
Red Circle
Healthcare
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Driving
Productivity
Gains
From
Analogue To
Digital
What Makes
Good Costing?
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DRIVING PRODUCTIVITY GAINS IN THE NHS:

What can Finance Directors do to make this happen?

Over the past decade, the NHS in England has seen significant increases in funding, staffing, and to a degree capital investment. Yet, paradoxically, overall productivity has stalled or even declined in some areas. According to the latest data from the Office for National Statistics, NHS productivity fell by around 1.3% in 2022, following a sharp drop during the pandemic and only partial recovery since. In the face of rising demand, constrained budgets, increasing expectations and a favourable funding allocation from the Spending Review improving productivity is now not just a desirable goal—it's an urgent imperative.

For NHS Finance Directors, this presents both a challenge and a profound opportunity. As the custodians of financial strategy, resource allocation, and business intelligence, Finance Directors and their teams are uniquely positioned to drive the changes that can unlock significant productivity improvements—both in the short term and over the longer horizon. This article suggests how Finance Directors and their teams can work with colleagues to drive significant productivity gains in the NHS.

Understanding the Productivity Imperative

Productivity in the NHS can be defined as the ratio of outputs (healthcare delivered) to inputs (money, staff time, estates, technology, etc.). A productive NHS can do more with the same resources—or the same with fewer.

Productivity gains are not abstract. A 1% increase in NHS productivity nationally would be worth approximately £1.5 billion annually—equivalent to the cost of building a new major hospital or funding around 25,000 additional nurses. Trust-level gains, even in the range of 3–5%, could significantly improve financial resilience, reduce waiting lists, and enhance patient outcomes.

What Can Finance Directors Do—Now and in the Future?

Red Circle have been talking to a cross-section of Finance Directors and other C-suite Executives to get their views. This together with our experience of working with the NHS and other business sectors over many years has informed these suggestions.

1. Leverage Data to Identify and Act on Inefficiencies

Finance teams are sitting on a wealth of operational and clinical data. A strategic priority must be to harness that data to illuminate variation, inefficiency, and opportunity:

- **Costing and Benchmarking:** Use Patient-Level Information and Costing Systems (PLICS) and Model Hospital data to benchmark services, identify outliers, and inform cost-improvement plans.
- **Service Line Reporting:** Drive better decision-making by linking income and cost data to clinical outcomes and activity volumes.
- **Productivity Dashboards:** Develop visual, intuitive dashboards to support executive and clinical leaders in tracking productivity metrics in real time.

Immediate gains can come from focusing on the "high opportunity" areas—elective care pathways, diagnostics, outpatient redesign, and unwarranted variation in prescribing or theatre use.

2. Embed Finance in Operational and Clinical Transformation

True productivity improvement comes when finance and operations work hand in hand. Finance Directors should:

· Co-lead productivity programmes alongside Chief Operating Officers and Chief Medical Officers. Finance teams can bring discipline, analytical rigour, and commercial acumen to transformation efforts.

· Support clinical leaders in understanding the financial impacts of their decisions. Clinician engagement is essential for sustainable productivity change.

- Encourage a shift from cost-cutting to value-creation. This means investing in areas like digital technology, AI-enabled diagnostics, or community services, where upfront investment can yield downstream savings and better care.

3. Align Financial Incentives with Productivity Goals

The way resources are allocated within a Trust—or across a system—can either support or obstruct productivity.

- Internal resource allocation models should reward efficiency and discourage unnecessary activity. Use marginal costing where appropriate to evaluate new service models.
- Make better use of capital investment. Ensure capital business cases are underpinned by clear productivity assumptions, with measurable post-investment benefits tracked over time.
- Collaborate across systems (ICBs) to design shared savings schemes that incentivise upstream investment in prevention, early discharge, or virtual wards.

4. Invest in Automation and Digital Innovation

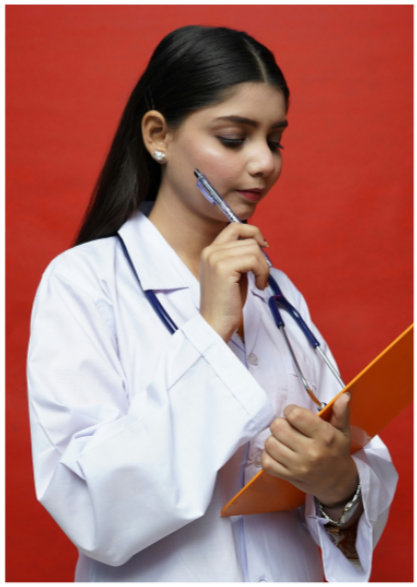
Digital transformation is not a panacea—but when well executed, it can radically improve workforce productivity and reduce administrative burdens.

- Target back-office automation. Finance, HR, and procurement functions are ripe for robotic process automation (RPA), delivering both savings and speed.
- Drive adoption of digital clinical tools—such as electronic patient records (EPRs), AI-based imaging diagnostics, and digital outpatient platforms—which can support faster, safer, and more efficient care.
- Use cost-benefit analysis to prioritise investments with a clear return on productivity. Finance Directors should champion robust benefits realisation tracking.

5. Focus on Workforce Productivity and Retention

With approximately 75% of NHS spend going on people, workforce productivity is central to system productivity.

- Analyse job planning and rostering data to optimise staffing models, reduce premium rate agency spend, and align capacity with demand.
- Support wellbeing and retention initiatives, which reduce costly turnover and maintain organisational knowledge.
- Promote skill mix optimisation—helping clinical and operational leaders explore new staffing models that free up senior clinicians for complex care while delegating appropriate tasks to other staff.



The Long-Term Prize

While short-term gains are possible—and necessary—the greatest opportunities lie in long-term transformation. Finance leaders should be integral to the following:

- Population health strategies that shift resource upstream and reduce pressure on acute services.
- Estate rationalisation and Net Zero initiatives that reduce operational costs while improving care environments.
- Digitally enabled models of care that are more personalised, preventative, and efficient.

By aligning financial strategy with long-term productivity goals, NHS Trusts can begin to decouple funding growth from activity growth—delivering more value per pound spent.

Conclusion: A Strategic Role for Finance

Improving NHS productivity is not just an operational necessity; it is a financial imperative. Finance Directors and their teams have the tools, insight, and influence to lead and support this agenda—moving beyond the traditional boundaries of financial management to become architects of sustainable improvement.

By taking a proactive, data-led, and collaborative approach, Trust Finance Directors can help their organisations achieve meaningful productivity gains in the range of 3–5% (or more) over the next 2–3 years. Across the Service, this could release billions in value—money that can be reinvested into front-line care, capital renewal, and staff wellbeing.

The opportunity is real. The need is urgent. And the time to act is now.

