A Commissioner’s Perspective
How services are funded, and how to get agreement to new diagnostic tests

Andrew Wood
Chief Finance Officer, South Eastern Hampshire and Fareham & Gosport CCGs
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?)
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?