To do

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2.6
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How are funding decisions made in the NHS?

Now that you understand how money flows through the NHS, what commissioning is and who is responsible for it, it's time to hand over to you.

We asked you to post your questions to our Guest Educator, Ruth Robertson and we received over 200 questions. Many of these questions touched on similar themes so we have grouped them together into seven broad questions to try and address as many points as possible.

How is funding allocated between clinical commissioning groups (CCGs)?

NHS England is responsible for determining how much money is allocated to each CCG each year. The allocation is designed to reflect local health care needs and to help reduce inequalities.

To do this NHS England uses a 'weighted capitation formula' which allocates resources based not only on the size of the local population, but also their health needs – which might differ because of things like age, health status and level of deprivation. The formula also considers the different costs of delivering services in different parts of the country. For example, staff and buildings cost more in some parts of the country.

This formula provides a 'target' allocation for each CCG. Their actual budget is based on the amount of money they currently get (their historic allocation) which then has an adjustment applied to it to bring it closer to the target allocation. You might wonder why they don't just give each CCG its target allocation? This can't be done because a sudden large reduction in a CCGs allocation would destablise local health services.

This is a complex process and you can find more information on it in this NHS England slide pack.

How do CCGs make their decisions, what information do they use and what impact do those decisions have?

First let me answer the question about decision making. Each CCG has a governing body that consists of GPs, other clinicians such as nurses and secondary care consultants, patient representatives/lay people and general managers. Some CCGs also have GP practice managers and local authority representatives on their governing bodies. The governing bodies are responsible for ensuring that the CCG has appropriate arrangements in place to commission services effectively, efficiently and economically. They are the major decision-making body for each CCG and they have a series of sub-committees that take decisions on particular areas. For example, if the CCG commissions general practice (most do), they will have a primary care commissioning committee that takes decisions about GP services. Increasingly, CCGs are working with their neighbouring CCGs and with other commissioners and providers to take joint decisions – I've written more about this in response to the question below about future models of commissioning.

CCGs use a range of information sources to inform their commissioning decisions. Importantly, this includes the Joint Strategic Needs Assessment (JSNA), which is an assessment of the current and future health and care needs of the local community produced by CCGs and local authorities (through their health and wellbeing board). It is a broad assessment of need that includes information on wider determinants of health like employment, the environment and transport. Your local area's JSNA is available online, for example here is a link to Devon's JSNA.

CCGs also use a range of other data sources depending on what they are commissioning. These include information about historic service use, views from patients and the public, best practice commissioning guidance, NICE guidelines on the care patients should receive for particular conditions and more.

In reality many service contracts change little year to year, other than having an efficiency assumption added into the cost calculations. There is debate about what impact commissioners have on local service provision and therefore what value commissioners add to the health system. This is a difficult question to answer as research evidence is scarce – in any study it is difficult to attribute changes in service provision or outcomes to commissioners, and because the structure of the commissioning system changes regularly it is difficult to assess the impact of any particular model over a long period of time.

A review of evidence about the impact of earlier forms of commissioning (before the introduction of CCGs) found that despite some positive outcomes, overall 'commissioning has had limited impact in shifting services out of hospital, reducing avoidable use of hospitals and developing new forms of care', it also concluded that 'there was little evidence that any form of commissioning had had a significant or strategic impact on hospital services'. Commissioners appear to be more effective in bringing about small-scale changes in service provision, particularly in primary care and they were also successful in reducing waiting times. CCGs were designed to have a bigger impact than their predecessors due to being clinically-led. We do not have clear evidence on what impact CCGs have had on local service provision or the cost effectiveness of the current model for planning services.

Doesn't local commissioning lead to a 'postcode lottery' of

health care?

Our system of commissioning allows the health care available in each area to be tailored to local needs. For example, in an ex-coal mining community with a lot of older people with respiratory problems it makes sense for the local commissioner to have the freedom to invest more money in respiratory services to meet that need.

As the NHS only has a limited amount of money available to spend, it has to make decisions about what it will and won't fund, and inevitably in a system based on local decision making, this means there are some differences in the services available in different parts of the country. However, although local commissioners have powers to tailor services locally, a lot of the decision about what care is available are taken nationally and implemented through national policies and guidelines. The NHS Constitution, for example, outlines the rights that all NHS patients have in the system. Your local NHS is shaped by a blend of national requirements and guidance and local decisions by commissioners.

