Red Circle Healthcare Advisory

Healthcare Finance Matters

Winter 2025/Spring 2026

Definitely Maybe - Why Productivity Matters So Much in the NHS

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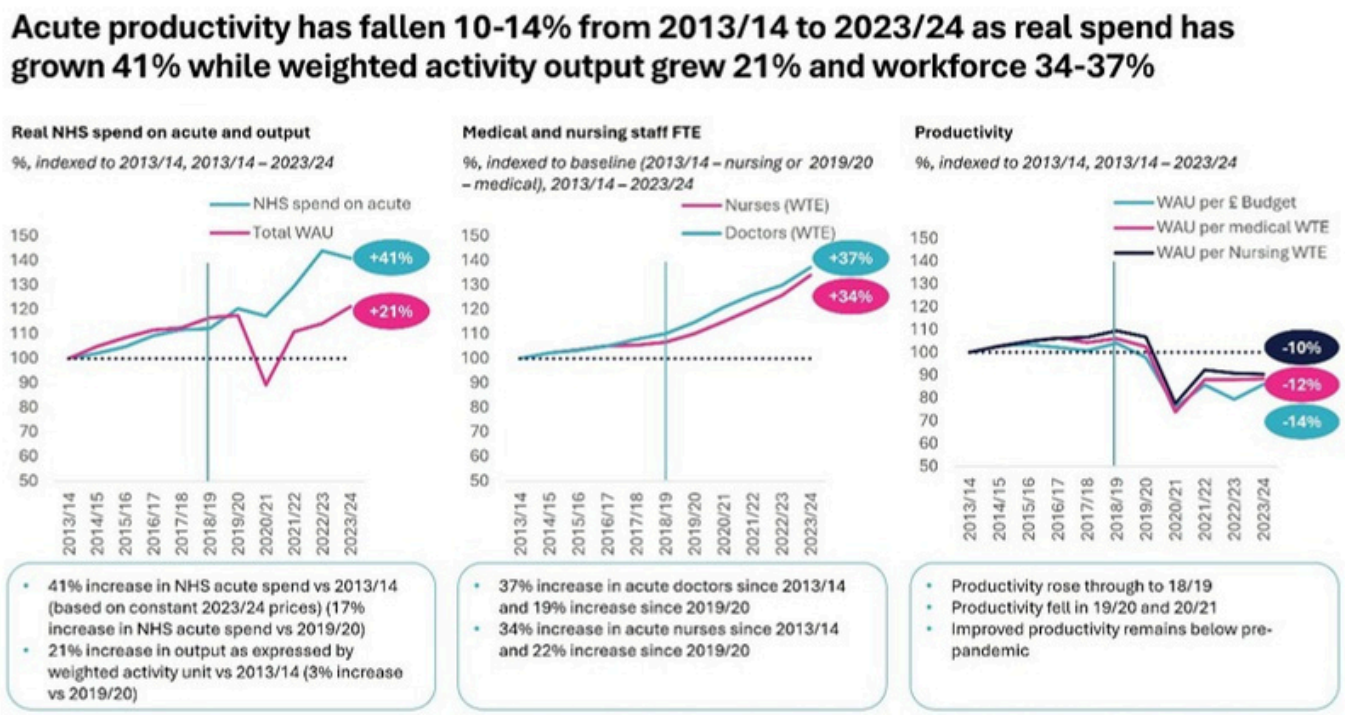
THE NHS PRODUCTIVITY CHALLENGE - TURNING THE CURVE

"Productivity is the new frontier of NHS sustainability"

The State of Play

NHS productivity has fallen by 12–18% since 2018/19, despite record investment and workforce growth. In simple terms, we are spending more and delivering less.



This diagram was created by Carnall Farrar Ltd (CF), a consultancy focused on improving health and healthcare through collaboration, innovation, and investment.

For Chief Finance Officers, this is one of the most pressing strategic issues in the system. Productivity underpins financial balance, workforce planning, and tax payer confidence. It is therefore the lens through which the Treasury and DHSC will judge future funding settlements.

"The productivity gap is now the single biggest threat to NHS financial sustainability."

