**Business Case: Commissioning a community pharmacy Minor Ailment Service**

## **Commissioning background**

Minor ailments are defined as “common or self-limiting or uncomplicated conditions which can be diagnosed and managed without medical intervention”.

Pharmacy based services to treat minor ailments were introduced locally across the UK more than 15 years ago,[[1]](#footnote-1) to reduce the burden on higher cost settings such as general practice and A&E departments. Consultations for minor ailments are less expensive when provided through community pharmacy and evidence suggests that the pharmacy service provides a suitable alternative to GP consultations.[[2]](#footnote-2)

Nearly one in five (18%) of GP consultations are for minor ailments alone;[[3]](#footnote-3) many of which could be managed in community pharmacies through a Minor Ailment Service.With the prevailing economic climate, services such as these – which reduce costs, create GP time for the management of more complex long-term conditions and that have a positive impact on urgent and emergency services – should form part of system redesign.

The NHS England evidence base report on the urgent care review[[4]](#footnote-4), published in June 2013, highlighted the role that pharmacies could play in providing accessible care and helping many patients who would otherwise visit their GP for minor ailments. It concluded that:

**“Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions*.”***

Around 80% of all care in the UK is self-care[[5]](#footnote-5) and this is an area in which community pharmacy can make a real difference. NHS England highlighted that:

* self-care for minor ailments can reduce dependence on emergency care services;
* there is a need to improve awareness among patients about how to access self-care support services; and
* there is a need to ensure such services are used consistently by patients.

General practice and A&E departments are both in crisis. GP workload has increased substantially in recent years and has not been matched by growth in either funding or in workforce. As the pressures on general practice have grown, the experience for patients has deteriorated, albeit from high levels[[6]](#footnote-6) and data suggests that patients are finding it increasingly difficult to get appointments – the number of people who have failed to get an appointment has increased from 9% to 11% since 2011/12, which suggests there is some growth in unmet demand.[[7]](#footnote-7)

In 2012/13, there were an estimated 22 million attendances at A&E departments in England, one third of which involved ‘guidance or advice only’[[8]](#footnote-8) and 5.8 million of the attendances to A&E or walk-in centres followed patients not being able to get an appointment or a convenient appointment in general practice.[[9]](#footnote-9)

A&E departments have been struggling to meet the four-hour standard, failing most months to hit this target[[10]](#footnote-10). There are numerous reasons for this; however, patients accessing A&E because of not being able to get a GP appointment is contributing to this failure.

**The consequential diversion of patients to urgent care, such as A&E departments, could be reversed if a community pharmacy Minor Ailment Service is implemented, freeing up GP appointments and capacity in A&E departments; while also reducing costs by moving demand from higher cost settings to community pharmacy.**

## **Why [insert commissioner name] should commission a Minor Ailment Service**

The benefits of a Minor Aliment Service commissioned through community pharmacy, which have already resulted in national commissioning of the service in Scotland[[11]](#footnote-11) and Wales[[12]](#footnote-12), are primarily:

### Reducing costs and saving GP time

### Nearly one in five (18%) of GP consultations are for minor ailments alone. If these consultations could be handled by a pharmacist, at least an hour a day could be released for every GP to see patients with more complex needs3 and it could potentially reduce patient waiting times. In the CCG area, this equates to approximately [insert the CCG figure from Appendix 1 – Column E of *PSNC Briefing: Building a business case for a Minor Ailment Service*] consultations per year[[13]](#footnote-13) that could potentially move to community pharmacy.

Such consultations in pharmacy are less costly than general practice consultations and have been shown to provide favourable health-related outcomes. A modelling analysis of the cost of a national Minor Ailment Service in community pharmacies in England in 2011 showed that there was a significant cost saving.[[14]](#footnote-14) The Department of Health (DH) undertook a Partial Impact Assessment in 2008 which suggested that a saving of £300 million could be made with wide-scale implementation of local services.[[15]](#footnote-15)

Pinnacle Health Partnership carried out an analysis of data recorded on PharmOutcomes[[16]](#footnote-16) of 74 Minor Ailment Services across England which involved 1,722,230 consultations. Patients were asked what action they would have taken if the community pharmacy Minor Ailment Service was not in place and 87% of patients would have made an appointment with their GP and only 8% of patients would have purchased medicines if the Minor Ailment Service was not available.[[17]](#footnote-17) This shows that where a Minor Ailment Service is commissioned, patients are being diverted away from GP practices.

