Commissioning Support: Clinical Commissioning Group Running Costs Tool

A ‘Ready Reckoner’

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	**Commissioning**
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

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Description	An interactive tool that helps CCGs to work through the financial implications of different commissioning support arrangements. It provides the flexibility to consider the potential impact that different populations have on resources and the different costs for internal staffing structures. We hope for it to support a range of local discussions between CCGs and with PCT clusters about where it makes sense to share functions and enter into more federated models in order to generate better value for money.
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For Recipient's Use	

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1 Introduction

1.1 Last month we shared the draft authorisation framework *'Developing CCGs: Towards Authorisation'* that set out the proposed process by which you - as emerging clinical commissioning groups (CCGs) - will be able to demonstrate that you are ready to take on your commissioning and other statutory duties.

1.2 Subject to parliamentary approval of the Health and Social Care Bill, Clinical Commissioning Groups (CCGs) will be able to begin submitting applications to the NHS Commissioning Board to be established and authorised from the summer of 2012.

1.3 Before that time, you will need to be confident that you have robust and appropriate commissioning support arrangements in place that will allow you to commission effectively for each of the services that you are responsible for, from early health needs assessment, service design and procurement to communications, contract management and quality control.

1.4 The way in which you discharge your functions and harness the full potential of commissioning support will be critical. The challenge will be to use your resources innovatively that will allow you to provide your functions effectively and efficiently leaving the maximum amount possible for clinical and quality design.

1.5 There will clearly be some overlap and variation, with some larger CCGs choosing to undertake some functions for themselves and other smaller CCGs securing support from external sources. In some cases, you may look to work together, either within a shared operating model or by providing services to each other. These delivery models are likely to vary depending on the nature of the service and CCG style of commissioning.

1.6 To help work through the potential options and understand the financial implications of different models, the Department of Health has been working closely with a number of NHS stakeholders, including SHAs, PCT clusters and Pathfinder groups, to co-design a simple tool that will support some of these local discussions and decisions.

1.7 The interactive 'ready reckoner' tool will help CCGs to work through the potential impact that their population size has on resources, the opportunities and impact of sharing some functions with other commissioning groups, and the potential costs for different internal staffing structures. We hope that it will support you in your discussions with PCT clusters about where it makes sense to share particular functions and enter into more 'federated' models in order to

generate better value for money and ensure that future commissioning support arrangements are of sound quality, affordable and responsive to your needs.

1.8 In order to demonstrate and test the tool with different stakeholders, we have included a range of illustrative figures and average costs, but they are nothing more than that. It is crucial that you enter your own figures that best reflects your local arrangements and assumptions. Your PCT cluster will be able to help you ensure that your modelling takes into account the full range of functions and responsibilities.

2 What is commissioning support?

2.1 Put simply, commissioning support is the support that you will buy in or share with other organisations to help carry out your functions. It does not include those things that you are likely to need to do, or choose to do, for yourselves. It is likely to be shared or bought in from NHS developed commissioning support organisations, local authorities, other CCGs, commercial and voluntary sector bodies.

2.2 It is important to recognise that commissioning is not one action, but a broad range of diverse activities, functions and service lines. CCGs are uniquely placed to deliver the clinical elements of commissioning but you will also need to build, share or buy in support to help deliver other parts of your functions.

Clinical Commissioning Groups - bringing clinical leadership, vision and accountability – have the freedom to decide whether to

Build/do

Buy ***Share***

Health Needs Assessment
Developing Joint Strategic Needs Assessment (JSNA), building on collected data to forecast local health needs and identify gaps in service provision.

Business intelligence
Information collection and analysis (eg patient activity and costs, clinical outcomes, patient experience), including using data warehouses and hubs etc.

Support for redesign
Developing clinical specifications and pathway design, service reviews, performance monitoring and demand management.

Communications and PPE
Engaging with key stakeholders and patients, including local consultations, media/press handling and social marketing.

Procurement and market management (agreeing contracts)
Identifying best value providers to respond to service needs. Formal contract management, tendering and negotiation.