Why productivity is falling

Several interlocking factors have driven the decline:

1. Post-pandemic recovery drag – Lost elective capacity, infection control measures, and patient safety issues, combined with staff absences (including industrial action).
2. Workforce expansion without matching output – Clinical staff have grown faster than activity, diluting productivity ratios.
3. Fragmented pathways – Poor integration between acute, community, and primary care leading to deterioration, duplication and delay.
4. Digital under-adoption – Uneven implementation of technology, with limited automation or AI/ML -enabled processes.
5. Legacy estate and capital constraints – Ageing infrastructure limits throughput and innovation.

These factors collectively equate to up to £18 billion in lost productivity each year.

The Impact

Falling productivity is eroding the system's ability to meet demand and sustain financial balance. The implications are stark:

- ***Financial:*** Cost pressures rise faster than funding, creating structural deficits.
- ***Operational:*** Backlogs persist despite record staffing levels.
- ***Workforce:*** Staff morale and retention suffer as output fails to match effort.
- ***Systemic:*** The NHS risks a vicious cycle of higher costs and lower performance.

Without reversing the productivity curve, even substantial new investment will not deliver visible improvement to patients or taxpayers.

The Red Circle ○ approach – data-driven improvement using Prediction and Prescription Analytics

Red Circle ○ has developed a new suite of analytical tools designed to help NHS Trusts analyse, predict, and prescribe significant productivity improvement.

Using multi-level data - from workforce deployment to patient flow and digital utilisation - the models links Artificial Intelligence/machine learning with human intelligence and experience to:

- Quantify the productivity gap and highlight opportunities at specialty, site, and system level.
- Identify the drivers of underperformance (staffing patterns, digital adoption, estate usage).
- Predict improvement trajectories under different scenarios.
- Prescribe practical specific actions for sustained gains, supported by financial modelling and real time programme planning, management and delivery tools.

"The ability to predict and prescribe productivity gains is the next frontier for NHS analytics."

This approach enables CFOs to work with C-suite colleagues, general managers and clinicians to move beyond retrospective efficiency reporting into proactive, evidence-based transformation planning and delivery.

How CFOs can drive improvement

CFOs are uniquely positioned to turn data into insight, and insight into action. Their influence spans the organisation's most powerful levers:

1. ***Investment allocation*** – Channel capital and revenue towards productivity-enhancing innovation (digital, estates, automation).
2. ***Incentive design*** – Embed productivity metrics in internal budgets and divisional targets.
3. ***Data transparency*** – Make performance visible at every level, linking input cost to outputs and outcomes.
4. ***Workforce economics*** – Align staffing models with demand patterns, skill mix, and flexible deployment.
5. ***Partnership working*** – Use integrated budgets within IHOs or systems to address bottlenecks across care boundaries.
6. ***Developing and aligning culture, systems and processes*** - So that productivity improvement is rewarded.

"Finance functions that understand the real drivers of productivity gains beyond cost, will lead the recovery and accelerate growth"

Time horizons – Realistic Recovery

Productivity recovery will not happen overnight. Evidence from high-performing international systems suggests a three-phase trajectory:

	Phase	Timeframe	Focus
1	Stabilisation and moderate improvement	18 months	Contain cost growth, restore baseline output, improve data quality, highlight and action greatest gains
1	Transformation	2-3 years	Invest in digital, workforce redesign, eliminate unwarranted variation, optimise systems and processes. “Be your best you.”
3	Sustained performance	4+ years	Culture of continuous, rapid and sustainable improvement; AI adoption, and cross-sector integration

CFOs should plan investment, cash flow, and performance expectations across this timescale — balancing immediate savings with long-term returns.

Feeding into the wider C-suite

Productivity is clearly not just a finance issue; it is a strategic alignment challenge involving every part of the organisation and system. CFOs must work alongside all their C-suite and Board colleagues to:

- Embed productivity measures in operational, workforce and infrastructure strategies and plans.
- Ensure digital investments deliver measurable throughput and productivity gains.
- Link financial sustainability directly to improved patient services and population health outcomes.