**A community pharmacy Minor Ailment Service is a cheaper alternative to patients presenting at a GP practice for the treatment of a minor ailment and has been shown to divert patients away from GP practices.**

### Reducing demand and costs for urgent care

Minor ailments are one of the most common issues that result in the use of urgent care services and it has been found that 8% of A&E consultations could be managed by a pharmacist if a pharmacy service was commissioned.[[18]](#footnote-18)

The Government has an aim to improve the performance of A&E departments, which are under rising pressures, and trusts and CCGs will be required to meet the Government’s 2017/18 mandate to the NHS that: in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within four hours – up from 85%; the majority of trusts meet the 95% standard in March 2018; and the NHS overall returns to the 95% standard within the course of 2018.[[19]](#footnote-19) Additional NHS funding will be provided to support the implementation of the processes required to achieve this and minimising attendances through the commissioning of a community pharmacy Minor Ailment Service could be considered which could also potentially reduce attendances at the “Urgent Treatment Centres” when these are rolled out across the country.

Community pharmacies can have an important role in diverting patients away from A&E and managing demand for local urgent and emergency care services. When commissioned, these services can potentially be accessed through triage by GP practice staff or clinical streaming within A&E departments, NHS 111 when included in their Directory of Services, or by self-referral, depending on the commissioner’s requirements.

Community pharmacy offers the most cost-effective provision of the treatment of minor ailments, with treatment in an A&E department costing a minimum of £63[[20]](#footnote-20) for each presentation, and each visit to a walk-in-centre or similar service[[21]](#footnote-21) or a GP consultation[[22]](#footnote-22) costing the NHS around £36. NHS funded community pharmacies provide potential solutions to all these urgent care challenges.

**A community pharmacy Minor Ailment Service is a potential solution to local urgent care challenges.**

### Providing quality patient care

### Data from Pinnacle Health Partnership16, which analysed 74 Minor Ailment Services across England and 1,722,230 consultations, showed that 95.8% of patients who attended a pharmacy to access a Minor Ailment Service required no onward referral to another healthcare professional and the patient was provided with appropriate advice and medicines without further NHS resource. Of the referrals, the clear majority were for a non-urgent appointment with the individual’s GP through the usual appointment system, therefore not adding pressure to “sit and wait” style GP practice visits.

[The options for treating minor ailments in community pharmacies have increased over the years, with many medicines being reclassified from prescription only medicines (POMs) to medicines that can be supplied over the counter (pharmacy only (P) medicines) in a pharmacy. This gives pharmacy teams a wider breadth of medicines to choose from when recommending a medicine to a patient to treat a minor ailment.] – the emphasis in this paragraph should be amended if your service is a PGD only service.

There are over [**insert number**] community pharmacies in the [**CCG / local NHS England area (delete as appropriate]**, situated in high-street locations, in supermarkets and in residential neighbourhoods and they are easily accessible. An estimated 99.8% of people from the most deprived areas live within just a 20-minute walk of a community pharmacy and overall 89.2% of the population is estimated to have access to a community pharmacy within a 20-minute walk.[[23]](#footnote-23) Patients are seen by qualified staff in the pharmacy consultation area without the need for an appointment. There are community pharmacies in most areas, many of which are open for extended hours including Saturdays and Sundays, which will reduce the demand on urgent care further, and increase patient choice.

**A community pharmacy Minor Ailment Service provides patients with easy access to high quality treatment for minor ailments.**

## **Achieving financial balance**

Although there is a clear need for change to meet the challenges of the healthcare system, it is important that the funding for services meets the needs of commissioners.

**The provision of a pharmacy service would have several routes to immediate cost savings:**

* reduction in A&E presentation for minor ailments;
* reduction in attendance at walk-in centres [**delete if you do not have any in your area**]; and
* releasing opportunity costs through freeing up GP consultations.

There are additional savings that would be made through improved opportunities for continued independent living and improvements in early identification of long-term conditions. However, these savings and other non-monetised benefits have been excluded from this business case.

### Reduction in urgent care presentations

The National Tariff Payment System 2017/18 and 2018/1918 requires a minimum payment of £63 to be made when patients present at A&E departments. The payments are based on A&E attendances, so are triggered at the point of registration within the A&E department.