Provider Management (monitoring contracts)
Good practice provider management tools and techniques to ensure fulfilment of agreed contracts, service level standards and key performance indicators.

Back office – core functions such as finance, IT systems and support, legal services, and HR that underpin the successful running of the organisation

2.3 The decision about which of these are done in-house (for example through direct employment) and those where you seek support from external organisations is one that has to be made by yourselves with help from PCT clusters to understand the potential implications.

2.4 It is unlikely, even in the largest commissioning group, that everything will be done in-house. For smaller CCGs where fixed costs take up a greater proportion of spend it is more likely that commissioning support will be bought in and/or shared between other groups. This will mean that you have the ability to concentrate your clinical skills on some of the most important parts of commissioning whilst being supported by a commissioning support infrastructure which will assist in the delivery and implementation.

2.5 The reduced levels of funding growth and the increased number of organisations will require the whole system to work together to really drive economies of scale in ways that we have not done in the past.

2.6 The CCG authorisation process will ensure that you are capable of carrying out your functions and that you have appropriate plans in place to improve quality and secure the best value from public funds. As part of this, aspiring CCGs will need to show that they have the necessary capacity – internally or from external sources – to deliver their duties and be able to demonstrate that their commissioning support arrangements are of sound quality and represent excellent value for money.

2.7 To support the development of the best possible arrangements of commissioning support, and to ensure that you have a dependable and comprehensive choice of suppliers, we will be working with SHAs, PCT clusters and with yourselves over the coming months to ensure that the emerging models for different commissioning support functions are appropriate, affordable and efficient.

2.8 We will shortly be setting out our vision and expectations for future commissioning support services, how we aim to support the system in overcoming some of the emerging challenges and barriers and the key steps along the critical path during the transition and beyond.

3 Step-by-step guide

3.1 The ‘ready reckoner’ tool builds on existing work undertaken by SHAs, PCT clusters and Pathfinders across the country to understand the financial implications of different commissioning support arrangements and delivery models, the potential impact that different populations have on resources and the potential costs for different internal staffing structures.

3.2 By allowing data to be entered and shared in a consistent format, we hope to help stimulate a range of local discussions between commissioning groups and with PCTs clusters about where it makes sense to share functions and enter into more federated models in order to generate better value for money. Pathfinders will be invited to share their analysis and submit feedback via the Pathfinder Learning Network, and to share any alternative tools that have developed locally.

3.3 In order to demonstrate and test the tool with stakeholders, the current version contains some illustrative figures. We expect Pathfinders to change these and enter their own information to reflect their local arrangements and assumptions.

3.4 To navigate through the worksheets, click the links contained within the navigation sheet or use the tabs at the bottom of the tool. Each worksheet provides information to guide you through the steps. Pale blue cells indicate that data can be entered or amended. The next few pages take you through the seven key steps:

- **Step 1:** Base Costs Details
- **Step 2:** Base Costs Summary
- **Step 3:** Clinical Leadership Costs
- **Step 4:** CCG Costs Summary One
- **Step 5:** Other CCG Functions
- **Step 6:** Staffing Requirements
- **Step 7:** CCG Costs Summary Two

Step 1: Base Costs Details

There will be some minimum corporate functions that a CCG will need to carry out. However, these are likely to vary across different CCGs. Some illustrative examples along with costs for these functions have been estimated in the table. Some of these costs (eg, Chair, Non Executive Directors and Fees) have been based on current PCT costs. The cost estimations can be amended by selecting where in the payband range costs should be estimated and by changing the grades (in column C) using the drop down menus. The values can be changed to reflect more local arrangements by simply overwriting the cells (overwriting values in column G will remove the link between the unit costs and the drop down menus in column C). The costs of GP leadership are a core cost but are calculated in the next section.

