceived as manageable because case numbers were relatively low during the pilot. The respondent who highlighted that workload resulting from the service was "completely unacceptable" provided the following explanation:

> *People book in with their doctor for a 1-1 consultation. In pharmacy, patients walk in and demand they get their medication/ advice/ services right there and then. There is far too much pressure put onto pharmacists with no extra help to accommodate the extra workload. Accuracy is obviously key in my role, but with all this extra workload and no appointment system, nor extra help, it is getting very unsafe.*

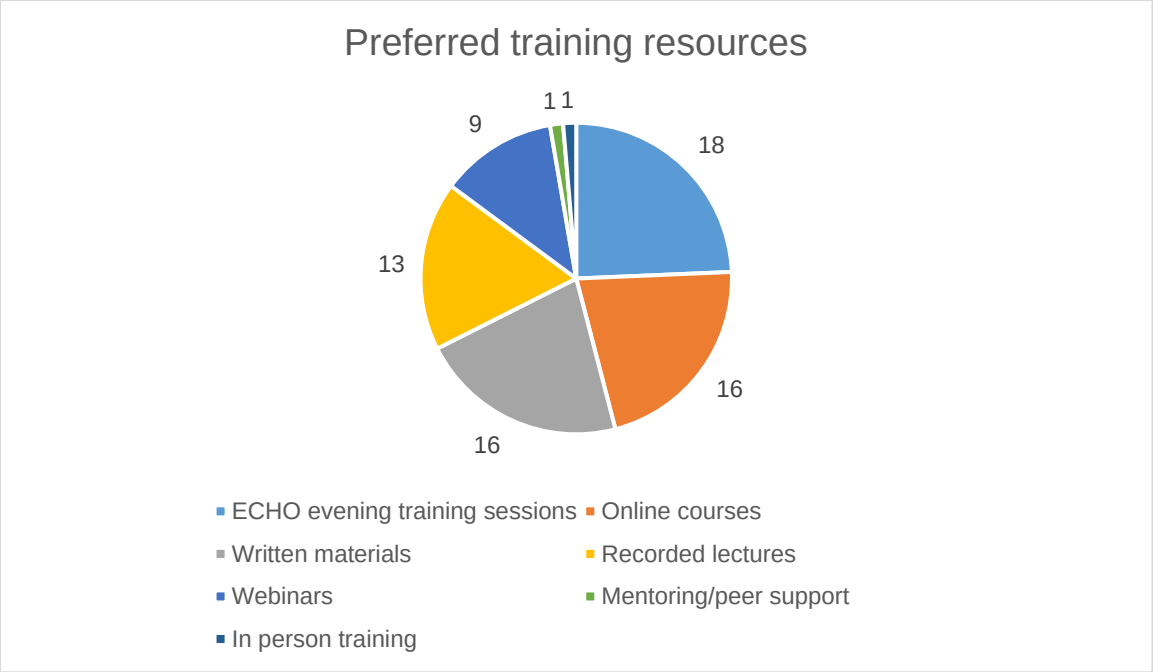
Participants were also asked if they had any other comments relating to delivery of the service. Key themes from feedback included that the service was: viewed as worthwhile; well received by patients; supported prompt access to treatment; and, was a good example of community pharmacy contributing to urgent primary care pathways. However, the subjective nature of diagnosis for shingles in comparison to other Pharmacy First Services i.e. Pharmacy First Services for Sore Throat and Urinary tract infection (UTI), was highlighted as a factor which made this service more complex to provide.

Training, resources and communication

The majority (n=22/25, 88%) of pharmacists considered the resources supplied for delivery of the pilot (service specification, Patient Group Direction (PGD), privacy notice, poster etc.) to be adequate. Further explanation offered by respondents did however identify some improvements that would be helpful, including: clearer supplementary guidance such as more practical aids; and, more explicit support for complex cases.

All participants reported completing the Extension of Community Healthcare Outcomes (ECHO) training with the vast majority rating it as extremely or somewhat useful (n=23/25; 92.0%) and only two individuals rating the usefulness as “neutral” (n=2/25, 8.0%).

When asked what training resources they would consider most beneficial in delivering this service ECHO evening training, online courses and written materials were identified most consistently.



Participants were also asked if they had any unmet training requirements or proposed resource improvements. Feedback highlighted a desire for more practical training resources including access to visual examples of different rash presentations. For example:

> *There could be some more actual examples of what shingles can look like on various parts of the body and also when to be concerned that a GP referral is needed.*

In July 2025, pharmacists were advised (via SPPG secure email) that patients presenting with shingles affecting the head and/or neck should no longer be treated

via the service. Participants were asked whether they were aware of this change and all confirmed that they were aware (n=25/25, 100%), with the vast majority indicating that the process used to update pharmacies on the change to head and neck exclusions was completely acceptable or acceptable (n=22/25, 88%). Comments indicated that the communication about the change to head and neck exclusions was broadly acceptable but highlighted the importance of ensuring that locums and all relevant pharmacy staff receive updates promptly. A centralised and easily accessible source of service updates was also suggested e.g. publishing on BSO website alongside other communications.