**The most significant A&E department locally is [insert the name of the hospital from Annex 2 – Column A],which saw attendances at the A&E reach [insert the CCG figure from Annex 2 – Column B] in 2014/15, the latest period for which statistics are publicly available.[[24]](#footnote-24) With 8% of attendances being able to be dealt with in other settings such as pharmacy17, this means that [insert the figure from Annex 2 – Column C] A&E attendancesare costing the CCG a minimum of [insert the £ from Annex 2 – Column D] per year, dependent upon HRG coding by the hospital18.**

### Reduction in walk-in centre presentations

Many walk-in centres have seen greater numbers of patients than commissioners initially anticipated. In some cases, this has led to higher payments to walk-in centre providers than expected. Commissioners have cited annual costs for a walk-in centre as being between £450,000 and £1.5 million.[[25]](#footnote-25)

[Walk-in centres have a locally decided tariff, often based upon block contracts that have base activity with trim points which can lead to additional costs. The following paragraph is provided as an exemplar but will require local editing. If the discussion is not applicable and this paragraph is deleted, then you will also need to remove the bullet point from the main paragraph above.]

[The following paragraph will require adjustment to local circumstances and uses a theoretical example for illustration only].

**The local Walk-in Centre at [insert name] operates with a block contract which provides for 52 patient consultations per day with a ±5% variance allowable and a £3619 per patient premium for those in excess. Thus, where the Walk-in Centre is currently seeing 63 patients per day on average, this amounts to an additional [(63 -52) x 36 x 365 = £144,540].**

**A pharmacy Minor Ailment Service would potentially reduce this to below the lower trim point of a block contract, leading to further savings as well as providing care for patients closer to their home.**

### Releasing opportunity costs in general practice

Moving care from secondary to primary care is a clear direction of travel for most CCGs. One of the limiting factors is the capacity available within general practice to manage the increased workload sufficiently quickly. As a community pharmacy Minor Ailment Service would produce an immediate effect, with practice staff able to signpost patients for an immediate consultation at their local pharmacy without needing to make an appointment, plans for new GP services could be implemented quickly with the instant release of capacity to produce savings in the current financial year.

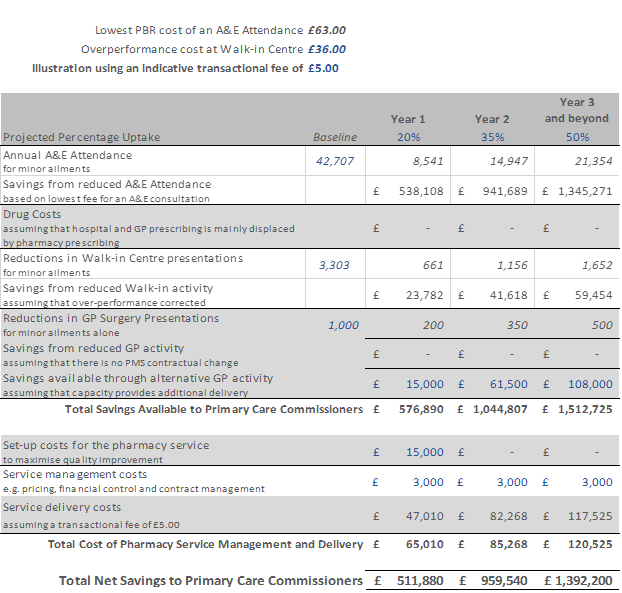
Using two NICE case studies of primary care projects as exemplars,[[26]](#footnote-26) the DAFNE project produced savings of £93,133 per 100,000 population in the medium-term and the Glaucoma project released £15,000 per 100,000 population in the short-term. Both could quickly be implemented locally and the savings gained if capacity existed to do so.

## **Financial projections**

The following analysis follows the methodology of the DH Impact Assessment and takes the most conservative view of savings ranges where applicable. Non-monetised benefits and those savings made in areas outside health, such as costs to society and cost savings to patients, have also been excluded. There might also be an expectation that drug costs would be lower because of the control of the formulary and the pack sizes used, but this has been excluded from the analysis.

In the first year of the service and following the DH methodology, it is assumed that 20% of activity would move to pharmacy and, given appropriate promotion of the service, would follow the experience of other areas to reach 35% and then stabilise at 50% over the following years.

[The spreadsheet below should be deleted and replaced with the financial projections spreadsheet containing your local data.]



**Mobilisation planning**

A small number of steps would need to be taken to fully utilise community pharmacy in delivering capacity and cash releasing savings. There are many of these services being delivered throughout the country and PSNC has produced a ‘Minor Ailment Service toolkit to support this. The toolkit includes a template:

* Service specification which includes:
  + Details of record keeping and patient consent requirements;
  + A list of suggested indications treatable under a Minor Ailment Service;
  + A list of suggested medicines that could be supplied under Patient Group Direction;
  + Details of service sign up;
  + GP notification form; and a
  + Claim form.
* Patient Group Directions – support document;
* Implementation guide;
* Briefing document for GPs; and
* Template letters for GPs (for a non-PGD service or a PGD service).