FIgures in column J are estimated costs for a CCG with no shared costs. To see how base costs are affected by sharing some costs with other CCGs, select a population size for partner CCGs using the drop down menu. Estimated shared costs for your CCG will be shown in column L. It may not make sense to share some base costs, for example, those in the pale yellow cells. However, the values for these functions can still be changed to reflect local circumstances.
Shared costs are calculated on the assumption that each share will be in proportion to CCG population size.

To see a summary of revised base costs following any changes, click on the 'Show me summary table and chart' button.

Select from drop down box to show costs for lower, middle or upper range for paybands	Middle	Select population sizes for each CCG	Shared Corporate costs with other CCGs: Own CCG Population	CCG Partner (s) Population
			-	-

Corporate Management Base Costs

Director level appointments to support the Clinical Commissioning Group as a statutory body	Payband	Estimated Unit Cost	WTE/number of units	Full cost for own CCG	Own CCG Share	CCG Partner (s) share
Accountable Officer	CEO	£ 147,684	1	£ 147,684	£ -	£ -
Clinical Board Members - GPs	GP	£ 137,500		£ -	£ -	£ -
Clinical Board Members - Other	Band 9	£ 110,929		£ -	£ -	£ -
Chief Operating Officer (Senior officer responsible for running all day to day CCG business)	VSM	£ 110,763	1	£ 110,763	£ -	£ -
Chief Finance Officer	VSM	£ 110,763	1	£ 110,763	£ -	£ -
Ch	Chair	£ 47,500	1	£ 47,500	£ -	£ -
No	NED	£ 8,000	4	£ 32,000	£ -	£ -
Admin (support to Chair/NEDs and Executive)	Band 3	£ 20,668	2	£ 41,336	£ -	£ -
Non_pay oncost per person (covers payroll, HR, travel, IT, stationery)	N/A	£ 4,000	5	£ 20,000	£ -	£ -
Accommodation (eg. rental rates etc.)	N/A	£ 6,000	5	£ 30,000	£ -	£ -
OT						
Int	N/A	£ 50,000	N/A	£ 50,000	£ -	£ -
Ext	N/A	£ 175,000	N/A	£ 175,000	£ -	£ -
Co	N/A	£ 30,000	N/A	£ 30,000	£ -	£ -
An	N/A	£ 20,000	N/A	£ 20,000	£ -	£ -
Pu	N/A	£ 50,000	N/A	£ 50,000	£ -	£ -

Su

Dire						
Head of Corporate Services (reports to either COO or CEO - responsible for running the board; overall governnance; risk; communications and PPI issues)				£ 75,847	£ -	£ -
PPI Manager (ensures that PPI is embedded across the organisation, reports to Head of Corporate Services)				£ 52,933	£ -	£ -
Governance and Risk Manager (specific role in looking at governance and risk, reports to Head of Corporate Services				£ 42,573	£ -	£ -
Admin support for all above	Band 3	£ 20,668	1	£ 20,668	£ -	£ -
Head of Performance and Procurement (required for ensuring performance information from all CSUs is co-ordinated and ready for users and the Board. All ensuring that any procurement is carried out effectively. Reports to COO)	Band 8c	£ 75,847	1	£ 75,847	£ -	£ -
Head of Financial Planning and Strategy	Band 8c	£ 75,847	1	£ 75,847	£ -	£ -
Financial Accountant	Band 7	£ 42,573	1	£ 42,573	£ -	£ -
Finance Assistant	Band 3	£ 20,668	1	£ 20,668	£ -	£ -
Admin support for Performance and Finance	Band 3	£ 20,668	1	£ 20,668	£ -	£ -
Non-pay oncost per person - (covers payroll, HR, travel, IT, stationery)	N/A	£ 4,000	9	£ 36,000	£ -	£ -
Accommodation (eg. rental rates etc.)	N/A	£ 6,000	9	£ 54,000	£ -	£ -
OTHER UNAVOIDABLE COSTS						
General Ledger/Financial System - provided external i.e. SBS but an "oncost" to finance function	N/A	£ 50,000	N/A	£ 50,000	£ -	£ -
Communications/PPI Costs	N/A	£ 25,000	N/A	£ 25,000	£ -	£ -
				£ 592,624	£ -	£ -