Boards that treat productivity as a shared goal - not a cost-cutting exercise - will achieve faster, deeper and transformational beneficial change.

In summary

NHS productivity is now one of the top and defining challenges for financial sustainability. It is a challenge that cannot be solved through traditional efficiency measures. It requires a fundamental shift in how organisations understand, diagnose, and improve performance. CFOs can, and should lead and support this shift.

This is where the next generation of analytical capability becomes essential. Red Circle's ○ Predict & Prescribe Analytics tool provides something the NHS has never had before: the ability to quantify the true productivity gap, predict performance trajectories, and prescribe targeted, evidence-based actions that CFOs and operational leaders can take immediately.

With this intelligence, productivity improvement stops being a retrospective exercise and becomes a forward-looking, precision-led strategy. CFOs can see exactly where value is lost, which interventions will have the greatest impact, and how to sequence investment to unlock sustainable gains.

But tools alone are not enough. CFOs must pair analytical insight with active leadership — aligning investment with value, redesigning incentives to reward improvement, and embedding transparency across clinical, operational, and digital domains. When clinical , operations, workforce, finance and digital strategies are aligned around the same productivity insight, the organisation's ability to improve accelerates dramatically.

"Productivity is not about doing more with less — it's about doing better with what we have. And for the first time, we can measure precisely what 'better' looks like and how to achieve it"

The NHS productivity challenge is both important and urgent. It is a real problem and also a real opportunity. With the right AI and human analytical insight, CFO inspired system redesign, working alongside C-suite led clinical and general management driven improvement, significant and sustainable productivity growth in the NHS is undoubtedly achievable. And it is achievable 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.

COMMERCIAL INCOME & THE NHS

It is over a year now since Red Circle launched its commercial income advisory service for NHS Trusts, and what a busy year it's been. In that time Red Circle has:

Generated comparative statistics for every Trust in England, organised into appropriate peer groups and income category.

Produced 190 free 'insight' reports for Trusts, which provide an 'at a glance' comparison of high-level performance for each Trust in the country by income category.

Generated a range of qualitative metrics that help explain relevant performance in each income category.

Maintained a library of case studies to demonstrate best practice in generating commercial income.

Worked with over 20 trusts on detailed diagnostic reviews providing concrete and actionable advice on how commercial income can be increased.

Continue to provide follow up support to several trusts in relation to assessing overseas visitors charging processes, supporting Trusts in developing private patient pricing strategies, supporting Trusts in strategy development (especially Research and Development and commercial strategies) and generating plans for the expansion of private patient services.

But what prompted Red Circle to offer this service in the first place?

Financial pressures across the NHS have intensified focus on public sector entrepreneurialism, with Trusts increasingly exploring commercial opportunities to generate additional income whilst driving innovation and service improvements.

The Health and Social Care Act 2012 significantly expanded commercial freedoms within the NHS; Foundation Trusts can now generate up to 49% of their income from non-public sources, whilst NHS Trusts face no such restriction.

Despite these opportunities, commercial income varies dramatically between organisations, suggesting substantial untapped potential for revenue optimisation.

It was this in mind that Red Circle decided to develop this service using the significant experience of its highly skilled staff who, since the service began, have expanded their knowledge and understanding even further.

So what have we learned over the last twelve months?

- In 2023/24 Trusts in England wrote off £37m of overseas visitor's income and provided for bad debt of £66m.

- Very few mental health and community trusts generate overseas visitor income even though the bulk of their services are not excluded or exempt.

COMMERCIAL INCOME & THE NHS

- There are a range of qualitative metrics that can help predict the income expected from overseas visitors in helping to assess relative performance (including overseas tourists and overseas students amongst others).

- There are a range of quantitative and qualitative metrics that can help to identify opportunities for expanding private patient services (local market conditions, local and national prices, and Index of Multiple Deprivation amongst others)

- 19 Trusts, on closer examination, appear to be making a negative contribution overall on their leases, although the number of individual leases making a negative contribution is significantly higher.

- Very few Trusts have a visible R & D strategy with a clear commercial element.