Worries about a 'postcode lottery' are more prevalent during times of extreme pressure on the health service. For the past decade the NHS has been under a lot of pressure financially (it's budget has grown by around 1% a year on average, compared to 4% in the past) while the number of people – particularly older people – with complex care needs is growing. This means commissioners have to make increasingly difficult decisions about how to allocate resources between different services. Although the same core services are available across the country, these pressures have led to some high-profile decisions by some CCGs to do things like stop funding most IVF treatment or increase the threshold at which patients are eligible to get a hearing aid.

When thinking about the 'postcode lottery' it's important to remember most variations in care occur due to variations in clinical practice, rather than differences in the services that are commissioned by CCGs and other local commissioners. The NHS Atlases of Variation provides statistics on the extent of these differences in clinical practice – for example the proportion of stroke patients who received brain imagining within 12 hours of arriving in hospital in Q4 of 2015/16 ranged from 3.3% in Corby CCG and 43.6% in North Lincolnshire CCG. There is work going on across the NHS to try and reduce these variations in clinical practice. For example, the Right Care programme presents data on variations to CCGs and supports them to address variation. The Getting it Right First Time programme works with clinicians to address clinical variation.

What prices are paid for services?

This works in different ways in different parts of the health system. For example, most acute hospital care is traditionally paid for on tariff – this is a set price paid for each episode of care. The prices for each year are published by NHS England and NHS Improvement – they are currently consulting on the tariffs for 2017–2019. Under the tariff system, the more patients a hospital sees, the more money they get from the CCG at the end of the year.

For community services and many mental health services there is no tariff and providers receive a

block payment that covers the costs of care they provide for all patients during the year. This amount is agreed in advance through negotiations with the CCG based on things like historic services use, the services the commissioner wants to be available for patients during the year, planned productivity improvements and the commissioner's budget. When this type of 'block contract' is in place, the amount of money the provider receives at the end of the year does not change if they see more or less patients than was anticipated during the initial negotiation.

GPs are paid via 'capitated budgets' – that is, an amount paid for each patient on their registered list. They also receive additional payments for providing specific services to patients.
Each of these payment mechanisms creates different incentives (for example hospitals are incentivised to see more patients, as their funding is related to the number of patients they see).

The NHS is starting to develop new payment systems that pay providers based on a set of agreed outcomes, rather than the number of patients they see. The NHS is also starting to experiment with 'population budgets' that give a group of providers (including hospitals, GPs and community services, for example) a single budget for their care over the course of the year. These budgets are designed to incentivise providers to work together to keep patients healthy and out of expensive hospital. You can find more about different contracting approaches in the NHS in this report from the King's Fund.

Is there any possibility for a member of the public to join discussion and meeting at the local CCG?

Yes! All CCGs are required by law to meet in public. You can find meeting dates (often every two months) and papers from previous meetings on your CCG's website. For example, here is a link to information about Sheffield CCG's upcoming meetings.

Does commissioning just add another needless layer of administration and bureaucracy to the system?

The proportion of the NHS budget spent on administration has decreased since the Health and Social Care Act was introduced and CCGs were created. One of the aims of that legislation was to reduce NHS administration costs by a third. The Act completely removed one layer of management from the system (it abolished the regional level Strategic Health Authorities), and the budgets CCGs receive to cover their running costs continue to be reduced year on year. This chart shows that between 2010 and 2017 the number of managers in the NHS decreased by 18%, mostly because of these reforms. To reduce costs, many commissioners are starting to share back office functions with other commissioners , and they are many joint appointments being made for staff who work across a number of organisations.

It is important to remember that many of the tasks undertaken by CCGs would need to happen in any system, whether or not specific commissioning organisations existed. The commissioning

cycle includes work to (i) assess local population need and set priorities and strategy based on the assessment (ii) procure services (iii) monitor and evaluate services. We would always have to spend some money on tasks (i) and (iii) whether or not we had 'commissioning' organisations

Commissioning (and in particular, procurement) adds additional administrative costs to the system as contracting and tendering use up resources for both commissioners and providers. The goal of the process is to commission better value services (in terms of quality and cost). Unfortunately, there is very little robust research evidence available on the impact of commissioning to enable us to discern whether the cost of this process outweighs its benefits. The nature of commissioning means it is difficult to directly link benefits to the commissioning process. We do not have a counterfactual and a range of factors affect service quality other than just commissioning decisions (for example quality improvement initiatives within a hospital or GP practice). The limited knowledge about the effectiveness of commissioning shows that it has some modest successes, but the evidence is by no means unequivocal.