Bruce Finnamore is our Executive Chairman. He grew and sold Finnamore, the largest independent healthcare consultancy to GE in 2014. Since then he has continued to advise NHS organisations on strategy and transformation.

OVERSEAS VISITORS INCOME

The financial pressures facing the NHS have led to an increasing focus on public sector entrepreneurialism (PSE), where Trusts are encouraged to explore commercial opportunities for income generation. This approach not only supports financial sustainability but also fosters innovation and service improvements.

The Health and Social Care Act of 2012 (HSCA) has played a pivotal role in encouraging commercial behaviour within the NHS, giving Trusts more freedom to pursue revenue-generating activities. While Foundation Trusts must ensure that most of their income comes from public sources, they can now generate up to 49% of income from non-public sources, with no such cap for NHS Trusts. As expected, there is wide variation between individual organisations and their commercial income. There are significant opportunities to increase commercial income, maximise profit/contribution and add positively to the bottom line.

In light of this Red Circle has been working extensively with a number of Trusts nationally to identify opportunities for significantly increasing commercial income. Typically our work has involved undertaking benchmarking amongst various peer groups, where we identify and compare various aspects of commercial income as a proportion of Trust turnover and then overlay onto this a number of non-financial quantitative and qualitative metrics in order to better understand relative performance. This analysis is undertaken across ten key lines of enquiry (KLOEs). One of these KLOEs, and the focus of this article relates to overseas visitors income.

In 2023/24 NHS Trusts in England wrote off a whopping £37m of overseas visitors income, and hold in their accounts bad debt provision of significantly more than this. This has led to a much greater emphasis (especially from NHSE) on identifying overseas visitors liable to pay for their care, and the collection of outstanding debt.

The recovery of all debt relating to overseas visitors remains both a statutory and contractual obligation on all Trusts as enshrined in the 'The National Health Service (Charges to Overseas Visitors) Regulations 2015' and the 'NHS Standard Contract 2025/26 (Full Particulars)'.

From our analysis of all Trusts in England Red Circle has found that overseas visitors income as a percentage of total Trust turnover ranges from 0% to 0.62%, with the three 'best performing' Trusts being:

Hillingdon Hospital - 0.62%
London North West - 0.51%
Barts Health - 0.47%

That the top three performing Trusts (and indeed many of the top performing Trusts in the country) are in the Greater London area is of no surprise when we consider the main qualitative metrics that contribute to overseas visitors income. In our work to date we have found a strong correlation between overseas visitors income and:

1. Number of overseas tourists.
2. The local migrant and overseas visitors catchment population.
3. Number of overseas students.
4. Proximity to a major airport/airports.

By far the biggest factor here is the number of overseas tourists, and a look at the numbers illustrates why London Trusts continually 'outperform' other Trusts. In 2023 the five most visited cities in England were:

London 20,300,000
Manchester 1,721,000
Birmingham 934,000
Liverpool 900,000
Bristol 569,000

As you would expect the number of overseas tourists in London dwarfs all other cities in England. Ally this to its large multi-cultural population, number of universities, and its plethora of major and medium-sized airports, and the national picture in this KLOE is unsurprising.

This is, of course though, only half of the picture and only explains Trusts comparative performance against each other. It does not explain the significant write off of debt, mentioned at the start, or whether Trusts are identifying all overseas patients liable for charging, or whether Trusts are collecting that debt in a timely and efficient manner. In our work to date with Trusts in this area Red Circle has invariably found that there is room for improvement in both front-end processes for identifying patients liable to pay, and in back-end debt collection processes. The main weaknesses that we have found are generally:

- Lack of formal training for staff (e.g. mandatory training and staff induction)
- Underinvestment in upfront systems and processes
- Shortfall in capacity to robustly ensure that processes and guidance are being followed
- Relatively low priority at Executive and Board level

Red Circle encourages Trusts to undertake an audit of their current end-to-end process, taking into consideration the points above, for identifying overseas visitors liable to pay, how those are then charged and how that debt is collected.

Dean Marsh manages our commercial income portal. He was formerly a Director of Finance for a PCT and a Trust.

WHAT SHOULD GOOD NHS COSTING LOOK LIKE?

Overview

PLICS underpins the NHS Costing Transformation Programme, enabling NHS providers to understand the true cost of delivering care at the individual patient level. This approach replaces traditional average-based costing with more accurate, activity-based costing.

Key Characteristics of Good Patient Costing

1. Accuracy and Granularity

Costs are attributed to **individual clinical patient events below the episode level.** Too often, costing is talked about in terms of costing patient episodes and attendances. You can analyse and benchmark the variation in costs for specific activity at this level, but it's difficult to understand why the aggregate cost of some episodes are cheaper than others.

To effectively understand the causes of clinical variation, you must be able to analyse the clinical events and transactions that take place within the episode, and their associated cost.

For example, two identically classified patients (defined by HRG) are likely to have spent a different amount of time in their respective theatre procedures. The difference in the overall episode cost won't be understood unless you are able to analyse the drivers of cost (time in theatre).

Granurality in costing supports clinical engagement as it allows clinicians to understand the cost of every decision made for the patients under their care.

2. Timeliness and Data Quality

Regular, timely submissions of high-quality data are essential. Often only produced quarterly, half yearly or annually, Providers must invest in setting up an automated data capture and extraction process to create data for PLICS more frequently, ideally monthly. Trusts who are using PLICS effectively for value-based healthcare have an automated extraction process already in place and size isn't a barrier, as some of the larger NHS Trusts have shown.

Data should flow from collection systems via your informatics team and not have to be created or manipulated by the costing team before being processed. The costing team should not be responsible for the provision of patient-level data, they should only have to use it in the costing process. Too often, we see costing teams assume responsibility for gathering data from individual departments and worse, creating new datasets for the purpose of costing submissions.

3. Support for Strategic Decision-Making

PLICS must reach a wider clinical audience because it's their decisions that affect cost. In many organisations, PLICS outputs are only shared in summarised form at Trust Board level. Clinicians need to understand unwarranted variation so that they can address inefficient practices.

Costing can help NHS Providers improve productivity, efficiency, and resource allocation. Unfortunately, PLICS data is typically only dipped into for business cases and results are not considered a primary tool for organisational improvement.

4. Integration with Clinical and Operational Data

Combining costing data with clinical outcomes and operational metrics to support holistic performance management. Understanding the relationship between cost and better patient outcomes is fundamental.

Where possible, join data with other healthcare provider data and social care metrics to understand the cost of clinical pathways and healthcare disparities across the local population.

Good costing data encourages data-driven discussions on service improvement and financial sustainability.

5. The Focus Should Be on Value for the Organisation

Costing data often only targets the national submission, so models are set up to comply with mandatory costing guidance. PLICS is an enormously powerful internal tool that if used in the right way, can help stakeholders understand unwarranted variation. Unfortunately, the NCC requirements and format don't allow a full understanding of the patient journey through the system and associated costs.