Practical aspects of the service

Only one respondent (n=1/25, 4.0%) reported issues with ordering, storage, delivery or availability of formulary products. This suggests that supply chain arrangements generally functioned well during the pilot. Feedback focused on the supply of valaciclovir.

> *We found valaciclovir to be too expensive to sit on the pharmacy shelf just in case it was needed.*

> *Immunosuppressed patients (whom valaciclovir is indicated for) would probably be better seeing their GP to get a prescription which they can then take with them to find a pharmacy with valaciclovir in stock rather than wait for it to be ordered in.*

Most pharmacists (n=21/25, 84%) reported excluding patients from the service because of eligibility criteria or red flag symptoms. Analysis of responses showed that exclusions were most commonly due to: head, neck or ocular involvement; severe immunosuppression; chronic kidney disease; or, uncertainty regarding diagnosis. Respondents also described inappropriate referrals from other settings, suggesting that exclusion criteria for the Pharmacy First Pilot Service for the treatment of shingles were not always fully understood outside community pharmacy.

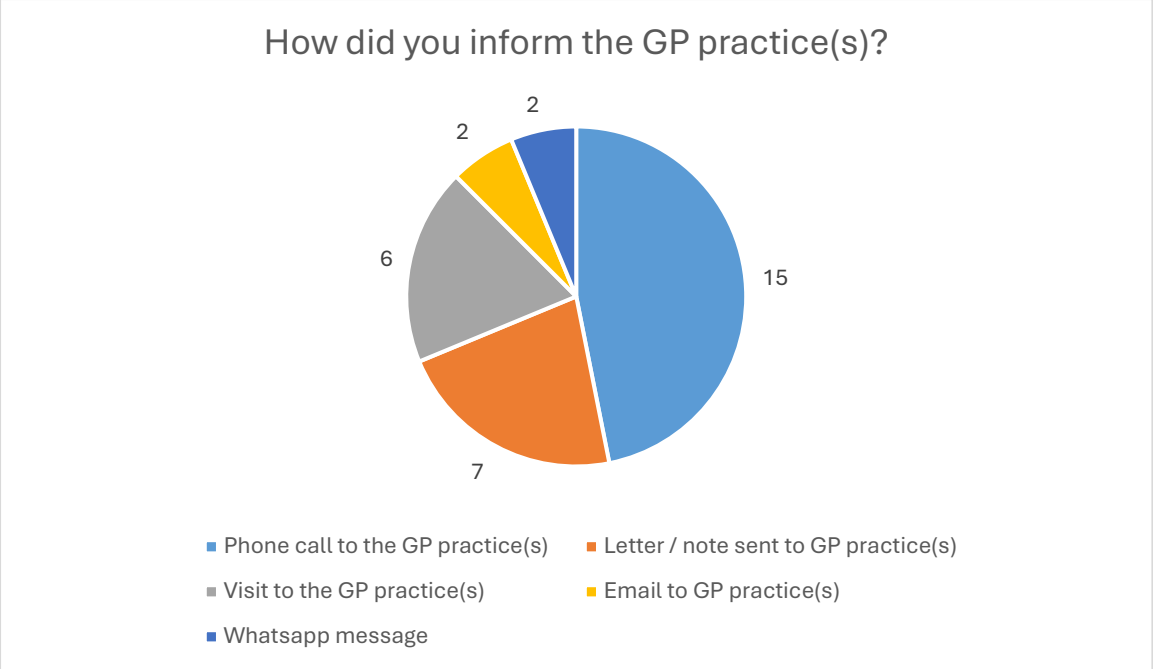
Only a minority of pharmacists (n=2/25, 8.0%) reported difficulties in managing immunosuppressed patients. The main difficulty described was distinguishing between those who were eligible for treatment and those who should be excluded as severely immunosuppressed. Respondents asked for clearer guidance to support this element of decision making.

When asked if they had any feedback on the consultation form only two participants (n=2/25, 8%) provided comments, repeating the request for clearer guidance for immunocompromised patients and a suggestion for additional space to document clinical rationale.

Awareness of the service

Pharmacists were asked whether they made their local GP practice(s) aware that their pharmacy was providing the Pharmacy First Pilot Service for the treatment of shingles with all but two respondents indicating that they had (n=23/25, 92.0%). The assumption of these two participants was that local GPs were already aware of the pharmacies providing the service.

Pharmacists reported informing the GP practice(s) via a range of approaches, the most common being via phone call.



Participants were also asked what methods they used to raise awareness of the service with the public. Responses showed pharmacists used methods such as: posters; social media; advertisements on digital screens within pharmacy; and, promotion on Pharmacy websites.

Impact on other services

It was the belief of most Pharmacists (n=23/25, 92%) that the availability of advice/treatment through the Pharmacy First Pilot Service for the treatment of shingles had impacted the number of patients seeking an appointment with their GP/Out-of-hours.