Total	£ 1,457,669	£ -	£ -
Total per head of population	£ -	£ -	£ -

Step 2: Base Costs Summary

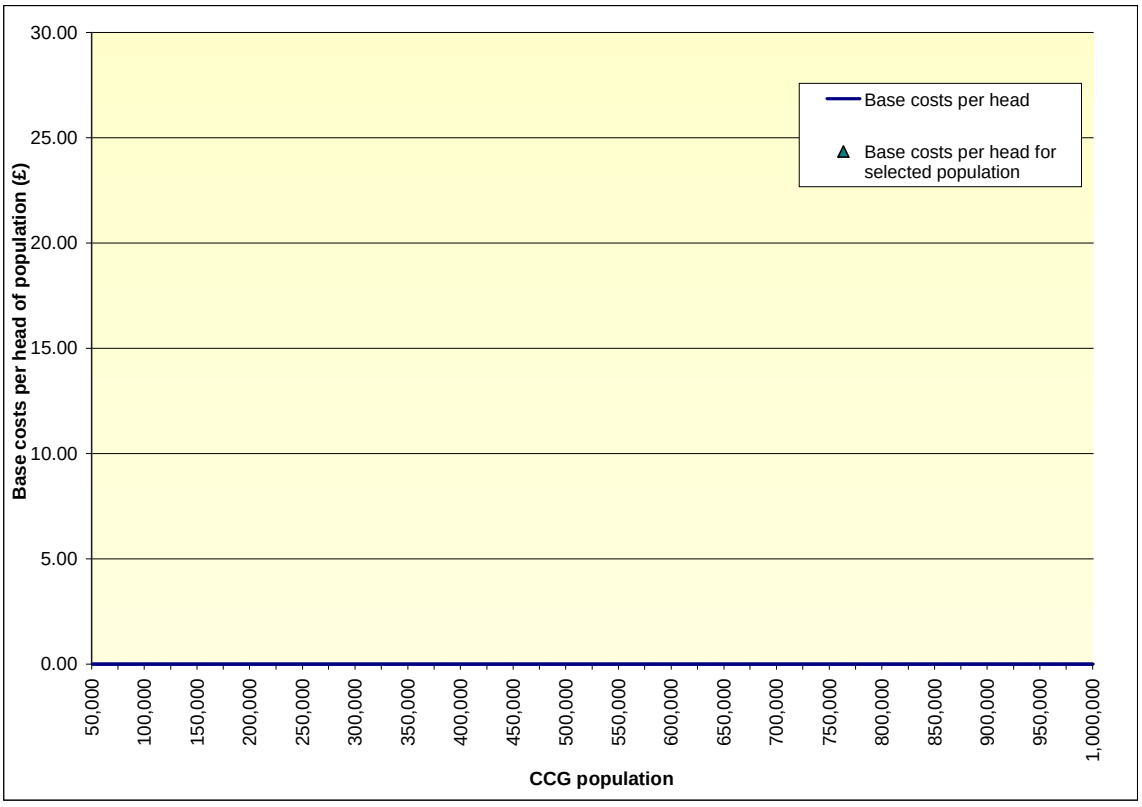
This table summarises corporate base costs taking account of any shared corporate function arrangements. The tables reflect figures entered in the Base Costs Details worksheet. To make additional amendments to the base costs details, click on the 'Show me how these costs are calculated' button.

See results for different population sizes using drop downs	Own CCG Population	CCG Partner (s) population

Summary of Corporate Base Costs	Own CCG Share of Costs	CCG Partner (s) Share of Costs
Corporate Management Team Base Costs	£ -	£ -
Corporate Management Team Supporting Functions Base Costs	£ -	£ -
Base Costs Total	£ -	£ -
Base Costs per head	£ -	£ -

Show me how these costs are calculated

Chart 1: Population size and estimated corporate base costs per head of population for own CCG based on shared costs



Step 3: Clinical Leadership Costs

This worksheet provides an estimate of costs relating to clinician time for Clinical Leadership and Practice Engagement. The assumptions are currently based on GP time for engagement in practice performance, service redesign and governance issues. These costs are based on an hourly rate for GPs and are assumed to vary primarily with number of practices. These figures and text can be changed in the pale blue cells. Text and figures can also be overwritten in the pink cells, although this may affect formulas and links to drop down menus in other worksheets.

