Who benefits from the cost-saving initiatives implemented by pharmacy departments? Here, we discuss gain share — an incentivising concept intended to save money for both commissioners and NHS trusts.

Save money from high-cost medicines using gain share

By Maureen O’Sullivan, MRPharmS

You are the chief pharmacist at a busy district general hospital that has been steadily providing more and more high-cost medicines to patients via homecare suppliers. You have read the Royal Pharmaceutical Society’s professional standards for homecare services and, with your team, compared the service you provide against the framework. You are keen to start implementing some changes to your homecare service that you think will save your trust some money in the coming year. However, how sustainable will these changes be? Can you be sure that your department will retain the money it needs to provide this service year on year? What incentive is there for making these cost-saving changes to your department? The answer is gain share.

Incentives

“Gain share is about the flow of money: where it comes from and who benefits from any savings that are made when a good idea comes into practice,” explained Margaret Dolan, vice-chairman of the Guild of Healthcare Pharmacists Procurement and Distribution Interest Group at its autumn symposium last month (Birmingham, 7 November 2013).

In November 2012, the Department of Health issued the document “Achieving savings from high-cost medicines using gain share incentive to be cost-effective in their use and procurement of high-cost medicines.”

According to the report, up to £2.6bn (approximately 60% of the total medicines budget) is spent on Payment by Results-excluded medicines in England each year — so the cost implications of not using the cheapest option or procuring medicines in the most cost-effective way are vast.

The report proposed that as an incentive for NHS trusts to be more cost-effective in their use and procurement of PbR-excluded medicines, commissioners should share a proportion of any resultant financial savings with them, and that arrangements need to be put into place that state this agreement clearly.
Homecare

Supplying more high-cost medicines through homecare services is one way the NHS believes it can save money for the whole of the NHS. In fact, a DH-commissioned review, “Homecare medicines: Towards a vision for the future”, had already recommended that “clear, up-front agreements on the share of financial savings with both commissioners and providers” should be part of regional procurement arrangements for homecare medicines.

Mark Hackett, chief executive of University Hospitals of North Staffordshire NHS Trust, conducted the 2011 report and is now chairman of the homecare medicines implementation group. Speaking at last week’s PDIG meeting, Mr Hackett told participants that the potential savings from using homecare services are “massive” and that they should do everything they can to push for these savings locally. He said: “We need to keep the incentive mindset between commissioners and providers in the NHS to ensure that they are both pulling together to work together.”

However, it seems that the lack of clear guidance on gain share arrangements is restricting pharmacy departments from buying into the homecare agenda. Kevan Wind, medicines procurement specialist pharmacist for London and East of England, who was in the audience at the PDIG symposium, is concerned.

“What is needed is clarity and certainty on gain share arrangements for homecare services. Currently these are not clear and without this certainty, NHS providers will not progress with homecare initiatives,” he later told Clinical Pharmacist.

Allan Karr, PDIG chairman and pharmacy business services manager at University College London Hospitals NHS Foundation Trust, voiced his concern about the distribution of the money awarded through gain share initiatives: “It is important that whatever funds are transferred to a trust are put in place specifically for those who are doing the work,” remarked Mr Karr. He added that if this is not the case it could leave those at an operational level struggling to cope. This means that a department that has invested resources to deliver savings will want to see a portion of that money come back to its service.

Mr Hackett suggested that many of the problems that are preventing local gain share agreements from being made are due to “personality-based issues” between commissioners and providers. “What we have been trying to do with the homecare work is to [encourage people] to put those issues aside or to use a third party to broker those differences.” He added: “[Chief pharmacists] have to show upward leadership to chief executives and trust boards to get them to buy into this agenda . . . and work out with the commissioners what the gain share arrangement should be. There is serious money here at stake for both parties.”

Best practice guidance

Clare Howard, deputy chief pharmaceutical officer at NHS England, prepared the 2012 DH report on gain share during her previous appointment as national lead for the “quality, innovation, productivity and prevention” (QIPP) medicines use and procurement programme. “I saw gain share as being something to grease the wheels to provide incentives to ensure the whole of the NHS was able to capitalise on the efficiencies that were available,” said Ms Howard, speaking at a later session at the symposium.

“As part of the QIPP role we developed a set of principles that described what sensible gain share should be,” explained Ms Howard. “NHS England still supports those principles . . . so anybody still struggling to get gain share off the ground should be reminded that [the 2012] document is still current.”

However, gain share incentives do not just apply to medicines supplied via homecare services and in light of the NHS reforms in England — which made NHS England the direct commissioner for specialised services — Ms Howard acknowledged that the guiding principles around gain share needed to be reviewed.

National arrangements

Charged with carrying out this review is the newly formed Specialised Commissioning Medicines Optimisation Clinical Reference Group.

“I see my role, although employed by the commissioner, as being somewhere in the middle,” explained Ms Howard, chairman of the group.

“I need to make sure there is enough of an incentive for NHS trusts to want to make sure efficiencies are delivered, yet also hold the purse strings and make sure [gain share arrangements] still remain good value for money and are being used in the right way.”

According to Ms Howard, the group has already started work on this review and has “gained headway on some of the really tricky issues” around gain share arrangements, such as determining on what basis financial savings should be calculated (eg, cost per item).

Ms Howard plans for the new gain share document to be available by the end of 2013 for commissioners and NHS providers to use when making plans for 2014. However, she warned that local leadership will still be required to make these schemes work and the document will not stipulate how NHS trusts should be spending the money awarded through gain share arrangements.

“How a trust conducts its business is up to that trust,” explained Ms Howard. However, she added that it would be rather shortsighted of a trust to make these efficiencies without recognising the contributions of the pharmacy.