> *It is a good service that definitely has reduced demand on GP and out of hours service. We had a lot of patients referred from out of hours (during weekends) to come to the pharmacy so they can have the service.*

However, some respondents believed that there was likely little observable impact, mainly due to low activity levels or because referring organisations and patients were not always aware of the service.

Patients have attended after surgery hours and at weekends if they are well informed about the service, however, I still see prescriptions for shingles medication prescribed from out of hours when the pharmacy could have supplied it.

Overall

Overall, most pharmacists (n=22/25, 88%) considered the service to provide a more timely and appropriate pathway than was previously available. Reasons offered by respondents to support this finding, included: earlier access to antiviral treatment; and, improved convenience for patients.

Pharmacists also reported that general feedback from patients regarding the Pharmacy First Pilot Service for the treatment of shingles was mainly positive (n=24/25, 96%).

The majority of pharmacists were happy for the service to continue as currently delivered (n=21/25, 84.0%), although a smaller proportion were unsure (n=3/25, 12%) with only one respondent not supportive. Further detail provided by this participant appeared to suggest their reservations were about delivery pressures and inappropriate referrals rather than the value of the service itself.

Pharmacists did highlight some challenges which they had encountered when delivering the service, including: diagnostic uncertainty; inappropriate referrals; disruption to workflow, and limited availability of the consultation room. Suggestions to improve the service were closely linked to these challenges, with key themes summarised as: reducing/streamlining paperwork; improving awareness of the service; providing clearer referral and exclusion guidance; strengthening training resources; and, considering wider roll-out.

Final comments from respondents were largely supportive of the service and the wider role of community pharmacy. One participant did take the opportunity to highlight that service specification should be amended to include more detail around exclusion

criteria that is contained in the PGDs, specifically reference to underlying neurological conditions.

3.2.2 GP and OOH feedback

There were 57 responses from GP practices (n=57/118, 48.3%) and three from OOH services (n=3/5, 60%). The very small number of responses from OOH staff means their feedback should be interpreted with caution.

In which LCG area do you work?

Table 14: LCG area of participating GP practices

	No. of responses	% of responses
Western LCG	15	26.3%
Northern LCG	13	22.8%
Southern LCG	13	22.8%
South Eastern LCG	8	14.0%
Belfast LCG	8	14.0%
Total	**57**	**100.0%**

GP responses were received from across all LCG areas, which provides a useful regional perspective on awareness and perceived impact of the pilot among general practice staff. All three OOH responses came from Belfast HSCT.

Respondents job role

Table 15: Respondents job role within GP service

Job role	No. of responses	% of responses
GP	29	50.9%
Practice Manager	21	36.8%
Practice Nurse	3	5.3%

GP pharmacist	4	7.0%
Total	**57**	**100.0%**

GP feedback was obtained from a range of professional roles. This broadens interpretation beyond a single professional perspective within general practice.

OOH feedback came from a small range of urgent care roles involved in coordination and triage i.e. Clinical Director, Band 7 Senior Nurse Co Ordinator Phone First and Phone triage advisor.

Awareness of the Pharmacy First Pilot Service for the treatment of shingles

Awareness of the Pharmacy First Pilot Service for the treatment of shingles among GP respondents was moderate (n=39/57, 68.4%) indicating that communication with general practice could still be strengthened.

Of those who were aware of the service most had been informed via SPPG communication (n=31) with seven respondents stating they were informed via Phone call, email, note or other contact from a pharmacy providing the service.

All three OOH respondents stated they were aware of the service, with all finding out via SPPG communication and one also having received a phone call, email, note or other contact from a pharmacy providing the service.

Satisfaction with communication received about the Pharmacy First Pilot Service for the treatment of shingles before it commenced

Table16: Level of satisfaction with communication

Level of satisfaction	No. of responses	% of responses
Very Satisfied	9	15.8%
Satisfied	22	38.6%

Neither satisfied nor dissatisfied	10	17.5%
Dissatisfied	6	10.5%
Very dissatisfied	2	3.5%
Blank	8	14.0%
Total	**57**	**100.0%**

Satisfaction with communication received before the service commenced was mixed, with just over 50% of GP respondents indicating they were satisfied or very satisfied (n=31/57, 54.4%). This finding is consistent with the comments left by some respondents stating they were unaware or did not recall receiving communication about the service.

All OOH respondents indicated they were satisfied or very satisfied with communication prior to service commencement.

Awareness of which community pharmacies provide the Pharmacy First Pilot Service for the treatment of shingles

Awareness of which pharmacies were providing the service was also split with nearly 50% of GP respondents stating they were not aware of the community pharmacies providing the service (n=27/57, 47.4%).

Similarly, two of the three OOH respondents stated they were aware of community pharmacy provision of this service.

Knowledge of how to access providers lists and service documentation on the BSO website was also variable with approximately half of GP respondents (n=26/57, 45.6%) unaware these resources were on the BSO website. This suggests value in more signposting to service information.