- Red Circle has generated a range of qualitative metrics that closely explain the relative performance of Trusts in generating R & D income (for example, hosting a Biomedical Research Centre contributes significantly to R & D income).

- Few Trusts have a visible, dedicated E and T strategy with a clear commercial element to it.

- Whilst considered to be a somewhat controversial topic by many, too few Trusts have a consistent and coherent car parking strategy, particularly when it comes to pricing. There are many opportunities across the country for optimising car parking income through having a clear trust-wide pricing strategy.

- In the current climate Red Circle has found that not many Trusts have a dedicated commercial team. Too often it is 'tacked' onto the end of somebody's day job. Very few Trusts have a dedicated commercial strategy and therefore visibility is lost, particularly at Board level.

There are however some notable Trusts that generate significant income in various of the income categories used by Red Circle these for the backbone of Red Circle's case studies:

Great Ormond Street Hospital for Children NHSFT (Overseas & Private Patients)

The Royal Marsden NHSFT (Overseas & Private Patients)

Moorfields Eye Hospital NHSFT (Overseas & Private Patients)

King's College Hospital NHSFT (Overseas)
Oxford Health NHSFT (Research & Development)

University College London Hospitals NHSFT (Research & Development)

Oxford University Hospitals NHSFT (Research & Development)

King's College Hospital NHSFT (Education & Training)

Guy's and St Thomas' NHSFT (Other Commercial)

Frimley Health NHSFT (Other Commercial)

University Hospitals Birmingham NHS FT (Other Commercial)

University Hospital Southampton NHS Foundation Trust (Other Commercial)

The Newcastle Upon Tyne Hospitals NHSFT (Other Commercial)

- There remain certain cultural barriers in the NHS to generating 'commercial' income. It can sometimes still be seen as a dirty phrase that will ultimately detract from NHS patient care. The largest question for Red Circle still remains. How do we overcome these cultural barriers?

- Overcoming the cultural barriers to generating commercial income in the NHS requires reframing the narrative around what "commercial" means in a healthcare context. The key is to position it as a way of strengthening patient care rather than undermining it. Commercial activity should be explained as an enabler: additional revenue can fund innovation, improve facilities, and reduce reliance on constrained budgets.

Practical steps include embedding clear communication from leadership that commercial ventures are aligned with NHS values. Case studies of successful initiatives such as research partnerships, training programmes for international clinicians, or leasing underused estate, can demonstrate tangible benefits to patient services. Staff engagement is critical: workshops and forums should invite clinicians and managers to co-design opportunities, ensuring transparency and trust.

Another strategy is to integrate commercial thinking into everyday operations. Framing opportunities as "maximising value" or "making best use of assets" resonates more positively than "profit." Finally, building capability through training in business development and contract management helps staff feel confident and empowered. By linking commercial income directly to improved patient outcomes, the NHS can overcome cultural resistance and embrace sustainable innovation.

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

PLICS AND PRODUCTIVITY: USING PATIENT-LEVEL COSTING TO IMPROVE CARE AND STRENGTHEN THE NHS

Healthcare systems across the world are under pressure to deliver more for patients while operating within tighter financial constraints and increasing operational challenges. In England, the NHS faces rising demand, workforce pressures, and heightened expectations for both care quality and value for money. In this context, accurate, transparent, and meaningful costing information is no longer optional — it is essential.

This is where Patient-Level Information and Costing Systems (PLICS) play a crucial role. PLICS provides a detailed view of the resources used to deliver individual episodes of care. When paired with activity data and clinical insight, this information becomes a powerful enabler of productivity, service redesign, and smarter decision-making.

This article explores what PLICS is, how it supports productivity, and why organisations that embed costing into everyday conversations are better positioned to improve both efficiency and patient outcomes.

What Exactly Is PLICS?

At its core, PLICS is a methodology — supported by national costing standards — that assigns the actual cost of care to each patient. Rather than costing an average procedure or an entire service line, PLICS tracks the resources consumed by individual patients.

