NHS
Fareham and Gosport
and South Eastern Hampshire
Clinical Commissioning Groups

A Commissioner’s Perspective

How services are funded, and how to get agreement to new diagnostic tests

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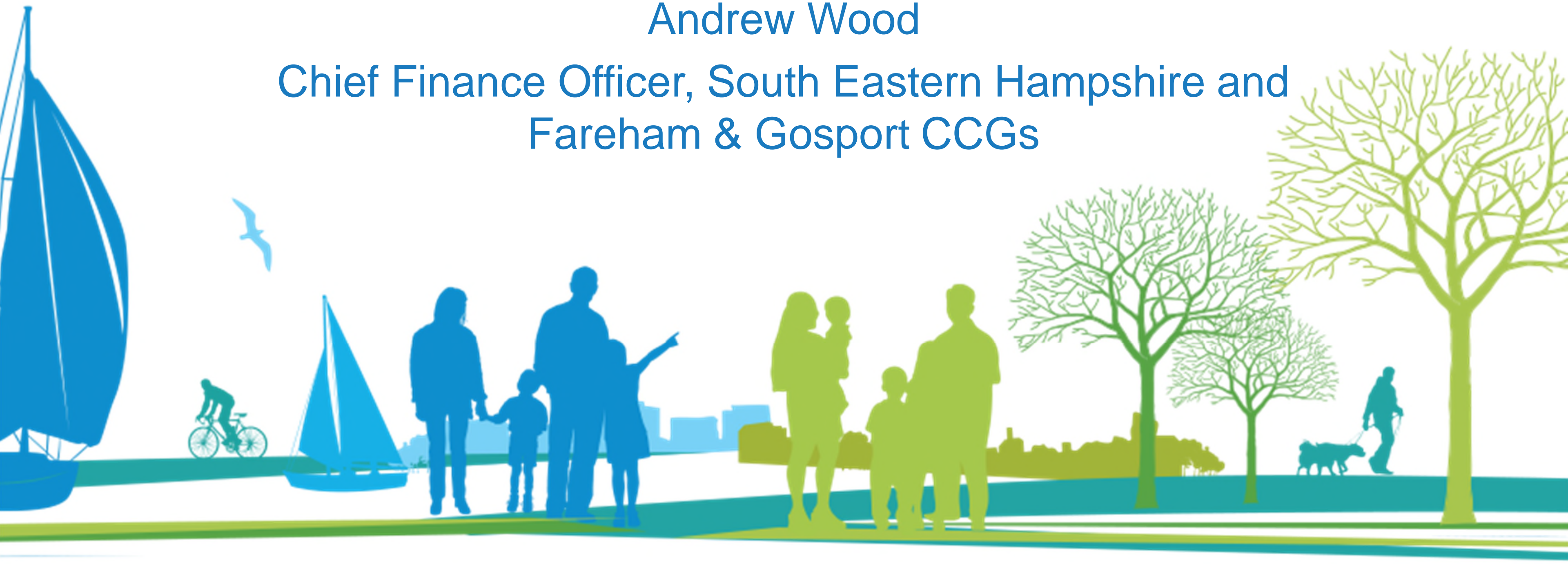


About Our CCGs

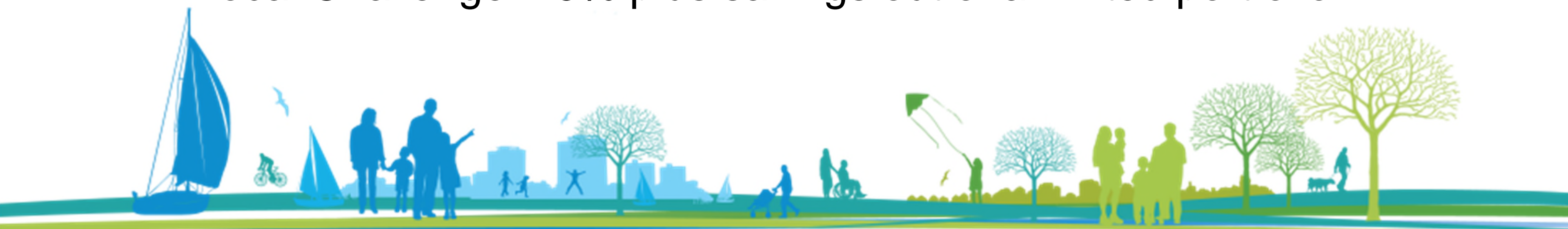
- Separate organisations with shared infrastructure
- Different populations (total c. 420,000)
- 10th and 11th worst funded in the country (£500m allocations)
- 2/3rds of the local acute contract , but not the lead commissioner
- Shared commissioning team
- Success in keeping GP referrals and non elective admission growth lower than national figures
- Relentless change – Vanguard, primary care, Better Care Fund

Financial Context

- National Challenge – 5 Year Forward View - £30bn funding gap

"The funding and efficiency gap: if we fail to match reasonable funding
levels with wide-ranging and sometimes controversial system efficiencies,
the result will be some combination of worse services, fewer staff, deficits,
and restrictions on new treatments."

- Local Challenge – 5% plus savings out of a limited portfolio



Commissioning Context

- Fragmented arrangements - CCGs now commissioning primary, community and secondary care , mental health and learning disabilities.
- Not Specialised services (yet)
- Still commissioning at different levels – single CCG , 3 CCGs, Hampshire, SHIP
- Annual contracts and Payment by Results in place
- Desire and need to do things differently eg capitation based contracts

How do we set priorities?

- Informed by JSNA and CCG clinical strategies
- *But* tend to rollover contracts, agree activity and argue over coding and counting changes
- Good clinician to clinician engagement (doesn't always translate into organisational agreement)
- Priorities Committee in place
- Take each case on its own merits
- Evidence/ NICE?? or driven by what GPs and commissioners want to focus on?
- NICE technology appraisals– see Nuffield Trust rationing paper
- Finance is a key driver for the prioritisation process

Payment by Results

- Tariff – a disincentive to innovation?

- Direct access – ordered by GPs , separate tariff
- Unbundled diagnostics in outpatients – everything bar plain film
- Some diagnostics as outpatient procedures (Radiology, 24 hr cardiac tapes, complex ECG, all scopes)
- Everything else in national tariff as an overhead

But – before PbR Trusts were more dependent and sought approval from commissioners for every change

Variations to the national tariff

- In the past – had a mechanism to pay for new treatments and procedures as a top up to tariff – rarely used. Approval through regional clinical networks.
- Any changes seen as a “coding and counting” change and subject to 6 months notice (or refused)
- Now have local variations and modifications; tariff setting run by Monitor and the direction of travel is to be more flexible, but needs national signoff.

Payment by Results – the national tariff

- Based on reference costs, so always out of date
- Reference costs not audited – no transparency
- Not always clear what is in or out of tariff
- What is an overhead (i.e. within the main tariff?)

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Developing a case for funding – what the CCGs would like to see

- The population affected
- The clinical evidence base
- Cost of the test
- What the test will gain us – the "so what?"
- Impact on the patient pathway (eg impact on follow ups)
- Overall – the case for change

What does the future hold?

- Outcome based , capitated contracts
- 5 Year Forward View – MCPs, PACs
- Increasing uses of technology
- More potential for innovation?
- How can we help you to get early input from commissioners into new developments in diagnostics?