The three OOH respondents were all aware of the resources available on the BSO website.

Patient referral to the Pharmacy First Pilot Service for the treatment of shingles

Over 40% of GP respondents reported referring patients to the service (n=25/57, 43.9%), with 36.8% (n=21/57) saying they did not and 19.3% (n=11/57) stating they were unaware whether patients were referred. Two key reasons for non-referral, identified from comments left by respondents, were: 1) local pharmacies not taking part in the pilot; and, 2) cases where patients had not been referred by staff at telephone triage. In the latter, GPs felt it was more "straightforward" to see the patient themselves rather than redirecting to community pharmacy by the time a patient had come through to the GP.

Two of the three OOH respondents indicated that patients had been referred to the Pharmacy First Pilot Service for the treatment of shingles from their OOH service.

Table 17: Were eligibility criteria clear?

	No. of responses	% of responses
Yes	29	50.9%
No	4	7.0%
Unsure	9	15.8%
Did not see documentation	15	26.3%
Total	**57**	**100.0%**

Around half of GP respondents felt it was clear which patients were eligible for referral (n=29/57, 50.9%) while a further 26.3% stated they had not seen service documentation and the remaining 22.8% felt unsure regarding eligibility criteria or felt it was unclear (n=24/57).

Eligibility criteria were considered clear by all OOH respondents.

Participants were asked whether they were aware of any patients who had a consultation with the GP because they did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles. Most GP respondents were not aware of patients declining referral in favour of a GP consultation (n=28/57, 49.1%), although others reported that this had occurred (n=13/57, 22.8%) suggesting patient preference was a barrier in some cases. Over 25% said they didn't know (16/57, 28.1%).

Respondents were asked to indicate why they believed patients did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles; patient preference for GP review and limited local participation in the service were highlighted as the main factors.

One OOH respondent was aware of patients declining referral to the Pharmacy First Pilot Service for the treatment of shingles.

Most GP respondents were not aware of patients being referred back from Pharmacy First Pilot Service for the treatment of shingles by community pharmacists for GP review, or did not know whether this had happened (n=46/57, 80.7%). This suggests that referral to a GP for review following assessment occurred relatively infrequently or was not always evident to respondents.

Where respondents had received referrals back to the GP for assessment (n=10/57,17.5%), they were asked how appropriate they felt these referrals were. Eight out of the ten respondents stated that the referrals were appropriate, with the other two indicating that the referrals were neither appropriate nor inappropriate.

One OOH respondent was aware of patients being referred back from Pharmacy First Pilot Service for the treatment of shingles by community pharmacists for review at the OOH service.

Perceived benefit to patients

Table 18: Was the service beneficial to patients?

	No. of responses	% of responses
Yes	30	52.6%
Unsure	24	42.1%
No	2	3.5%
Blank	1	1.8%
Total	**57**	**100.0%**

When asked whether the Pharmacy First Pilot Service for the treatment of shingles was beneficial to patients, participants views were split. Just over 50% stated they felt it was beneficial with over 40% feeling unsure of the benefit. Less than 5% felt the service was not beneficial to patients.

Further feedback highlighted that those who viewed the service as beneficial felt it offered improved access and facilitated faster treatment in addition to alleviating pressure on overloaded GP practices. However, some respondents were unsure of the extent of benefit because uptake appeared low locally or because awareness of the pilot was lacking, others suggested the service needed to be rolled out on a wider scale to determine benefit.

Two OOH respondents considered the service beneficial with the other being undecided.

Impact on practice

Most GP respondents reported no impact on practice workload (n=38/57, 66.7%), while a smaller group did perceive an effect (n=16/57, 28.1%). This impact was viewed as both positive and negative. While most respondents believed the service helped “alleviate” pressure from GP services by freeing up appointments, a small number of respondents highlighted they felt the service diverted funding from general practice:

It will likely reduce the need for some patients to present to primary care. But I am concerned that more straightforward work designed for general practice is taken away, fragmenting our service and permitting removal with associated payment away from primary care budget and only allowing more complex, less profitable patients back to primary care.

OOH respondents did not report an impact on their service.

Support for roll out of the Pharmacy First Pilot Service for the treatment of shingles

Table 19: Do you agree the service should be rolled out?

	No. of responses	% of responses
Strongly agree	21	36.8%
Agree	20	35.1%
Neither agree nor disagree	11	19.3%
Disagree	1	1.8%
Strongly disagree	1	1.8%
Blank	3	5.3%
Total	**57**	**100.0%**

Support for broader roll-out to all community pharmacies was strong among GP respondents, with most agreeing or strongly agreeing (n=41/57, 71.9%). This provides an indicator of wider stakeholder acceptability.

All OOH respondents supported wider roll-out of the service.

Suggestions for improvement

Final feedback from GP respondents on potential improvements to the service focused on greater publicity, clearer and more accessible provider lists, regular reminders to practices, and wider roll-out to support equity of access across areas. One participant

also emphasised that more work is needed to determine the opportunity cost of Pharmacy First Services.