It is also assumed that clinicians will need support from non-clinical managers for these activities. Estimated costs for these are included in Table 2. These estimations can be changed by amending values in the pale blue or pink cells.

Any other additional clinical leadership costs can be entered in Table 3.

Select from drop down box to show costs for lower, middle or upper range for non-clinical paybands	Middle	Assumed Hourly Rate (including backfill & oncosts)	97
		Number of Practices per own CCG	
		Population Size	

Table 1: Clinical leadership and practice engagement (probably sessional staff and not "direct" employees of the CCG)

Clinical Leadership responsibilities	Pay scale	No. of Hours per meeting (inc. preparation time)	No. of meetings per year	No. of hours per meeting x no. of meetings per year	Estimated GP hours per year (per CCG)	Estimated cost to CCG
Practice performance This is time used to engage practices in discussion about performance (eg. referrals etc.) This cost is only for the GP leading the discussions from the CCG. (Default assumption is 2 hours meeting and 2 hours preparation time every 6 weeks per GP practice)	GP	4	9	36	-	£ -
Service redesign This is the time involved in designing and implementing changes (eg pathways). May be outsourced but need CCG GPs input to define what needs to change from their knowledge of their practice behaviour (Default assumption is 2 hours every 6 weeks per GP practice)	GP	2	9	18	-	£ -
Governance at CCG level (Default assumption is one GP per 100,000 population, six meetings a year with 4 hours paid for each meeting)	GP	4	6	24	-	£ -
Clinical sub-total					-	£ -

Table 2: Non-clinical managers

Operational cost category and functional areas	Pay scale			Salary (inc. on costs)	Indicative WTE	Total cost
Non-clinical Managers (to support the clinical managers - generalist staff who can deliver such functions as interpretation of information; performance management; etc. Covering 6 practices - in theory may be aligned to work streams more than practices)	Band 8a			£52,933	-	£ -
Admin Support	Band 4			£24,767	2.0	£ 49,535
Non pay costs for above @ £10000					2.0	£ 20,000
Non-clinical sub-total						£ 69,535

Table 3: Additional Clinical Leadership responsibilities

Additional Clinical Leadership/Engagement responsibilities	Pay scale			Salary (inc. on costs)	Indicative WTE	Estimated cost to CCG
Use these lines to add in any additional clinical leadership/clinical engagement costs (note that clinical board member costs should already be included within base costs)				#N/A		£ -
Use these lines to add in any additional clinical leadership/clinical engagement costs (note that clinical board member costs should already be included within base costs)				#N/A		£ -
Use these lines to add in any additional clinical leadership/clinical engagement costs (note that clinical board member costs should already be included within base costs)				#N/A		£ -
Sub Total						£ -

Clinical Managers	£ -
Non-clinical Managers	£ 69,535
Additional Clinical Leadership	£ -
Total Cost	£ 69,535

Step 4: CCG Costs Summary One

This table summarises base costs and clinical leadership costs in relation to population size and running costs allowance. Own population size and that of CCG partners can be amended using the drop down menus. You will also need to enter a number for your anticipated running costs allowance in cell F13. Our working assumption is - as stated in this year's Operating Framework - that CCG running costs could be in the range of £25 to £35 per head of population. The balance of running costs allowance available for other CCG functions is calculated. If the balance is shown in a red box, this indicates that the combined sum of fixed costs and clinical leadership costs exceeds the running costs allowance.