Good costing should be produced regularly and in a timely manner for the audience,

but NCC rules mean that costing teams have focused on creating something vastly different from the regular outputs created in year.

6. Share the data and involve Stakeholders

Good costing doesn't come from a costing team trying to create the perfect model and then releasing cuts of it infrequently. Stakeholders should be involved in all aspects of its evolution, so a transparent and open process is essential for gaining trust.

In examples where PLICS data and outputs are used for real change, costing outputs are part of regular reporting so the information is pulled by clinicians and transformation leads, not pushed onto them.

7. A Continuously Evolving Model

Costing is subjective and not an exact science, so it's essential that you concentrate on the 'big wins' first, not the intricate overheads that sometimes only account for twenty per cent of the overall cost base and often don't materially affect the costing from one area to another. The more patient level data that you can bring into the model, the higher the level of confidence you will have in the output. You are not limited to the standard list or structure of datasets used for national returns.

Creating a robust PLICS output is not just about the capability of the software, it's largely dependent on how the model has been set up. No two healthcare providers are the same in terms of activity data and ledger so how you use the data available to create value is something to consider in detail.

Effective NHS costing hinges on granularity and good quality, timely data. By attributing costs to individual clinical events rather than broad episodes, providers can uncover the true drivers of variation and engage clinicians in meaningful improvement and integrating costing with clinical and operational metrics will support data driven decisions.

How We Can Help Your Trust

Since entering the NHS costing market in April 2025 Red Circle have invested heavily in staff and AL powered software.

We believe that our experience and cutting edge technology make us the leading player in helping Trusts to collate meaningful costing information.

We know that every NHS organisation is different and we aim to reflect the reality in your Trust, rather than using a 'cookie cutter' approach.

Please do reach if you'd like to learn more.

Mauli Hewavitarne is our new Director of Costing. He has over 25 years experience of costing for NHS Trusts

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MINDSET BY DR. CAROL S. DWECK

If you've ever wondered why some people seem to thrive under pressure while others crumble, or why certain individuals bounce back from setbacks stronger than before, Carol S. Dweck's "Mindset" offers a fascinating answer.

This groundbreaking book explores how our beliefs about our abilities can fundamentally shape our success, happiness, and resilience. For anyone working in demanding environments—like NHS finance teams—Dweck's insights could be genuinely transformative.

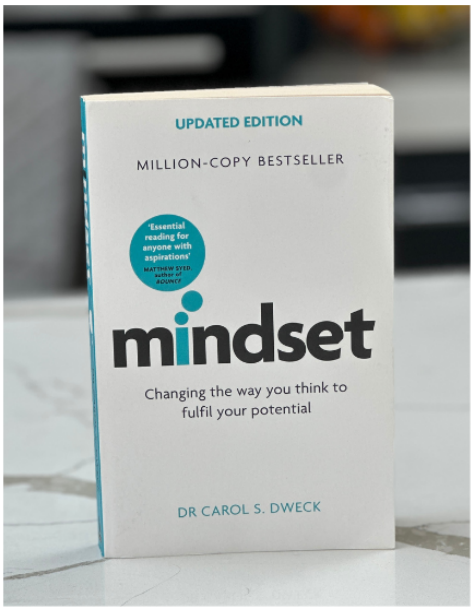
The Core Idea: Two Mindsets That Change Everything

Dweck's central premise is elegantly simple yet profound: *people operate from one of two mindsets that dramatically influence their approach to challenges, learning, and success.*

Fixed Mindset: People with a fixed mindset believe that abilities, intelligence, and talents are static traits. You're either smart or you're not. You're either good at maths or you're not. This mindset leads people to avoid challenges (what if I fail and prove I'm not clever?), give up easily when faced with obstacles, and see effort as a sign of inadequacy—after all, if you were truly talented, things would come naturally.

Growth Mindset: Those with a growth mindset believe that abilities can be developed through dedication, hard work, and learning from failure. Intelligence isn't fixed; it can be cultivated. This mindset embraces challenges as opportunities to improve, persists through setbacks, and views effort as the path to mastery.

The difference sounds subtle, but Dweck demonstrates through decades of research how these contrasting beliefs create



entirely different life trajectories.

Real-World Examples That Drive the Point Home

What makes "Mindset" so compelling is how Dweck illustrates these concepts with fascinating real-world examples across multiple domains:

Business Leaders: She contrasts CEOs like Lee Iacocca (fixed mindset), who became defensive when Chrysler faced challenges and blamed external factors, with leaders like Jack Welch (growth mindset), who continuously sought feedback and viewed setbacks as learning opportunities.

Sports Psychology: Dweck examines how athletes with growth mindsets—like Michael Jordan, who was famously cut from his high school basketball team—use failures as motivation to improve, while fixed mindset athletes often plateau or crumble under pressure.

Education: Perhaps most powerfully, she shows how praising children for intelligence ("You're so smart!") versus effort ("You worked really hard on that!") can shape their entire approach to learning and challenge-seeking behaviour.

Relationships: The book explores how mindsets affect personal relationships, with growth mindset individuals more likely to work through conflicts and view relationship challenges as opportunities for mutual development.

Why This Matters for NHS Finance Professionals

Working in NHS finance presents unique psychological challenges that make Dweck's insights particularly relevant:

Dealing with Constant Change: Healthcare finance is a field in perpetual flux—new regulations, changing tariffs, evolving costing methodologies. A growth mindset helps you see these changes as opportunities to develop new skills rather than threats to your existing competence.

Learning from Criticism: Whether it's audit feedback, peer review comments, or challenging questions from clinical colleagues, a growth mindset reframes criticism as valuable information rather than personal attacks on your abilities.

Embracing Complex Challenges: Tasks like implementing Activity-Based Costing or producing NCC returns can feel overwhelming. A growth mindset helps you break down complex challenges into learning opportunities rather than fixed tests of your intelligence.

Building Resilience: NHS finance work involves plenty of setbacks—missed deadlines, data quality issues, unexpected budget pressures. Growth mindset thinking helps you bounce back from these inevitable challenges stronger and wiser.

The Neuroscience Behind the Theory

Dweck doesn't just rely on anecdotal evidence. She presents compelling research showing that our brains are far more malleable than previously thought. When people learn about neuroplasticity—the brain's ability to form new neural connections throughout life—it literally changes how they approach learning and challenges.

Studies show that students who learn about brain plasticity subsequently perform better academically, particularly when facing difficult material. The simple knowledge that struggle and effort physically change your brain for the better can transform your relationship with difficulty.

Practical Applications: Changing Your Internal Dialogue

One of the book's strengths is its practical focus on how to cultivate a growth mindset.