This includes:

- Direct costs such as consumables, and clinical staff time.
- Indirect costs including theatre time, imaging, pathology and drugs.
- Pathway-specific activity, showing how patients move through the system and where bottlenecks or delays occur.
-

The strength of PLICS lies in its granularity. It moves costing away from broad averages and instead provides a realistic, patient-level view that reflects the true complexity and variation of healthcare delivery.

Why PLICS Matters More Than Ever

Historically, costing data in the NHS was primarily used for external reporting — submissions to NHS England, benchmarking exercises, or reference cost calculations. While still important, the focus has shifted.

Today, organisations need costing data to:

- Understand where resources are being used inefficiently.
- Identify variations in care that cannot be justified clinically.
- Target improvement efforts where they will have the greatest impact.
- Support financial recovery and sustainability plans.
- Enable clinicians and managers to make better-informed decisions.

In short, PLICS helps trusts see clearly, act decisively, and reduce the gap between what services cost and the value they provide.

How PLICS Drives Productivity in Practice

Productivity in healthcare isn't simply about delivering more activity; it's about achieving the best possible outcomes with the resources available. PLICS helps organisations improve productivity in several key ways:

1. Identifying Unwarranted Variation

One of the most powerful uses of PLICS is its ability to reveal variation within and across pathways, specialties, and clinicians. For example, why does one surgical consultant have significantly shorter theatre times for a similar case mix? Why is the length of stay for a particular procedure longer on one ward than another? Are there differences in diagnostics usage, consumables, or pre-operative preparation that are affecting cost and throughput?

Variation is not automatically negative, but PLICS helps distinguish between clinically justified variation and avoidable inefficiency. This creates a starting point for improvement discussions that are based on data rather than anecdote.

2. Linking Costs to Outcomes

A growing focus across integrated care systems is the relationship between cost, quality, and outcomes.

PLICS enables trusts to explore whether a lower-cost pathway delivers comparable or better outcomes, if higher-cost cases are linked to complexity or inefficiencies or how resource use correlates with patient experience or safety metrics.

This encourages a value-based approach to care, shifting attention away from isolated financial savings and toward changes that improve both productivity and quality.

3. Empowering Clinicians with Meaningful Information

Clinicians are often the biggest drivers of productivity, yet historically they have been provided with limited financial insight. PLICS changes that dynamic.
By giving clinicians access to case-level costing, comparative pathway data and variation dashboards, PLICS turns abstract financial metrics into practical, clinically relevant information.

When clinicians understand the true resource implications of their work, they are better equipped to challenge inefficiencies, share best practice, improve pathway flow and support investments that will deliver long-term benefits.

4. Supporting Service Redesign and Planning

Service redesign requires a detailed understanding of where time, money, and workforce effort are currently being spent. PLICS provides clarity on:

- Which pathways place the greatest burden on resources,
- Where demand is outstripping capacity,
- Which processes create delays or unnecessary cost,
- How changes to a pathway could affect downstream services.

For example, a trust may discover through PLICS that a high-cost pathway is driven by excess imaging, repeated outpatient appointments, or a higher-than-average requirement for post-operative care. This insight allows teams to redesign the pathway with clear evidence underpinning the changes.

5. Improving Financial Sustainability

Financial recovery is a key focus across the NHS. While cost improvement plans (CIPs) are essential, they are most effective when supported by accurate data.

PLICS can help identify savings that will not compromise quality and highlight areas where demand and complexity are driving unavoidable costs. It can reduce reliance on temporary staffing by understanding workload drivers or support negotiations for appropriate tariff and funding for services.

Better costing doesn't reduce budgets on its own — but it ensures that every pound spent delivers maximum value.

Turning Insights into Action: What Effective Use of PLICS Looks Like

PLICS is only valuable when integrated into everyday decision-making. Successful organisations share several characteristics:

. Collaboration Between Finance, BI, and Clinical Teams

Costing is not a finance exercise; it is a whole-system activity. Trusts that align costing analysts, operational leaders, and clinicians see far greater improvements.

2. Transparent, User-Friendly Reporting

Dashboards, visual tools, and clear narratives help translate complex costing data into actionable insights.

3. A Culture of Improvement Rather Than Blame

PLICS should initiate supportive conversations about improving care, not punitive comparisons.