	Own CCG Population	CCG Partner (s) population	No. of practices per own CCG	
See summarised results for different population sizes by selecting from the drop downs				

	Own CCG Costs: not shared		Own CCG costs: shared	
	Total Cost	Cost/head	Total Cost	Cost/head
Running Cost Allowance	£0			
Corporate Base Costs	£1,457,669	£0.00		
Clinical Leadership Costs	£69,535	£0.00		
Minimum costs of in-house services	£1,527,204	£0.00		
Balance of running cost allowance	-£1,527,204	£0.00		

Step 5: Other CCG Functions

This table provides information on the other functions that CCGs will need to consider in order to estimate costs accurately.

Completing the table will assist CCGs in identifying which functions they want to deliver in-house and functions they want to consider buying in. CCGs will need to consider the associated costs and benefits of delivering/purchasing specific functions. CCGs must ensure that they have considered the full range of functions that they are required to carry out when estimating future running costs. Working with PCT Clusters to understand their FMA running costs returns should assist CCGs in understanding the associated costs.

Use the drop-down menu in the 'Deliver in-house' column to select whether you intend to deliver all, none or part of the function in-house. The 'Buy-in' column will automatically populate based on the information entered in the 'Deliver in-house' column.

FUNCTIONS	WHAT'S INCLUDED	Deliver in-house	Buy-in
Primary Care - Medicines Management	Prescribing advice, financial projections; review of new drugs etc	-	-
Primary Care - Community Commissioning (including childrens services)	Assessment of community need; re-design where appropriate; procurement (where needed); contract negotiation; contract monitoring	-	-
Practice - health needs and population interpretation (specific not generic JSNA)	Detailed production for each practice looking at their local practice population needs etc	-	-
Commissioning Acute Contracts	Assessment of community need; re-design where appropriate; procurement (where needed); contract negotiation; contract monitoring; PBR expertise and local knowledge of exclusions from contract	-	-
Commissioning MH Contracts	Assessment of community need; re-design where appropriate; procurement (where needed); contract negotiation; contract monitoring; and local knowledge of local funding arrangements (remember LA links)	-	-
Commissioning Ambulance Services	Dependent on how "lead arrangements happens" - need to understand local usage; interface with unplanned care; financial and activity implications	-	-
Commissioning - Continuing Care possibly include specific funding requests	Nursing needs assessments; contracting with providers; ensuring standards and quality are meet. Clear links with Las	-	-
Quality - Looked After Children and Safeguarding	Needs further national definiton of what will be responsibility of CCGs - but must discharge this function (currently carried out by mainly nurses) securely and to highest standard	-	-
Quality - Infection Control	Needs further national definition of role - need to be clear where responsibilty for all provider IC issues sit and Primary Care ones?	-	-
Finance - final accounts; processing; monthly reporting	Need to understand how "far" the national system will take accounts to define what sits outside of CCG (i.e. not strategy) and not any national system	-	-
Finance - General Ledger/Creditors/Debtors/Cash Management	Need to be clear how invoice processing; agreeing year end balances; cash management will take place - assumed not in CGG	-	-
Estates - Management and Strategic	Needs clear national guidance on what responsibility commissioner will have but will not sit in a CCG	-	-
Communications	Need to understand what the national hub model will provider - likely to need a local communications "presence"	-	-
Information Governance	Assume that this is a NCB function for GPs as providers. Governance role in CCG should set protocols and monitor CCGs use of information	-	-
IT	Assume tiny and in oncosts for staff	-	-
HR	Assume tiny and in oncosts for staff	-	-
Finance - Payroll	Assume tiny and in oncosts for staff	-	-

Step 6: Staffing Requirements

Staff costs for other CCG functions (i.e. for those not already included within base costs or clinical leadership/engagement) can be estimated using the table. For functions where you have decided to carry out some or all of the service in house, include details of staff required to deliver the services. If you intend to share this function with another CCG only insert your own CCG share of the W.T.E. For functions which you have decided to buy-in rather than carry out in-house, include any staff which are required for contract management purposes. The CCG costs summary 2 worksheet will provide information on the amount available for buying-in functions after own staff costs have been accounted for.