4 Discussion

The Pharmacy First Pilot Service for the treatment of shingles was introduced to test whether community pharmacy could provide an accessible and clinically appropriate pathway for the assessment and treatment of adults presenting with shingles, while displacing some activity from general practice and other urgent care settings. The results of this evaluation suggest that the pilot was broadly successful in achieving these aims.

Consultation forms were returned from all LCG areas, self-referral was the most common route into the service, and over four-fifths of recorded presentations occurred within 72 hours of rash onset. This is an important finding because the service specification is built around timely recognition and prompt antiviral treatment, and the data indicates that many patients reached community pharmacy within the window in which intervention is likely to be most useful.

Shingles incidence and severity are known to increase with age, and the pilot appears to have reached the population in whom timely treatment are particularly relevant with approximately 50% of service users in the first six months of the pilot being aged 55 years and over.

Medicine supply data support consistent application of the service formulary. Aciclovir was the principal antiviral supplied and, where strength and quantity were recorded, the dominant pattern was 800mg tablets supplied as a quantity of 35, which is in line with the recommended seven-day regimen. Valaciclovir was used infrequently and was only in cases where aciclovir was unsuitable or where patients were immunocompromised. The evaluation did highlight issues with completeness of data particularly with regarding to medicine formulation which should be addressed.

The consultation form data shows that only a small proportion of patients were referred onwards to another healthcare professional and the recorded reasons for referral were

consistent with the exclusion criteria and red flags described in the service specification. This is encouraging as it implies that pharmacists were generally using the service boundaries and safety criteria as intended. In addition, the very small number of ineligible presentations identified within the consultation form data suggests that the inclusion criteria were generally being applied appropriately. However, reports of inappropriate referrals into community pharmacy for patients who then required re-direction to general practice or OOH would suggest there is a need raise awareness of eligibility criteria outside the community pharmacy setting if the Pharmacy First Pilot Service for the treatment of shingles was to be rolled-out.

Provision of advice appeared to be a relative strength of the pilot. Most consultation forms indicated that patients were advised to seek further medical review if symptoms worsened, and most were also told to contact GP or OOH services if symptoms did not improve after the antiviral course. Provision of the BAD leaflet was also recorded for most patients. One area where performance appears less strong is vaccination advice. Only a minority of consultations recorded that advice had been provided about shingles vaccination following recovery. This may represent a missed opportunity to influence future prevention.

Feedback from stakeholders provides useful context for understanding how the pilot functioned in practice. Pharmacists were positive about the value of the service and viewed it as beneficial to patients and broadly acceptable in workload terms. However, analysis also highlighted important pressures identified by Pharmacists, such as: disruption to workflow when a single pharmacist was on duty; and, administrative duplication. Further consideration of implementing digital documentation and staffing arrangements in sites providing the service would be advisable if the service is to expand.

Training and implementation resources were generally viewed positively, nevertheless, respondents described a need for more practical support, especially for differentiating atypical rash presentations and for managing immunosuppressed patients.

Feedback from GP and OOH respondents was supportive overall but more mixed than pharmacist feedback, particularly in relation to awareness and communication. Not all GP respondents were aware of the service, not all knew which pharmacies were participating, and only around half felt that patient eligibility was clear from the documentation. This matters because the service can only function efficiently if referring professionals understand who can be managed in the Pharmacy Frist Pilot Service for the treatment of shingles and where service providers are located.

Overall, the findings suggest that the pilot was successful in demonstrating that community pharmacy can provide a timely, acceptable and clinically appropriate pathway for many adult patients experiencing shingles. The service aligns well with the objectives: it improves access, makes greater use of pharmacist skills, supports cost-effective use of primary care resources and promotes the role of pharmacy as a first port of call for selected common conditions. At the same time, the evaluation identifies several areas where improvements could be made before wider roll-out. These include strengthening documentation, simplifying administration, improving communication with general practice and urgent care, clarifying exclusion criteria, providing more practical training resources and ensuring that the service is visible and equitable across participating areas.

5 Learning points

- The pilot demonstrated that community pharmacy can provide timely assessment and treatment for many adults with shingles.

- Aciclovir supply was consistent with the service formulary, but medicine documentation and completion of some clinical fields could be improved.

- Onward referral decisions generally aligned with exclusion criteria and red flag symptoms, suggesting that service providers were operating within service boundaries.

- Administrative burden and workflow disruption were the most frequently cited operational challenges, especially in single-pharmacist pharmacies.

- Additional practical training resources could strengthen pharmacist confidence, particularly for atypical presentations and immunosuppressed patients.

- Communication with GP practices and other referral sources should be strengthened so that eligibility criteria and provider locations are consistently understood.

- Advice on future shingles vaccination appears under-recorded and may represent an opportunity for improvement in future.