### The toolkit is available at: [www.psnc.org.uk/ctp](http://psnc.org.uk/services-commissioning/commissioning-toolkit-programme/)

### Service specification

The indications listed in the above template service specification are treatable with General Sales List (GSL), P medicines or certain POMs which can be supplied under PGD. [You may wish to amend this wording if your business case is for a PGD service only.]

When looking at which minor ailments should be included in the service, it is worth considering that ten ailments have been found to account for three quarters of all minor ailment consultations and three quarters of all minor ailment costs to NHS budgets.[[27]](#footnote-27)

The top ten minor ailments by number of GP consultations identified by IMS Health in 2006/7 were:

|  |  |
| --- | --- |
| **Minor Ailment** | **Annual Consultations (millions)** |
| Back pain | 8.4 |
| Dermatitis | 6.8 |
| Heartburn and indigestion | 6.8 |
| Nasal congestion | 5.3 |
| Constipation | 4.3 |
| Migraine | 2.7 |
| Cough | 2.6 |
| Acne | 2.4 |
| Sprains and strains | 2.2 |
| Headache | 1.8 |

**PSNC website**

The Services and Commissioning section of the PSNC website has a section on minor ailments[[28]](#footnote-28) with additional information and examples of services that have been commissioned locally are available on the PSNC online services database[[29]](#footnote-29); these show the extensive range of ailments that may be included.

### Accreditation

The Declaration of Competence (DoC) system[[30]](#footnote-30) has been developed to assure commissioners that pharmacists are service-ready and have the appropriate skills, knowledge and behaviours to deliver high quality, consistent services. There is a DoC for minor ailments and many commissioners now include DoC in their service specifications, service level agreements and PGDs rather than requesting pharmacists to complete certain training courses when offering a PGD Minor Ailment Service.

The Declaration of Competence (DoC) system is supported for use across England by Health Education England and endorsed by NHS England and Public Health England; it is intended to support professionals and employers in assuring the delivery of high quality services for patients. By working through a self-assessment tool, the pharmacy professional reflects on current competence to deliver a service and identifies the steps they need to take to develop and maintain their knowledge and skills in relation to a service before signing a self-declaration of competence statement.

### Set up, monitoring, reporting and service evaluation

[Insert commissioner name] will want to ensure robust service set up; monitor service activity and costs; demonstrate service outcomes; evaluate financial benefits to the local health system and capture quantitative and qualitative feedback. Typical costs have been built into this business case. The simplest and most effective way to achieve this is to use a web-based tool such as PharmOutcomes16. These tools ease the burden of record keeping, service management and financial tracking for both commissioners and community pharmacy providers and allows local and national level analysis and reporting on the effectiveness of commissioned services, helping to improve the evidence base for community pharmacy services.

The Local Pharmaceutical Committee (LPC) can offer initial set up and ongoing support for this service and will be able to advise on setting up reports that can be tailored to meet your requirements.