Dweck provides specific strategies:

Reframe Internal Dialogue: Instead of "I'm terrible at presenting," try "I'm still learning how to present effectively." Instead of "This costing model is too complex for me," try "I haven't figured out this costing model yet."

Focus on Process Over Outcome: Rather than celebrating only final achievements, acknowledge the effort, strategy, and persistence that led to progress.

Embrace the Power of "Yet": Adding "yet" to statements transforms fixed limitations into temporary states. "I don't understand this financial regulation yet" implies future possibility rather than permanent inability.

Learn from Setbacks: When things go wrong, ask "What can I learn from this?" rather than "Why does this always happen to me?"

Limitations and Criticisms

While "Mindset" is compelling, it's worth acknowledging some limitations. Critics argue that Dweck's research sometimes oversimplifies complex psychological and social factors that influence success. The book occasionally feels like it promises mindset changes can solve any problem, which may underestimate the role of systemic barriers, resources, and opportunities.

Some researchers have also struggled to replicate certain mindset interventions, suggesting the effects may be more nuanced than initially presented. However, the core principle—that beliefs about ability influence behaviour and outcomes—remains well-supported by research.

Key Takeaways for Professional Development

So, what are the biggest lessons you can take away from Dweck's work? Here are the most impactful insights:

1. **Effort is the Path to Mastery** – Rather than seeing struggle as evidence of inadequacy, recognise it as the mechanism through which competence develops.
2. **Feedback is Information, Not Judgment** – Criticism and setbacks provide valuable data about how to improve, rather than verdicts on your worth or ability.
3. **Challenges are Opportunities** – Difficult projects and complex problems are chances to grow rather than tests to pass or fail.
4. **Learning Never Stops** – Professional competence isn't a destination you reach, but an ongoing journey of development and improvement.
5. **Language Matters** – How you talk to yourself and others about abilities and challenges can significantly influence motivation and performance.
6. **Process Over Person** – Focus on praising effort, strategy, and improvement rather than innate talent or intelligence.

Final Thoughts: Is Mindset Worth Reading?

Absolutely. Whether you're managing a team, developing your own career, or simply trying to maintain motivation in a challenging field, "Mindset" offers valuable psychological tools. The book's insights are particularly relevant for anyone in professional environments that demand continuous learning and adaptation—which certainly describes NHS finance work.

Carol Dweck's writing is accessible and engaging, making complex psychological research feel practical and applicable. While some concepts may feel familiar (most of us have heard about "positive thinking"), Dweck's research-backed approach provides a more nuanced and actionable framework than simple optimism.

For NHS professionals juggling demanding schedules and complex responsibilities, the book offers a way to reframe inevitable challenges and setbacks as opportunities for growth rather than threats to competence. In a field where continuous learning and adaptation are essential, cultivating a growth mindset isn't just helpful—it's practically essential.

The book serves as an excellent reminder that our greatest limitations often exist not in our actual abilities, but in our beliefs about what we're capable of learning and achieving. Sometimes, the most powerful change we can make isn't in our circumstances, but in our mindset about what those circumstances mean and what's possible moving forward.

If you'd like to get a copy of mindset just scan our Amazon affiliate link

CLINICAL ENGAGEMENT 2.0

Making Finance Data Irresistible to Doctors

The age-old struggle between finance teams and clinicians in the NHS has persisted for decades. On one side, finance professionals armed with spreadsheets, cost centres, and efficiency targets. On the other, clinicians focused on patient care, clinical outcomes, and professional autonomy. The result? A disconnect that undermines both financial sustainability and patient care quality.

But what if we could transform this relationship entirely? What if financial data became as compelling to doctors as clinical research? Welcome to Clinical Engagement 2.0—a revolutionary approach that makes finance data not just accessible, but genuinely irresistible to clinical teams.

The Traditional Approach: Why It Fails

Most NHS trusts still rely on outdated methods to engage clinicians with financial information. Monthly reports filled with abstract figures, budget meetings that feel punitive, and cost-reduction targets that seem disconnected from patient care. It's no wonder that many doctors view finance as an unwelcome distraction from their primary mission.

Dr. Sarah Chen, Consultant Cardiologist at a major teaching hospital, recently told us: "When finance comes to me with a spreadsheet showing I'm £50,000 over budget, my first reaction isn't curiosity—it's defensiveness. Those numbers don't tell me anything about how I can improve patient care while managing costs."

This reaction is entirely predictable. Traditional financial reporting fails because it:

- **Lacks clinical context:** Raw financial data doesn't connect to patient outcomes or clinical decision-making
- **Feels punitive: Most financial conversations focus on what's wrong rather than opportunities for improvement**
- **Uses the wrong language:** Financial jargon doesn't resonate with clinically-trained minds
- **Arrives too late:** Monthly or quarterly reports provide historical data when real-time insights are needed
- **Ignores clinical workflow:** Financial processes often conflict with how doctors actually work

The Neuroscience of Clinical Decision-Making

To understand why traditional approaches fail, we need to understand how clinicians think. Medical training develops specific cognitive patterns that prioritise:

- **Pattern Recognition:** Doctors excel at identifying patterns in symptoms, test results, and patient presentations. They need financial data presented in ways that leverage this strength.
- **Evidence-Based Thinking:** Clinicians are trained to question assumptions and demand robust evidence. Financial recommendations must meet the same evidential standards as clinical guidelines.
- **Patient-Centred Focus:** Every decision ultimately relates back to patient benefit. Financial data that doesn't clearly connect to patient

outcomes will be dismissed as irrelevant.

- **Immediate Applicability:** Doctors prefer information they can act on immediately. Abstract or theoretical financial concepts have little appeal.

Understanding these cognitive preferences is crucial for designing financial engagement strategies that actually work.

Visual Storytelling: Making Numbers Come Alive

The first principle of Clinical Engagement 2.0 is transforming how we present financial data. Instead of traditional tables and charts, we need visual storytelling that speaks the clinical language.

Patient Journey Cost Mapping

Rather than showing departmental budgets, map costs to actual patient journeys. For example, instead of reporting *"A&E overspent by £200,000 last quarter,"* show: *"Each emergency admission costs £450 more than the national benchmark, primarily due to extended waiting times that could be reduced through improved triage protocols."*

This approach works because it:

- Connects costs directly to patient experience
- Identifies specific, actionable improvement opportunities
- Uses clinical language and concepts
- Suggests solutions rather than just highlighting problems

Real-Time Clinical Dashboards

Modern costing systems can provide real-time insights that integrate seamlessly with clinical workflows. Imagine if a surgeon could see, immediately after a procedure, that using the premium stent added £300 to the case cost but typically results in 15% fewer readmissions.

This isn't about constraining clinical judgment—it's about providing complete information for informed decision-making.