Appendix 1 – Consultation form

HSC Health and Social Care **Pharmacy First for Treatment of Shingles Service: Patient Consultation Form** Pharmacy First

Patient's name & address		**Pharmacy name & address**	
Patient's phone number		**Pharmacist's name**	
Age of Patient		**Date of consultation**	
GP Practice		**Did consultation take place on a Saturday or Sunday?**	**Yes ☐ No ☐**
		Is Consultation time after 6pm?	**Yes ☐ No ☐**

1. Initial assessment

The pharmacist makes an initial assessment of the patient referring to the service specification and PGDs and applies the exclusion criteria. **Patients aged 17 years and younger are excluded.**
Excluded patients should be referred to another appropriate healthcare professional e.g. GP, OOH medical services, ED

Patient referred to the service by: Self-referral ☐, Pharmacist ☐, GP practice ☐, OOHs ☐, Other ☐ specify_____

2. Consultation - assessment of the signs/symptoms of shingles

Patient has shingles and has presented within 72 hours of rash onset? Yes ☐	**Does the patient meet ANY of the following criteria?** **☐ Aged 50 years & over** **☐ Immunosuppressed*** **☐ Non-truncal involvement (shingles affecting limbs or perineum)** **☐ Moderate or severe pain** **☐ Moderate or severe rash (defines as confluent lesions)**
Patient has shingles, MORE than 72 hours and up to one week after rash onset? Yes ☐	**Does the patient meet ANY of the following criteria?** **☐ Aged 70 years & over** **☐ Immunosuppressed*** **☐ Continued vesicle formation** **☐ Severe pain** **☐ High risk of severe shingles (e.g. severe atopic dermatitis / eczema)**
Patient has a shingles rash but has presented more than a week after rash onset Yes ☐	**☐ Provide advice and leaflet. Do not supply antiviral treatment.**

Medicine(s) supplied

Antiviral supplied	Strength quantity and formulation	If Valaciclovir supplied tick reason	Other medicine(s) supplied	Strength quantity and formulation
Aciclovir		☐ Patient is immunosuppressed* ☐ Aciclovir is unsuitable ☐ There is an adherence risk	Paracetamol	
Valaciclovir			Ibuprofen	

3. Provision of advice

*** For IMMUNOSUPPRESSED patients:**

☐ Offer treatment if appropriate; URGENTLY notify patient's GP/OOHs that antiviral has been supplied and request GP review

☐ Advise patient to attend ED or call 999 if symptoms worsen rapidly or they become systemically unwell, or the rash becomes severe or widespread

For ALL patients:

☐ Advise patient to attend GP/OOHs if symptoms worsen rapidly or significantly at any time

☐ Advise patients who have received antivirals to contact their GP/OOH if symptoms have not improved following completion of 7 days treatment course

British Association of Dermatologists (BAD) leaflet supplied: Yes ☐ Shingles vaccine advice provided (if appropriate) Yes☐

4. Referral to another healthcare professional (e.g. GP, OOHs, ED) Yes ☐ No☐

If Yes, referred to: GP ☐, OOHs ☐, ED ☐, Reason (please specify):

5. Patient declaration

The patient has confirmed they have: received advice and/or treatment listed above ☐ Understood that details of this consultation will be shared with GP practice, SPPG and MOIC ☐ **Patient/carer signature**

Appendix 2

Exploring Community Pharmacists' views on the Pharmacy First Pilot Service for the treatment of shingles

The Pharmacy First Pilot Service allows eligible patients to use participating community pharmacies as the first port of call for the treatment of shingles. The pharmacist advises, treats or refers patients according to their needs.

The purpose of this survey is to hear your views and experiences of delivering the Pharmacy First Pilot Service for the treatment of shingles.

The Medicines Optimisation Innovation Centre (MOIC) is conducting the evaluation and will receive and review all survey responses. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.

An evaluation report will be made available to SPPG and CPNI once completed. Results, including direct quotations may be published in this report and in journals, publications and conferences. Any quotes used will be anonymous.

By completing this survey, you confirm that you voluntarily consent to participate in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the Pharmacy First Pilot Service for the treatment of shingles.

If you would like any further information on the evaluation please contact: suzanne.martin@northerntrust.hscni.net

PHARMACY DETAILS

Pharmacy Contractor Number

Pharmacy Name

Pharmacy Address

Pharmacy HSCNI Email

Please tick the LCG area in which you work:
Western LCG
Northern LCG
Southern LCG
South-Eastern LCG
Belfast LCG

IMPACT ON PRACTICE

On average, how much time did you spend per patient for assessment and provision of advice/treatment through the Pharmacy First Pilot Service for the treatment of shingles?
Less than 10mins
10-15 mins
15-20 mins
20-30 mins
More than 30 mins
I don't know

Has the Pharmacy First Pilot Service for the treatment of shingles impacted on patient flow in other services in your pharmacy e.g. dispensing?
Yes
No
I don't know

Please provide detail

Do you consider the admin/paperwork involved in providing the Pharmacy First Pilot Service for the treatment of shingles to be:
Completely acceptable
Acceptable
No opinion
Unacceptable
Completely unacceptable

Please explain your answer:

Overall, how acceptable was provision of the Pharmacy First Pilot Service for the treatment of shingles to your pharmacy in terms of workload?
Completely acceptable
Acceptable
No opinion
Unacceptable
Completely unacceptable

Please explain your answer:

Please add any other comments you have in relation to delivering the service:

TRAINING, RESOURCES AND COMMUNICATION

Were all resources provided to enable service delivery for the Pharmacy First Pilot Service for the treatment of shingles adequate? (Service spec, PGD, privacy notice, poster etc.)
Yes
No

If no, please provide further detail:

Did you complete the ECHO training (either live or recorded)?