In evaluations of previous forms of clinically led commissioning in England, the most widely cited achievements relate to improvements in primary and community care, with less evidence of change in secondary care. Primary care commissioners have been particularly successful in reducing the rate of growth in prescribing costs, although often only for a certain period of time after which costs continue to rise at the same rate. For more information on the evidence on the impact of clinically led commissioning see this review from the Policy Research Unit in Commissioning and the Healthcare System which summarises studies of commissioning forms that existed before CCGs.

How is commissioning changing?

The current system is based on arrangements set out in the Health and Social Care Act 2012, which aimed to put GPs at the forefront of the commissioning process. Although the structures established by the Act have remained in place since it came into force in 2013, the way that commissioning is delivered in practice has evolved since then – and is continuing to do so.

Key changes include the delegation of some commissioning responsibilities from national to local organisations, greater joint working at a local level, and an increasingly population or 'place-based' approach to commissioning. All these changes are intended to support the development of more integrated systems of care, including between health and social care.

Commissioners are starting to work more closely with each other and with providers to take joint decisions about the shape of local services. This is happening through sustainability and transformation partnerships (there are 44 of these in England, in which commissioners and providers come together to plan local services), and in the most advanced areas these sustainability and transformation partnerships (STPs) have evolved into integrated care systems. You can find out more about the future of commissioning in this explainer from The King's Fund. And in Week 4, we will be looking in greater detail at the move towards collaboration and integration.

Thank you to all learners who submitted questions and participated in this Q&A.

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Discussion

?

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CF

Chris FLATT

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  15 hours15h

  Thank you to everyone who has contributed to this discussion, we received over 200 questions! There were lots of interesting points and issues raised but unfortunately we couldn't answer everything. We have just posted Ruth's answers in the step and we hope that

this covers most of the questions. Please feel free to continue the discussions in the comments.

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- SD
  Sophie Dodgeon
  Follow
  19 hours19h

  I have some practical questions: how often do CCGs meet? What is the day to day work of a commissioner, or is this something they do in addition to another role? How many commissioners are there on any CCG? And are decisions made once a year in one big budget planning process, or on a rolling basis?

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- ss
  stella shackle
  Follow
  19 hours19h

  With all these organisations now running the NHS, the phrase 'too many chiefs and not enough Indians' springs to mind. We need medical practitioners, and not tiers of managers. I worked in mental health, and my team was fairly constantly bombarded by so called project managers (who ever they were meant to be?) telling us how to do our job - they knew nothing about the service we provided, as nice as they were, when 'they' left, I told my team not to be concerned, but to just continue doing the job, which we recognised (through constant review) our patients wanted and appreciated!

  Like
  Reply
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- 
  Lynnette Lee
  Follow
  23 hours23h

  You hear news stories about how different areas are paying vastly different amounts of

money for the same things. Could supplies that everyone needs, ie gloves, paper sheets, etc not be centralised - not only would that get costs down, but all would pay the same amount.

Like
Reply
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- PC
  Pam Cairns
  Follow
  29 OCT29 OCT

  What information sharing exists between regional commissioning bodies to ensure that they make the most cost effective commissioning decisions based on the most up to date information on resources, usage and future prediction? Also Do commissioning bodies collaborate in order to leverage better deals as a group from suppliers?

  Like2 Likes 2
  Reply
  Bookmark
- JB
  John B
  Follow
  29 OCT29 OCT

  When ordering supplies & equipment is this monitored & would you say there is a tremendous waste.

  Like
  Reply
  Bookmark
- JC
  Jin CHUAH
  Follow
  29 OCT29 OCT

  1.Who monitors the "commissioners - NHS England, local authorities and the CCGs?"
  2. Where does innovation fit in the commissioning process and priorities?
  3. How does the Department ensure that the commissioners look at the system as a whole rather than planning, purchasing, procuring and monitoring of services in silos?