Comparative Outcome Visualisation

Clinicians respond well to peer comparison, especially when it includes both cost and quality metrics. A dashboard showing "Your hip replacement outcomes: 95% success rate, £4,200 average cost vs. trust average: 92% success rate, £4,800 average cost" tells a compelling story of both clinical excellence and cost efficiency.

Gamification: The Unexpected Engagement Tool

While it might seem trivial, gamification principles can dramatically increase clinical engagement with financial data. This doesn't mean turning cost management into a literal game, but rather applying game design principles to make financial engagement more compelling.

Achievement Unlocking

Recognition systems that celebrate both clinical and financial achievements can be surprisingly effective. *"Dr. Smith achieved the 'Triple Win' badge this month: highest patient satisfaction scores, lowest complication rates, and most cost-effective treatment protocols in orthopaedics."*

Team Challenges

Department-level challenges that combine quality and efficiency metrics can harness competitive instincts positively. *"Ward 7 reduced their length of stay by 0.8 days while maintaining their 98% patient satisfaction score—can Ward 12 beat that?"*

Progress Visualisation

Clear visual progress indicators help clinicians see the impact of their efforts over time. A simple dashboard showing how process improvements have led to both better outcomes and cost savings provides powerful reinforcement.

The Language Revolution: Speaking Clinical Finance

One of the biggest barriers to clinical engagement is language. Financial terms like "cost centres," "overhead allocation," and "variance analysis" mean nothing to clinicians. We need to develop a new vocabulary that bridges both worlds.

Instead of saying: *"Your department shows negative variance against budget due to high agency costs."*

Try: *"Your service could treat 12 additional patients per month with the money currently spent on temporary staffing."*

This reframing works because it:

- Focuses on patient benefit rather than financial metrics
- Quantifies opportunity rather than problems
- Uses concrete, clinically meaningful measures
- Suggests positive outcomes from change

Clinical Finance Glossary

Developing a shared vocabulary helps both sides communicate more effectively:

- **Resource Efficiency** instead of "cost control"
- **Patient Value** instead of "cost-effectiveness"
- **Care Optimisation** instead of "budget management"
- **Outcome Investment** instead of "expenditure"
- **Service Sustainability** instead of "financial viability"

Technology as the Great Enabler

Modern technology offers unprecedented opportunities to make financial data

clinically relevant and immediately actionable. The key is integrating financial insights seamlessly into existing clinical workflows rather than creating separate systems.

AI-Powered Clinical Finance Assistants

Imagine an AI system that could whisper in a clinician's ear: *"Dr. Patel, the patient you're about to see has diabetes and hypertension. Based on our data, patients with this profile respond best to the following treatment pathway, which also happens to be 23% more cost-effective than the standard approach, with 18% better long-term outcomes."*

This isn't science fiction—it's entirely achievable with current technology. The key is presenting the information as clinical decision support rather than financial constraint.

Predictive Costing Models

Advanced analytics can predict the likely cost implications of different treatment pathways, helping clinicians understand the financial impact of their decisions without constraining their clinical judgment. *"This treatment plan has a 78% chance of achieving target outcomes within budget, compared to 65% for the standard approach."*

Mobile-First Design

Financial insights must be accessible where and when clinicians need them—often on mobile devices between patients. Apps that provide quick access to relevant cost and outcome data can transform decision-making at the point of care.

Implementation Roadmap: Getting Started

Transforming clinical engagement doesn't happen overnight, but trusts can begin immediately with these practical steps:

Phase 1: Foundation Building (Months 1-3)

Assess Current Engagement: Survey clinicians about their attitudes toward financial data and current engagement challenges.

Identify Champions: Find clinically credible advocates who understand both clinical excellence and financial sustainability.

Develop New Metrics: Create measurements that combine clinical outcomes with cost efficiency.

Language Training: Train finance teams to communicate in clinically relevant terms.

Phase 2: Pilot Programs (Months 4-9)

Select Target Services: Choose 2-3 clinical areas with engaged leadership for initial implementation.

Deploy Visual Dashboards: Implement real-time dashboards showing integrated clinical and financial metrics.

Launch Recognition Programmes: Begin celebrating combined clinical and financial excellence.

Gather Feedback: Continuously refine approaches based on clinical input.

Phase 3: Scale and Embed (Months 10-18)

Roll Out Trust-Wide: Expand successful approaches across all clinical services.

Integrate with Governance: Embed clinical-financial integration into quality improvement processes.

Advanced Analytics: Implement predictive models and AI-powered insights.

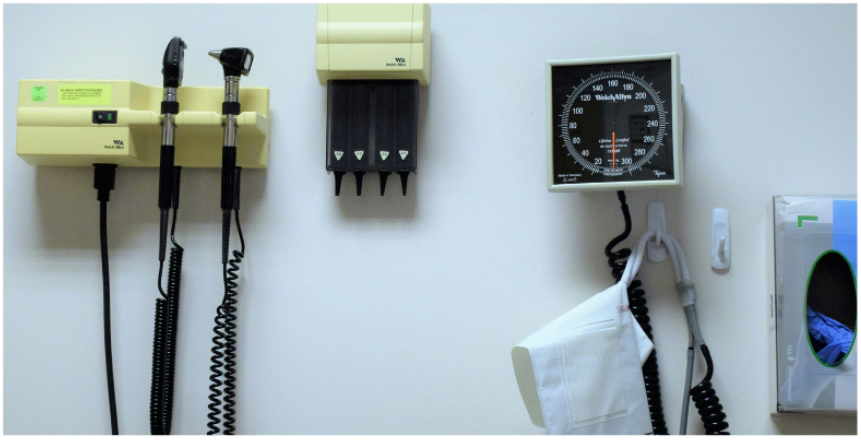
Cultural Transformation: Make clinical-financial collaboration the new normal.

Measuring Success: Beyond Budget Compliance

Traditional financial management focuses on budget compliance and cost reduction. Clinical Engagement 2.0 requires different success metrics:

Engagement Metrics:

- Frequency of voluntary financial dashboard usage
- Participation rates in financial improvement initiatives
- Staff satisfaction with financial support and information



Outcome Metrics:

- Patient satisfaction scores
- Clinical quality indicators
- Length of stay optimisation
- Readmission rates

Innovation Metrics:

- Number of clinician-led efficiency improvements
- Implementation rate of cost-saving suggestions
- Speed of adopting financial insights into clinical practice

The Future: Seamless Integration

The ultimate goal of Clinical Engagement 2.0 is making the distinction between clinical and financial excellence disappear entirely. In the future, we envision:

Clinicians who naturally consider both patient outcomes and resource efficiency in every decision, not because they're forced to, but because they have the information and tools to do so effectively.

Financial Teams who understand clinical workflows so well they can provide insights that enhance rather than constrain clinical decision-making.

Patients who benefit from care that's both clinically excellent and sustainably delivered, ensuring high-quality healthcare remains available for future generations.