Yes
No

How useful did you find the ECHO training session?
Extremely useful
Somewhat useful
Neutral
Somewhat not useful
Extremely not useful

If you did not find the training useful please provide further explanation:

What training resources would you consider most beneficial in delivering this service? (Select all that apply).
ECHO evening training sessions
Recorded lectures
Webinars
Online courses
Written materials
Mentoring/peer support

Other:

Please give details of any unmet training requirements or resource improvements:

In July 2025 pharmacists were advised (via SPPG secure email) that patients presenting with shingles affecting the head and/or neck should **no longer** be treated via the service, were you aware of this change?
Yes
No

Was the process of updating pharmacies of this change acceptable?
Completely acceptable
Acceptable

No opinion
Unacceptable
Completely unacceptable

Please explain your reason:

PRACTICAL ASPECTS OF THE SERVICE

Were there any issues with the ordering, storage, delivery or availability of the formulary products for the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

If yes, please explain:

Did you exclude any patients from the service due to exclusion criteria/red flag symptoms?
Yes
No

If yes, please provide more information on the reason for excluding the patient and how you dealt with this:

Patients who are immunosuppressed can be treated via this service, however patients who are severely immunosuppressed are excluded. Have you encountered any difficulties in managing immunosuppressed patients via this service?
Yes
No

If yes, please explain:

Do you have any feedback on the consultation form?
Yes
No

If yes, please indicate how the consultation form could be improved:
[Open text]

AWARENESS OF THE SERVICE

Did you make your local GP practice(s) aware that your pharmacy was providing the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

If no, please provide your reason:

If yes, how did you inform the GP practice(s)?
Visit to the GP practice(s)
Phone call to the GP practice(s)
Letter / note sent to GP practice(s)
Email to GP practice(s)

Other:

How did you raise awareness of the service with the public i.e. the availability of advice and treatment for shingles from community pharmacies e.g. social media, posters etc?

IMPACT ON OTHER SERVICES

Do you think the Pharmacy First Pilot Service for the treatment of shingles has impacted the number of patients seeking an appointment with their GP/Out-of-hours services regarding shingles?
Yes
No

Please provide further detail:

IN SUMMARY

Do you think this service has provided a more timely and appropriate service for shingles than was previously available?
Yes
No
Unsure

Additional information:

Has the general feedback from patients regarding the Pharmacy First Pilot Service for the treatment of shingles been:
Overall positive
Overall negative
Mixed

Would you be happy for the Pharmacy First Pilot Service for the treatment of shingles to continue as per the current delivery?
Yes
No
Unsure

If No/Unsure, please provide further information:

What challenges have you encountered in delivering this service?

Are there any changes you would suggest to improve the service?

Do you have any final/additional comments?

Thank you for completing this questionnaire.

Exploring General Practice views on the Pharmacy First Pilot Service for the treatment of shingles

The Pharmacy First Pilot Service allows eligible patients to use participating community pharmacies as the first port of call for the treatment of shingles. The pharmacist advises, treats or refers patients according to their needs.

The purpose of this survey is to hear your views and experiences of the Pharmacy First Pilot Service for the treatment of shingles, which will help inform the service's further development and implementation.

The Medicines Optimisation Innovation Centre (MOIC) is conducting the evaluation and will receive and review all survey responses. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.

An evaluation report will be made available to SPPG and CPNI once completed. Results, including direct quotations may be published in this report and in journals, publications and conferences. Any quotes used will be anonymous.

By completing this survey, you confirm that you voluntarily consent to participate in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the Pharmacy First Pilot Service for the treatment of shingles.

If you would like any further information on the evaluation please contact: suzanne.martin@northerntrust.hscni.net

About your Practice

In which LCG area do you work?
Western LCG
Northern LCG
Southern LCG

South-Eastern LCG
Belfast LCG

Please indicate your job role?
GP
GP Pharmacist
Practice Nurse
Other (please specify)

About the Pharmacy First Pilot Service for the treatment of shingles

Are you aware of the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

If Yes, how did you find out about the service? Please select all that apply:
Phone call, email, note or other contact from a pharmacy providing the service
SPPG communication
Social media
N/A
Other

How satisfied were you with the communication you received about the Pharmacy First Pilot Service for the treatment of shingles before it commenced?
Very Satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
N/A

Please explain your answer:

Are you aware of which community pharmacies are providing the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