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- SC
  Sarah Crossland
  Follow
  29 OCT29 OCT

  It would be interesting to know how much commissioners take inequalities into account when prioritising and buying services. Do they consider investing more where health outcomes are worse / in areas with higher levels of deprivation.

  Like
  Reply
  Bookmark
- ER
  Elaine Rodger
  Follow
  29 OCT29 OCT

  There are already some excellent questions. I would like to know what the formula is for setting budgets to CCGs now? It will presumably be some form of weighted capitation.

  Like
  Reply
  Bookmark
- LS
  Liz S
  Follow
  29 OCT29 OCT

  Does every new service offered by an acute trust have to be agreed by CCGs? For example if a hospital trust wanted to offer an insomnia service does this have to be agreed by the CCG first?

  Like
  Reply
  Bookmark
- RW
  Rachel Wood
  Follow
  29 OCT29 OCT

  Hi,
  Is this why it still feels like a 'healthcare lottery' for some services, which are based on decisions by CCGs? Who qualifies to make such decisions?

Like2 Likes 2

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- 

  Anita Devi

  Follow

  29 OCT29 OCT

  In the video, three level of commissioning were discussed: CCGs (200), Regional NHS England (wide area efficiency, I guessing about 8 or so) and local authorities (152). What mechanism is used to decide who is better for commissioning a service? For example, speech and language therapy services - if initially commissioned via CCG ... at what point is it effective to commission via Regional teams or even local authorities?

  Like2 Likes 2

  Reply

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- LS

  Liam Stubbington

  Follow

  29 OCT29 OCT

  What about hospitals that direct affiliations with Universities, for instance Guy's and St.Thomas hospital in London together with King's College London. Overlap of academic institutions and care providers surely affects the quality of equipment available, as well as access to clinical trails, to the patient population. At what level is this factored into the distribution of spending power?

  Like3 Likes 3

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- PH

  Pamela Humphries

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  29 OCT29 OCT

  From most of comments I have read regarding the way NHS funding is distributed with varying amounts of funding given to different areas. This is unfair because as a result of it, not all areas can offer the same facilities or range of treatments to its local population. This is a 'post code lottery'. Is this something else that individuals need to take into account when deciding where to live - what their lifelong health needs are likely to be?

Like2 Likes 2

Reply

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- MW
  Margarete Wiliams
  Follow
  29 OCT29 OCT

  I also believe that the "demand" is generally quite difficult to model well. If you look at something like the increased demand for mental health services and the lack of institutions and hospitals that has specialised mental health care,this was not something that was predicted, and it is not even something that we see as agenda of health discussion. So the structure in place of CCGs to allocate funds based on collection of data may be far from achieving realistic target in social primary care needs. It would be interesting to see in future if the distribution of financial resources will reach areas that seems pretty much neglected at present.

  Like

  Reply

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- MW
  Margarete Wiliams
  Follow
  29 OCT29 OCT

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  Like1 Like 1

  Reply

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- MO
  Mark O'Donnell
  Follow
  28 OCT28 OCT

  Am I correct in thinking that some CCGs operate "referrals centres" which scrutinize all

referrals from GP to, say, secondary care and can over-rule the GP referral?

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- MR
  Maxine Redsell
  Follow
  29 OCT29 OCT

  yes, you are right! Its not uncommon

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CF

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Your reply. 0/1200

- DM
  Dinesh Meessala
  Follow
  28 OCT28 OCT

  We are planning to setup prehabilation services which can benefit patients. It was slow progress to set up a business case and commissioners are involved. My question is do we need to present our business case for every service plan to set up to be presented to Commissioners .

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- HL
  Hannah Laidley
  Follow
  28 OCT28 OCT

  Who pays for and plans asset procurement such as renovating buildings or buying computers? I feel like if this was done in a centralised fashion this could be cheaper (e.g. the Department of HEalth and Social care buying 2 million computers a year in bulk would be cheaper than each hospital deciding how many new computers it can afford). Even if individual CCGs or Trusts decide on their budgets for these assets if they were bought in bulk by the Government they could make it cheaper for CCGs and other public organisations to buy equipment

Like2 Likes 2

Reply

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- cs
  clare smith
  Follow
  28 OCT28 OCT

  I tried to watch the Sue Larkey online course on "10 Key Strategies to Increase Engagement and Participation" and it didn't complete my registration - just sat on 'please wait'.