Healthcare Systems that achieve the triple aim of better outcomes, better experience, and lower costs through genuine collaboration between clinical and financial expertise.

Conclusion: The Irresistible Opportunity

Making finance data irresistible to clinicians isn't about manipulation or coercion—it's about recognition that excellent patient care and smart resource use are complementary goals that require the best of both clinical and financial thinking.

The healthcare challenges facing the NHS demand nothing less than this kind of transformation. We can no longer afford the luxury of professional silos when patients need integrated excellence. Clinical Engagement 2.0 offers a path forward that honors clinical autonomy while embracing financial responsibility.

The trusts that master this integration won't just survive the current financial pressures—they'll thrive by delivering care that's both outstanding and sustainable. The question isn't whether you can afford to implement Clinical Engagement 2.0, but whether you can afford not to.

The data is compelling, the technology is available, and the need is urgent. All that remains is the commitment to bridge the gap between clinical excellence and financial sustainability. Your patients—and your balance sheet—will thank you for it.

Phase 3: Scale and Embed (Months 10-18)

Roll Out Trust-Wide: Expand successful approaches across all clinical services.

Integrate with Governance: Embed clinical-financial integration into quality improvement processes.

Advanced Analytics: Implement predi

- Readmission rates

James Wilson leads our approach to clinical engagement

FROM ANALOGUE TO DIGITAL

Making the NHS Fit for a Digital Future

The NHS has a bold vision for its future—one that demands fundamental change across systems, services and culture. At the heart of this vision are three interlinked strategic shifts:

1.From Treatment to Prevention
2.From Hospital to Home
3.From Analogue to Digital

Each is ambitious. Each is essential. But of the three, the shift from analog to digital may be the most structurally disruptive and capital-intensive. It is also the enabler of the other two. Without high-quality data, digital infrastructure and a connected system, prevention and community-based care cannot be delivered effectively at scale.

Yet the NHS's track record in digital transformation has been uneven. While pockets of innovation exist, national attempts at digitisation have often faltered —beset by underinvestment, overambition, weak implementation, or failure to engage frontline users.

So how does the NHS make the analog-to-digital transition (and transformation) in a way that is affordable, achievable, and timely? How can it minimise, mitigate and manage the potential double running costs during the transition period ? And what can Finance Directors do to help lead and support the change?

Why This Shift Matters

Digital transformation is not just about replacing paper records or upgrading hardware. It's about creating an NHS where:

- Care is proactive, not reactive, using data to anticipate needs.
- Services are delivered flexibly, including through virtual, mobile and self-service channels.
- Clinicians have real-time access to reliable patient information, wherever care is delivered.
- Systems are integrated, reducing duplication, friction or gaps.
- Patients are partners, empowered with tools and information.
- Artificial intelligence is central to the development and application of beneficial change.

The benefits are potentially vast: reduced administrative burden, faster and more accurate diagnostics, improved patient safety, fewer unnecessary appointments, and better population health outcomes. But to unlock these, the NHS must move decisively and strategically - and quickly

What's the Business Case?

A robust digital business case must go beyond technology—it should be rooted in service transformation and measurable impact. To justify investment, a digital project should meet several key criteria:

1. Clear Alignment with Strategic Goals

Does the proposal support productivity, reduce avoidable demand, or improve clinical outcomes? Does it help shift care upstream or closer to home?

2. Measurable Return on Investment

How will it reduce costs or improve efficiency? For example, replacing manual processes with automation might cut finance or HR administration costs by 30–40%. Virtual wards could reduce bed days by thousands annually.

3. Realistic Total Cost of Ownership

Includes implementation, training, support, integration, and potential double running. Avoid underestimating ongoing revenue costs (e.g., licenses, maintenance).

4. Benefits Tracking and Accountability

Every business case should include a benefits realisation plan with baselines, KPIs, and named owners.

5. Interoperability and Scalability

Can it plug into other systems and be scaled across departments, Trusts or ICSs?

How to Implement Successfully

The NHS's past challenges in digital delivery offer important lessons. Successful implementation relies on five key enablers:

1. Make it Clinically and Operationally Led

Digital transformation is not an IT project. It must be driven by frontline clinical and operational leaders. Technology should serve clinical pathways—not the other way around.

2. Invest in Change Management

Digital adoption often fails not because the technology is poor, but because staff are not engaged, trained or supported. Investment in user training, process redesign, and communications must be part of every digital programme.

3. Focus on User Experience

Solutions must be easy to use, intuitive, and genuinely save time. Clinicians will reject systems that add friction or feel disconnected from workflows.

4. Start Small and Scale

Avoid "big bang" national solutions. Pilot first. Prove the case. Learn fast. Scale what works.

5. Make Digital Business-as-Usual

Digital cannot sit in a silo. It must be embedded in service planning, workforce design, capital allocation, and executive decision-making.

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What Makes a Good Transition Plan?

A well-structured transition plan is critical to moving from analogue to digital safely and sustainably. Key characteristics include:

- **Baseline Assessment:** Clear understanding of current digital maturity (e.g. using tools like the NHS Digital Capability Assessment).
- **Phased Rollout:** Prioritise high-impact areas first—e.g. diagnostics, outpatient scheduling, or community care coordination.
- **Staff Engagement Strategy:** Co-design with users, identify digital champions, and build continuous feedback loops.
- **Infrastructure Readiness:** Ensure estates, networks, and cybersecurity are prepared for new demands.
- **Benefits Realisation Framework:** Set measurable objectives and review points.

How to Minimise or Avoid Double Running Costs

Double running costs—maintaining old systems while bringing in new—are a genuine risk, particularly where legacy infrastructure is entrenched. Strategies to mitigate include:

- **Sequenced Retirement:** Set clear timelines for decommissioning outdated systems. Build this into procurement and delivery plans.
- **Modular Implementation:** Transition service by service, reducing the window of duplication.
- **Target Fast Payback Areas First:** Prioritise digital investments that generate quick savings (e.g. automating repetitive admin tasks, improving rostering).
- **Align Digital with Workforce Plans:** Use digital transformation to redesign roles and reduce reliance on agency staff or non-value-adding admin work.

What Are the Risks—And How Can They Be Avoided?

Risk	How to Mitigate
Implementation delays	Use agile delivery; hold vendors to account with performance KPIs.
Staff resistance	Invest in training and development. Engage staff early in design so they can see the benefits and "what's in it for them"
Poor system usability	Prioritise user-centred design and thorough testing.
Interoperability failures	Enforce adherence to national integration standards.
Benefits not realised	Build robust benefits tracking into programme governance.
Cybersecurity vulnerabilities	Ensure adequate cyber investment, training and resilience testing.