Do you know that you can access the providers list and other service documentation for the Pharmacy First Pilot Service for the treatment of shingles on the BSO website?
Yes
No

Were patients referred from your GP practice to the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

Please explain your answer:

Was it clear from the service documentation which patients were eligible for referral to the service?
Yes
No
Unsure
Did not see documentation

Are you aware of any patients who had a consultation with the GP because they did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

If yes, please indicate why patients did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles:

Patient’s usual pharmacy was not one of the pharmacies providing the service
Patient preferred consultation with the GP practice
Unsure
Other (please give details)

Are you aware of any patients who were referred from a community pharmacist to your practice for GP review following assessment under the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

If yes, how appropriate did you feel these referrals were?
Highly appropriate
Appropriate
Neither
Inappropriate
Highly inappropriate

If "Inappropriate/Highly inappropriate", please provide an example of an inappropriate referral:

Do you think the Pharmacy First Pilot Service for the treatment of shingles was beneficial to patients?
Yes
No
Unsure

Please explain your answer:

Did the Pharmacy First Pilot Service for the treatment of shingles impact your GP practice in any way?
Yes
No

If Yes, please explain how the Pharmacy First Pilot Service for the treatment of shingles impacted your GP practice?

The Pharmacy First Pilot Service for the treatment of shingles should be considered for roll out to all community pharmacies. Please rate how strongly you agree or disagree with the above statement:

Strongly agree

Agree

Neither agree nor disagree

Disagree

Strongly disagree

Do you have any other feedback or suggestions to improve the service?

Thank you for your time and feedback

Exploring Out of Hours practitioner views on the Pharmacy First Pilot Service for the treatment of shingles

The Pharmacy First Pilot Service allows eligible patients to use participating community pharmacies as the first port of call for the treatment of shingles. The pharmacist advises, treats or refers patients according to their needs.

The purpose of this survey is to hear your views and experiences of the Pharmacy First Pilot Service for the treatment of shingles, which will help inform the service's further development and implementation.

The Medicines Optimisation Innovation Centre (MOIC) is conducting the evaluation and will receive and review all survey responses. All responses will be stored securely and confidentially. Data will be analysed and presented when combined, individual responses will not be shared.

An evaluation report will be made available to SPPG and CPNI once completed. Results, including direct quotations may be published in this report and in journals, publications and conferences. Any quotes used will be anonymous.

By completing this survey, you confirm that you voluntarily consent to participate in this evaluation and that you also grant consent to the processing of your responses for the purpose of evaluation and dissemination of the Pharmacy First Pilot Service for the treatment of shingles.

If you would like any further information on the evaluation please contact: suzanne.martin@northerntrust.hscni.net

About your OOH service

In which area do you work?
Belfast HSCT
Dalriada urgent care
Southern HSCT

South-Eastern HSCT
Western urgent care

Please state your job role:

About the Pharmacy First Pilot Service for the treatment of shingles

Are you aware of the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

If Yes, how did you find out about the service? Please select all that apply:
Phone call, email, note or other contact from a pharmacy providing the service
SPPG communication
Social media
N/A
Other

How satisfied were you with the communication you received about the Pharmacy First Pilot Service for the treatment of shingles before it commenced?
Very Satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
N/A

Please explain your answer:

Are you aware of which community pharmacies are providing the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No

Do you know that you can access the providers list and other service documentation for the Pharmacy First Pilot Service for the treatment of shingles on the BSO website?
Yes
No

Were patients referred from your OOH service to the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

Please explain your answer:

Was it clear from the service documentation which patients were eligible for referral to the service?
Yes
No
Unsure
Did not see documentation

Are you aware of any patients who had a consultation within the OOH service because they did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

If yes, please indicate why patients did not want to be referred to the Pharmacy First Pilot Service for the treatment of shingles:
Patient’s usual pharmacy was not one of the pharmacies providing the service
Patient preferred consultation with OOH
Unsure
Other

Are you aware of any patients who were referred from a community pharmacist to your Out of Hours centre for GP review following assessment under the Pharmacy First Pilot Service for the treatment of shingles?
Yes
No
I don’t know

If yes, how appropriate did you feel these referrals were?
Highly appropriate
Appropriate
Neither
Inappropriate
Highly inappropriate

If "Inappropriate/Highly inappropriate", please provide an example of an inappropriate referral:

Do you think the Pharmacy First Pilot Service for the treatment of shingles was beneficial to patients?
Yes
No
Unsure

Please explain your answer:

Did the Pharmacy First Pilot Service for the treatment of shingles impact your OOH service in any way?
Yes
No

If Yes, please explain how the Pharmacy First Pilot Service for the treatment of shingles impacted your OOH service?

The Pharmacy First Pilot Service for the treatment of shingles should be considered for roll out to all community pharmacies. Please rate how strongly you agree or disagree with the above statement:

Strongly agree

Agree

Neither agree nor disagree

Disagree

Strongly disagree

Do you have any other feedback or suggestions to improve the service?

Thank you for your time and feedback