In the 'Function ' column, select the relevant function from the drop down menu.
In the 'Job Title' column, enter the job title relevant to the posts.
In the 'Grade' column, select the relevant grade for the post (s) from the drop down menu.
In the 'WTE' column, enter the number of Whole Time Equivalents required.
'Estimated non-pay related costs' are linked to those entered for extra on-cost and accommodation costs as entered in the Base Costs Details worksheet. To change the estimations of non-pay related costs amend cells G22 and G23 in Base Costs Details worksheet.

Select from drop down box to show costs for lower, middle or upper range for non-clinical paybands: Middle

Function	Job Title	Grade	Salary and on-costs (auto-calculates)	Enter Whole Time Equivalent	Salary and on-costs (auto-calculates)	Estimated non-pay related costs	Total
			-		-	-	-
			-		-	-	-
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			-		-	-	-
			-		-	-	-
			-		-	-	-
			-		-	-	-
						Total cost	£ -
						Cost per Head	£ -

Step 7: CCG Costs Summary Two

This table summarises estimated base costs, clinical engagement costs and staff costs in relation to population size and running costs allowance. Own population size and that of CCG partners can be amended using the drop down menus. Running costs allowance can entered in the pale blue cell in F13. The balance of running costs allowance available for other CCG functions is calculated. This provides an estimate of the amount of allowance available to pay for commissioning support that your CCG 'buys in'. If the balance is shown in a red box, this indicates that fixed costs, clinical leadership and staff costs exceed running costs allowance.

	Own CCG Population	CCG Partner (s) population	No. of practices in own CCG
See summarised results for different population sizes by selecting from the drop downs			

	Own CCG Costs: not shared		Own CCG costs: shared	
	Total Cost	Cost/head	Total Cost	Cost/head
Running Cost Allowance	£0	£0		
Corporate Base Costs	£1,457,669	£0.00		
Clinical Leadership Costs	£69,535	£0.00		
Minimum costs of in-house services	£1,527,204	£0.00		
Estimated staff costs for other CCG functions	£0	£0.00		
Total estimated in-house costs	£1,527,204	£0.00		
Balance of running costs available to buy-in other services	-£1,527,204	£0.00		

The balance of running costs allowance is the amount available to purchase the functions which you indicated that you intend to buy-in on the 'Other CCG Functions' Worksheet. The table below provides a summary of the functions and indicates whether you have selected to buy-in all, none or part of the function.

FUNCTION	Buy-in?
Primary Care - Medicines Management	-
Primary Care - Community Commissioning (including childrens services)	-
Practice - health needs and population interpretation (specific not generic JSNA)	-
Commissioning Acute Contracts	-
Commissioning MH Contracts	-
Commissioning Ambulance Services	-
Commissioning - Continuing Care possibly include specific funding requests	-
Quality - Looked After Children and Safeguarding	-
Quality - Infection Control	-
Finance - final accounts; processing; monthly reporting	-
Finance - General Ledger/Creditors/Debtors/Cash Management	-
Estates - Management and Strategic	-
Communications	-
Information Governance	-
IT	-
HR	-
Finance - Payroll	-

4 Q&A and technical queries

1. **Is this part of a Department of Health blueprint for commissioning services?**
   No. There is no 'one size fits all' model for commissioning support and there will be no prescribed approach from the centre. This is about clinical commissioning groups (CCGs) working together – with support from PCT clusters – to define their requirements and consider where they need additional support.

   The 'ready reckoner' gives CCGs the flexibility to explore their options and decide which is the best model for them.

2. **Does the tool establish a minimum population for a CCG? It seems to suggest that for some smaller CCGs the fixed costs will be unaffordable within their running costs allowance.**
   No. The tool allows CCGs to choose from a wide range of populations. The fixed costs between CCGs are likely to be very different and depend on a range of factors, including the extent to which a CCG aims to share particular functions with other local groups.