The Role of Finance Directors

Finance Directors have a pivotal role in making analogue-to-digital a success. Key actions include:

- **Championing Value:** Lead on business case quality, ROI analysis, and benefits realisation discipline.
- **Strategic Investment Planning:** Align digital investment with broader Trust priorities and medium-term financial strategies.
- **Driving Efficiency:** Use digital as a lever to unlock savings, particularly in non-clinical areas like procurement, finance and estates.
- **Governance and Risk Management:** Ensure digital investments have strong board oversight, with clear controls and assurance.
- **Cross-Functional Collaboration:** Work with digital, operational, and clinical leaders to embed digital into core service redesign.

Conclusion

The analogue-to-digital shift is not optional—it is essential. It underpins the NHS's ability to deliver on prevention, community-based care, productivity improvement and financial sustainability. While the challenges are significant, the opportunities are even greater—if the NHS can learn from the past, plan realistically, and act decisively.

Bruce Finnamore leads our transformation practice and has consulted widely with NHS Trusts.

THE SONG THAT CHANGED EVERYTHING

I Want To Hold Your Hand

by The Beatles

"I Want to Hold Your Hand" didn't just launch Beatlemania in America—it fundamentally altered the trajectory of popular music and youth culture. Released at the precise moment when America needed healing from JFK's assassination, this deceptively simple love song became the catalyst for a cultural revolution that empowered teenagers, challenged musical conventions, and demonstrated that British artists could conquer the American market.

The track represented a perfect storm of musical innovation, technological advancement, and cultural timing that would never be replicated.

The song emerged from what John Lennon described as *"eyeball to eyeball"* songwriting, marking a pinnacle of the Lennon-McCartney partnership before their later, more individual approaches. By October 1963, when they had their first break from relentless touring, the duo found themselves in the basement music room of Jane Asher's parents' house on Wimpole Street, both playing piano simultaneously in an unusually intense collaborative session.

The breakthrough came when McCartney struck what music theorists believe was an E minor chord, prompting Lennon's famous reaction: "That's it! Do that again!" This chord—outside the song's G major key—created the harmonic tension that made the track compelling. Both songwriters consistently cited this as their most collaborative effort, with McCartney confirming in 1994 that "'Eyeball to eyeball' is a very good description of it."

The musical structure itself was revolutionary for a pop song. Opening with vocals entering "two beats early" over an ambiguous harmonic foundation, the track used unconventional chord progressions that music analyst Ian MacDonald called "blatant contrivance" that somehow sounded natural due to the Beatles' performance energy. The controversial B7 chord on "understand"—featuring an F# melody note drop—created what scholars identify as the song's most distinctive harmonic moment.

Rather than following traditional verse-chorus patterns, the song employed what MacDonald described as a "two-bridge model" reminiscent of Tin Pan Alley techniques but executed with unprecedented rock energy. The close vocal harmonies, with no single lead singer but alternating Lennon-McCartney unison and harmony throughout, established a template that countless bands would emulate.

Four-track technology meets studio innovation

October 17, 1963 marked a technological watershed for the Beatles—their first recording session using four-track equipment at Abbey Road's Studio Two.

After 17 takes spanning a marathon 2:30pm to 10:00pm session (with a dinner break), producer George Martin and engineer Norman Smith captured a sound that would define the British Invasion.

Smith's engineering philosophy of capturing "the actual Beatles' sound, playing together in the room" without heavy reverb created a stark, clean aesthetic that contrasted sharply with the heavily processed pop records dominating American radio. The session featured extreme compression on Lennon's rhythm guitar, creating an "organ-sounding" effect that some sources suggest was enhanced by a Hammond organ overdub from Martin.

The band had essentially perfected the arrangement before entering the studio—Take 1 sounded remarkably similar to the final version, indicating thorough rehearsal.

This represented a shift from their earlier approach of working out songs in the studio, establishing the meticulous preparation that would characterise their later, more complex recordings.

Cultural trauma meets perfect timing

The song's American release exemplifies how cultural timing can determine a track's legacy. Originally scheduled for mid-January 1964 to coincide with the Ed Sullivan Show appearance, the release was accelerated to December 26, 1963, after Washington DJ Carroll James began playing a UK import following listener requests prompted by CBS News coverage of British Beatlemania.

America in early 1964 was a nation in mourning. JFK's assassination on November 22, 1963—just weeks before the song's US release—had left the country in profound cultural shock. The musical landscape was dominated by bland teen crooners and novelty acts, with even Elvis relegated to forgettable Hollywood movies. Into this void came four Liverpool lads offering joy, energy, and hope to a traumatised nation.

The Beatles' February 7, 1964 arrival at JFK Airport drew 3,000 screaming fans in scenes unprecedented for any musical act. Their February 9 Ed Sullivan Show performance—closing with this song—drew a record-breaking 73 million viewers, making it the most-watched television event of its era. The cultural impact was immediate and profound: teenage girls found a socially acceptable outlet for expressing desire and abandoning social constraints, while the "gang" aesthetic of the Beatles inspired countless American teenagers to form their own bands.

The numbers tell an unprecedented story of commercial success. Selling 250,000 copies in its first three days in America—reaching 10,000 copies per hour in New York City alone—the song topped charts in eight countries and became the Beatles' best-selling single worldwide with over 12 million copies. Capitol Records was so overwhelmed they contracted competitors Columbia and RCA to help press copies.

The song's success fundamentally restructured the music industry. It marked the beginning of the British Invasion, effectively ending what critics called "The Lost Years" of rock music following Buddy Holly's death in 1959. By April 1964, the Beatles held all top five positions on the Billboard Hot 100 simultaneously—a feat never repeated.

The cultural revolution extended far beyond music. The song established the guitar-bass-drums format as rock's standard configuration, created the template for modern pop fandom, and demonstrated that American cultural dominance could be challenged. Artists from Bob Dylan to Brian Wilson acknowledged its transformative impact, with Wilson admitting it "blew my mind" and motivated the Beach Boys to elevate their game.

The song that altered everything

"I Want to Hold Your Hand" succeeded because it arrived at a singular cultural moment when America desperately needed what the Beatles offered—joy, energy, and youth empowerment wrapped in sophisticated musical craftsmanship. The combination of innovative four-track recording technology, intuitive songwriting collaboration, and perfect cultural timing created a perfect storm that fundamentally altered popular music's trajectory.

Rocket salad with peach, mozzarella, prosciutto and mint

125g buffalo mozzarella
Handful of rocket leaves
2 or 3 sprigs of mint
2 peaches
4 slices of prosciutto
Glug of olive oil
½ a lemon
Salt and pepper to taste
Sprinkling of dried chilli (optional)

Get your nicest serving dish out of the cupboard. This is a fantastic looking salad and it really is worth taking a bit of time over the presentation of it.