  Like

  Reply

  Bookmark

- cj
  celia johnson
  Follow
  28 OCT28 OCT

  I recently attended the AGM of my local hospital Foundation Trust. They explained that one of their problems was that while the introduction of a helipad and a direct air ambulance service had greatly inproved survival rates, it was nevertheless helping to put them into deficit, particularly as demand continued to grow. They also explained that as one of the 4 hospitals in London with major trauma services they were serving the needs of a much larger community than the notional area covered by the Trust which again seriously affected their finances. It seems self-evident that services such as these are going to be among the more expensive to deliver. Which part of the great funding chart commissions them and how do they predict demand?

  Like3 Likes 3

  Reply

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- FH
  Fiona Hegarty
  Follow
  28 OCT28 OCT

  Is there a "threshold" level of services each CCG must provide within their locality? The demographic of the area would then dictate how much needs to be invested in that area. For example all areas must provide pulmonary rehab but areas with high levels of respiratory disease would need to commit more funding to that standard than one with a lower incidence.

Like3 Likes 3

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- MC
  Mike Chaney
  Follow
  27 OCT27 OCT

  It appears from the majority of comments I have read on the way NHS funding is distributed that allocating different levels of funding to different areas is unfair because, as a result, not all areas can offer the same facilities or treatment. This is called a 'post code lottery'. I can see plenty of reasons for such differences because different areas have different health needs. The county of the south coast of the UK where I live has become a magnet for people retiring from more densely populated cities where their previous homes can be sold at a profit when they move here. We know that the older the population the greater the cost of keeping them healthy. Thus counties nearer to London export their expensive old people, relieving their CCGs at the expense of ours. Funding the two equally, instead of evening out the 'post code lottery' in fact makes it worse.
  In fact the health of the communities of both the exporting CCGs and ours here are above the national average. Therefore justice is to be done to unhealthier areas of former heavy industry, their CCGs should be funded more generously than ours. One can see how the matter has been fudged so much for so long.

  Like

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- BS
  Bisola Sonoiki
  Follow
  27 OCT27 OCT

  who scrutinises the decision made by CCGs?

  Like2 Likes 2

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  - SC
    Sue Clarke
    Follow
    28 OCT28 OCT

    Hi Bisola - CCGs have non executive directors and lay members who scrutinise decision making and also quality of services

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Your reply. 0/1200 Add a reply...

- MK
  Mumtaz Khatun
  Follow
  27 OCT27 OCT

  I would like to know how do CCGs decide when they are going to merge with other CCGs? Also, could all of the CCGs merge to create one gigantic CCG, or is that not possible?

  Like2 Likes 2

  Reply

  Bookmark
- LB
  Lynda Banister
  Follow
  27 OCT27 OCT

  There used to be a funding formula which took into account demographics, deprivation indices other determinants of health etc. Of course there were always arguments about whether or not it was equitable but don't know what happens now.
  I also don't know how much, if anything, is commissioned under block contracts rather than by individual procedures. Of course the former protect the paymasters but put the providers at risk. Despite the rhetoric of competition I think local purchasers and providers continue to work together in the interest of their patients because they really do care about them. (There are much easier jobs than theirs!)
  Patient choice is as not as wide as it may appear as I understand that you can only go to a provider which have a contract with the commissioners (Correct me if I'm wrong!)
  There is now a lot of data which means that 'demand' (and therefore likely cost) can be modeled quite accurately. Factors like whether or not there's a flu outbreak, major accident/civil disturbance/natural disaster are by definition harder to evaluate. Detailed disaster planning involving all major public services is in place and regularly re-visted of course.

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- 

  Katrina Davis

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  28 OCT28 OCT

  I think that "demand" is generally quite difficult to model well. If you look at something like the increased demand for child mental health services, this was not something that was predicted, and it isn't even something we understand. So although we can collect lots of data, we don't yet know how to use it to predict demand yet (although people are starting to try https://www.mqmentalhealth.org/research/profiles/adolescent-data-platform)

  So there are lots of unknowns, and many of them are unknown unknowns. Twenty years ago, when the demographic explosion of old people became generally accepted, it was expected that there would be more of the same diseases seen in old people 20 years ago - mainly heart attacks and strokes that killed people - instead, we've got better at stopping people die of the old things, so instead they have very complex needs from chronic diseases.

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