   For some smaller CCGs, fixed costs are likely to take up a much greater proportion of spend so it will be particularly important for these groups to explore innovative and more federated and shared solutions that allow them to benefit from greater economies of scale.

3. **Will there be more central directives on what should be done at scale?**
   It is for CCGs themselves to decide what activities they choose to carry out in-house, those that wish to share with other CCGs and where they might buy-in external support from other organisations.

   There are clearly a number of areas where evidence suggests that it makes sense to do it at a particular population level in order to achieve sufficient economies of scale and ensure that scarce expertise is effectively utilised. We are working with NHS stakeholders and emerging CCGs to define these areas in more detail and hope to publish more information shortly.

4. **Why hasn't such a model been issued before now?**
   Various models that performed similar functions were emerging across the NHS and have been consolidated into a 'best of breed' model so that emergent thinking can be shared.

5. **How can the model be used when the actual running cost figures are yet to be issued?**
   The model allows CCGs to model various scenarios and to plan for most likely outcomes.

6. **How do you know that there will be enough money left to buy in services once the CCG functions and costs have been modelled?**
   It is expected that CCGs will want to see significant changes in the range of services provided by Commissioning Support Organisations and the model will stimulate that discussion.

7. **Is the structure within the corporate baseline costs mandatory for all CCGs?**
   The baseline costs within the tool are illustrative only and reflect some of the discussions with local CCGs about the minimum corporate functions that they will carry out. The values can be changed and overwritten to reflect local circumstances.

8. **Why does the tool use Agenda for Change pay bands when CCGs are expected to have freedom over employment terms and conditions?**
   The Agenda for Change pay bands are intended to be used as a guideline only and CCGs can enter their own figures instead. Subject to parliamentary approval, the Health and Social Care Bill will give CCGs the flexibility to best determine how to spend their ring-fenced administration budgets. We believe that in order to attract and retain the best staff, CCGs must be free to remunerate as they determine, within the confines of their budgets

9. **Who has developed the tool?**
   The tool has been co-developed and tested with a number of SHA, PCT cluster and Pathfinder representatives and builds on the existing work and modelling that is being carried out locally.

10. **What should we enter for the expected running costs?**
    The range identified for potential running costs has not changed. Our working assumption is - as stated in this year's NHS Operating Framework - that CCG running costs could be in the range of £25 to £35 per head of population.

    However, we have said that we will not determine the exact amount until further work has been undertaken with Pathfinders to explore the optimal balance between ensuring sufficient investment in organisational sustainability with maximising resources for front line services.

    The tool allows users to enter their own figures but we assume that you will wish to look at options within this range.

11. **Why does the tool not include the London weighting for paybands?**
    The tool does not include regional ranges but allows the user to select from a lower, middle and upper range of the paybands or to overwrite the costs with their own figures.

12. **Where have the figures for GP pay come from?**
    These are illustrative figures only and users will be expected to input their own data based on local arrangements.

13. **Why is communications/PPI classed as an unavoidable cost within the base costs?**
    There may be some communications and PPI activities that CCGs will need to do themselves but users have complete flexibility in the tool and can enter their own estimated costs.

14. **What population figures should be used?**
    Until further guidance is issued we believe it makes sense to use the collective list size of constituent practices for modelling purposes.

15. **Within the corporate base cost details, what happens if we don't want to share corporate staff with other CCGs but don't need a whole time equivalent?**
    Users can change the WTE field to a fraction if they wish to aim to recruit senior and other corporate staff on a part time basis.

16. **Where has the list of functions in the 'Other CCG Functions' sheet come from? Is this the full list of functions CCGs must deliver?**
    These functions have been developed and tested with SHA, PCT cluster and Pathfinder representatives. These functions are for illustration only and are not intended to be mandatory. Working with PCT clusters to understand their Financial Monitoring and Accounts (FMA) running costs returns should assist CCGs in understanding the associated costs.

If you have any further queries please email commissioningsupport@dh.gsi.gov.uk