1. [Department of Health: Pharmacy in the future: implementing the NHS Plan (September 2000)](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005917) [↑](#footnote-ref-1)
2. [Paudyal V, et al. Are pharmacy based minor ailment schemes a substitute for other service providers? Br J Gen Pract 2013; 63 (612), (July 2013):472-481](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3693804/) [↑](#footnote-ref-2)
3. [PAGB/PSNC: Joint submission to the Pharmacy White Paper (December 2007)](http://psnc.org.uk/wp-content/uploads/2013/07/PAGB_and_PSNC_paper_on_minor_ailments.pdf) [↑](#footnote-ref-3)
4. [NHS England: High quality care for all, now and for future generations: transforming urgent and emergency care services in England: The Evidence Base from the Urgent and Emergency Care Review (June 2013)](http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf) [↑](#footnote-ref-4)
5. [www.selfcareforum.org](http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/) [↑](#footnote-ref-5)
6. [The King’s Fund: Understanding pressure in general practice (May 2016)](https://www.kingsfund.org.uk/publications/pressures-in-general-practice) [↑](#footnote-ref-6)
7. [NHS England: GP patient survey – National summary report (July 2014)](http://gp-survey-production.s3.amazonaws.com/archive/2014/July/1301375001_Y8W2%20National%20Summary%20Report_FINAL%20v1.pdf) [↑](#footnote-ref-7)
8. [NHS Digital: Focus on Accident & Emergency (December 2013)](http://content.digital.nhs.uk/catalogue/PUB13040) [↑](#footnote-ref-8)
9. [House of Commons Committee of Public Accounts: Access to General Practice in England (March 2016)](https://www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/673/673.pdf) [↑](#footnote-ref-9)
10. [The King’s Fund: What’s going on in A&E? The key questions answered (March 2016)](https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters) [↑](#footnote-ref-10)
11. [Scottish Government: The new NHS Minor Ailment Service at your community pharmacy (June 2006)](http://www.gov.scot/Publications/2006/06/26102829/1) [↑](#footnote-ref-11)
12. [NHS Wales: New Choose Pharmacy scheme to be rolled out across Wales (March 2016)](http://www.wales.nhs.uk/nwis/news/40665) [↑](#footnote-ref-12)
13. PSNC Briefing: Building a business case for a Minor Ailment Service (July 2017) [↑](#footnote-ref-13)
14. Sewak NPS, Cairns J. A modelling analysis of the cost of a national minor ailments scheme in community pharmacies in England. IJPP (2011); 19 (S1): 50 [↑](#footnote-ref-14)
15. [Department of Health: Partial Impact Assessment of proposals to expand the provision of minor ailment services (2008)](http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083938.pdf) [↑](#footnote-ref-15)
16. PharmOutcomes is a web-based system which helps community pharmacies provide services more effectively and makes it easier for commissioners to audit and manage these services. By collating information on pharmacy services, it allows local and national level analysis and reporting on the effectiveness of commissioned services, helping to improve the evidence base for community pharmacy services. <https://pharmoutcomes.org> [↑](#footnote-ref-16)
17. [PSNC Briefing 044/17: Analysis of Minor Ailment Services Data (July 2017)](http://psnc.org.uk/services-commissioning/psnc-briefings-services-and-commissioning/psnc-briefing-04417-analysis-of-minor-ailment-services-data-july-2017/) [↑](#footnote-ref-17)
18. [Bednall R, et al. Identification of patients attending accident and emergency who may be suitable for treatment by a pharmacist. Fam Pract (2003); 20(1): 54–57](https://academic.oup.com/fampra/article/20/1/54/498917/Identification-of-patients-attending-Accident-and) [↑](#footnote-ref-18)
19. [NHS England: Next steps on the NHS Five Year Forward View (March 2017)](https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/) [↑](#footnote-ref-19)
20. [NHS improvement: National tariff payment system 2017/18 and 2018/19 (updated May 2017)](https://improvement.nhs.uk/resources/national-tariff-1719/). Lowest payment for an attendance at A&E is £63. [↑](#footnote-ref-20)
21. [Primary Care Foundation: Urgent Care Centres, what works best? (October 2012).](https://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf) A wide variation in cost per case was found, with most falling in the range from £28-£40. The median cost (£36) has been used for the above table. [↑](#footnote-ref-21)
22. [PSSRU: Unit costs of health and social care (2016)](http://www.pssru.ac.uk/project-pages/unit-costs/2016/index.php) [↑](#footnote-ref-22)
23. [Todd A, Copeland A, Husband A, et al. The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England. BMJ Open (August 2014)](http://bmjopen.bmj.com/content/4/8/e005764) [↑](#footnote-ref-23)
24. [NHS Digital: Hospital Episode Statistics: Accident and Emergency Attendances - provider level analysis (March 2015)](https://data.gov.uk/dataset/accident_and_emergency_attendances_in_england_experimental_statistics) [↑](#footnote-ref-24)
25. [Monitor: Walk-in centre review – Final report and recommendations (February 2014)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283778/WalkInCentreFinalReportFeb14.pdf) [↑](#footnote-ref-25)
26. [NICE QIPP collection (accessed July 2017)](https://www.evidence.nhs.uk/qipp) [↑](#footnote-ref-26)
27. [PAGB: Driving the self care agenda (2011)](http://www.selfcareforum.org/wp-content/uploads/2011/07/AndyTismanarticle.pdf) [↑](#footnote-ref-27)
28. [PSNC website – Minor Ailment Service](http://psnc.org.uk/services-commissioning/locally-commissioned-services/en8-minor-ailments-service/) [↑](#footnote-ref-28)
29. [PSNC Services Database](http://psnc.org.uk/services-commissioning/services-database/) [↑](#footnote-ref-29)
30. [Centre for Pharmacy Postgraduate Education: Declaration of Competence](https://www.cppe.ac.uk/services/declaration-of-competence) [↑](#footnote-ref-30)