First drain the mozzarella, rip it into fairly small pieces and scatter it evenly across your dish. Then cut the peaches into eighths and distribute across the cheese. Either cut or rip the prosciutto into mouthful sizes and scatter across the top.

The salad needs to handled delicately so take your time. Cut the mint into slivers and combine with the rocket leaves. Then dress with olive oil and a little lemon juice to taste.

If you're anything like me you may want to add a little dried chilli, just to mix things up. Add the salad leave to the serving dish and tuck in. We always eat this salad with a Cloud Factory Marlborough Sauvignon Blanc.

Benjamin Malbec 2024

Pour yourself a glass and you're immediately greeted with that classic Malbec calling card: a gorgeous purple-red hue that's both bright and intense. The nose delivers exactly what you'd hope for—fresh, fruity aromas of plum and cherry that practically leap from the glass. There's nothing overly complex here, but that's precisely the point. This is Malbec at its most approachable.

On the palate, Benjamin Malbec strikes a lovely balance. It's neither too heavy nor too light, with enough structure to satisfy wine enthusiasts while remaining smooth enough for casual sippers. The finish is clean and pleasant, leaving you wanting another glass rather than reaching for a palate cleanser.

The wine's food-friendly nature makes it incredibly versatile. Boutinot suggests cheese, pasta, and poultry, and they're spot-on.

This is the kind of wine that works beautifully with a Tuesday night dinner of spaghetti Bolognese or a weekend barbecue with friends. It's also robust enough to handle slightly spicier dishes—think chorizo pasta or herb-crusted chicken thighs.

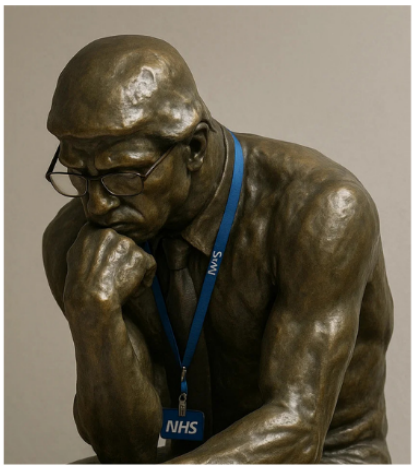
The Verdict

Benjamin Malbec succeeds because it understands its mission: to be a genuinely enjoyable, everyday wine that showcases why Argentina has become synonymous with excellent value Malbec. It's the kind of bottle you'll happily pour for guests without breaking the budget, and confident enough to stand up to more expensive alternatives.

Rating: 4/5 - A bright, honest expression of Malbec that delivers exactly what it promises.

The Last Word... on AI

Are You Really Embracing the Revolution, or Just Going Through the Motions?



Artificial Intelligence is everywhere in healthcare finance right now. Every software vendor claims to have "AI-powered" solutions, every conference features AI keynotes, and every strategy document mentions machine learning. But here's the uncomfortable question we need to ask ourselves: *Are we actually embracing AI, or are we just ticking boxes?*

The Reality Check

Let's be honest about where most NHS trusts really are with AI. You've probably got some automated data validation in your costing system. Maybe you're using predictive analytics for demand planning. Both good steps, but are they truly transforming how you work?

The gap between AI hype and AI reality in NHS finance is vast. While tech companies promise revolutionary change, many finance teams are still using AI like a slightly smarter Excel function. It's time for some straight talking about what's working, what isn't, and what we're missing.

The Uncomfortable Questions

Before we get carried away with AI enthusiasm, let's address the elephant in the room:

Are we solving the right problems? Most AI implementations in NHS finance focus on automating existing processes rather than reimagining how we could work. Are we using AI to do the same things faster, or to do fundamentally different things?

Do we understand what we're buying? When vendors say "AI-powered," do you actually know what that means? Machine learning? Natural language processing? Simple rule-based automation dressed up with buzzwords?

Are we measuring the right outcomes? Time saved and errors reduced are good, but are we tracking whether AI is actually improving decision-making quality or clinical engagement with financial data?

What about the human element? The best AI implementations enhance human capability rather than replacing it. Are your teams becoming more strategic and insightful, or just managing more automated processes?

The Missed Opportunities

While we've been cautiously automating routine tasks, we might be missing AI's bigger potential in healthcare finance:

Predictive Clinical Intelligence: Instead of just forecasting costs, what if AI could predict which patients are likely to become high-cost cases and suggest early interventions?

Real-Time Resource Optimisation: Beyond tracking where money goes, AI could actively suggest resource reallocation based on real-time demand patterns and outcomes data.

Intelligent Clinical Engagement: Rather than sending reports to clinicians, AI could provide personalized insights at the point of care, making financial considerations a natural part of clinical decision-making.

Dynamic Pricing and Contracting: AI could optimize commercial income by analyzing market conditions, demand patterns, and competitive positioning in real-time.

The Culture Question

Perhaps the biggest barrier to AI adoption isn't technical—it's cultural. Finance teams have spent decades developing expertise in specific processes and systems. AI threatens to make some of that expertise obsolete while demanding entirely new skills.

Are we ready for finance professionals who spend more time interpreting AI insights than creating spreadsheets? Can we handle the shift from being data processors to becoming strategic advisors? Are we prepared for the pace of change that AI enables?

... and that's the last word.

Red Circle Healthcare Advisory

Commercial Insight. Financial Growth.

Blending Commercial & NHS Experience

We are one of the UK's leading advisors specialising in NHS finance issues. Working exclusively in healthcare and employing many staff with a blend of commercial and NHS experience gives us a unique perspective on the issues that NHS Trusts face.

We are a commercial organisation, delivering a value for money service. We are committed to providing commercial insight, spreading best practice and enabling financial growth for NHS Trusts across the country - and doing so sustainably – through a combination of understanding your cost base and also growing your commercial income.

Our approach is based on the development of close working relationships with key local stakeholders. We will ensure we develop an understanding of your organisational culture and ambitions so that we can align our work with your strategic goals and operational plans.

We have two areas of focus:

1.The provision of best-in-class costing software and advice. The software will calculate your National Cost Collection return and we also provide you with detailed insights that enable cost effective decision making across your Trust.

2.Increasing commercial income. Through our detailed understanding of commercial income streams across all NHS providers, using our Benchmarking tools we can highlight the commercial opportunities in your Trust. We will also help you to run commercial schemes if needed.

Feedback from clients shows we are proud of the fact that we are considered trusted advisors - a compliment we value highly and work hard to maintain and develop. Our work is confidential and highly protected at all times. We work collaboratively and in partnership alongside your existing team to help achieve the near and long term outcomes you require.

01454 406100
james.wilson@redcirclehca.com

Visit our website at:
www.redcirclehca.com

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Address:
Red Circle Healthcare Advisory,
Somerset House, Church Road,
South Gloucestershire, GL9 1HT

Editor: Holly Wilson
Art Editor: Will Griffiths