4. Strong Data Quality and Pathway Mapping

Accurate inputs lead to meaningful outputs. Trusts investing in coding, activity capture, and digital systems benefit from far more reliable PLICS data.

A Practical Example: Using PLICS to Improve Surgical Productivity

In one NHS organisation, PLICS data revealed significant variation in costs for similar elective surgical procedures. By drilling into the detail, the trust discovered that length of stay varied by consultant, some procedures had double the theatre turnaround time and certain teams used significantly more consumables.

Working collaboratively, the teams redesigned elements of the pathway, standardised consumables where clinically appropriate, and reduced delays between cases.

The result: Higher throughput, shorter stays, better patient experience, and lower overall cost. This was not achieved through cuts but through smarter working supported by robust data.

Conclusion: PLICS as a Catalyst for Better, More Productive Care

PLICS is more than a costing system.

It's a transparent tool that supports better decision-making, more efficient use of resources and clinically-led improvement.

When costing becomes part of everyday conversations, organisations gain the clarity they need to make meaningful, patient-centred improvements. In an NHS where every decision matters, PLICS provides the insight to ensure that productivity and quality go hand in hand.

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

BEYOND DASHBOARDS: PRESCRIPTIVE ANALYTICS THAT ANSWERS "SO WHAT?"

Every NHS trust has dashboards. Performance metrics tracking theatre utilisation, outpatient DNA rates, length of stay, waiting lists - all colour-coded, all updating in near real-time, all competing for executive attention.

For most trusts, the challenge isn't accessing data. It's that data alone doesn't tell you what to do about it.

When a trust sees their average length of stay is 6.2 days versus the GIRFT benchmark of 4.8 days, the dashboard has done its job. It's identified a gap. But then what? Which patients are driving that excess? Which wards? Which consultants? Which specific clinical decisions are extending stays? And most critically: **where should the trust invest limited improvement resources to get the best return?**

That's the "so what?" question. And it's where most analytics initiatives stop.

The Analytics Maturity Gap

NHS trusts typically progress through three stages of analytics capability:

Descriptive Analytics tells you what happened. Your theatre utilisation was 73% last month. Your DNA rate increased by 2.3%. You're in the third quartile for elective activity in your ICS.

Predictive Analytics tells you what might happen. Based on current trends, you'll miss your 62-day cancer treatment target by 8% next quarter. Emergency admissions will likely spike 15% in January.

Prescriptive Analytics tells you exactly what to do about it - and prioritises those actions by impact.

Many trusts have strong descriptive analytics but find the leap to prescriptive challenging. The journey to prescriptive analytics remains challenging for most. Yet prescriptive analytics is where the real value lives.

From "We Have a Problem" to "Here's Exactly What To Do"

At Red Circle Healthcare Advisory, our prescriptive analytics platform is built around answering four specific questions that descriptive analytics can't:

1. Which Specific Patients/Pathways Drive Your Performance Gap?

A trust might know their orthopaedic length of stay is above benchmark. But which patients specifically? Our analytics drill into the patient-level data to identify, for example:

- The 12% of patients whose complexity doesn't match their HRG grouping
- The 8% experiencing avoidable delays between procedures
- The 15% who could have been managed as day cases

This isn't population-level insight - it's patient-specific, consultant-specific, ward-specific actionable intelligence.

2. What's the Financial Impact of Each Improvement Opportunity?

Knowing you could reduce length of stay is one thing. Knowing that reducing orthopaedic LOS by 1.4 days could potentially:

- Free up to 2,800 bed days annually
- Enable 350 additional elective procedures
- Generate potential value of £2.1m in additional activity
- Reduce agency spend by up to £400k

That's what drives business cases and secures improvement funding.

3. Which Actions Should You Prioritise?

Every trust has dozens of improvement opportunities. Prescriptive analytics ranks them by:

- Implementation difficulty (easy wins vs complex transformations)
- Financial impact (cost reduction and income opportunity)
- Clinical risk (safety and quality implications)
- Resource requirements (workforce, capital, time)
-

Instead of trying to fix everything, you fix the right things in the right order.

4. How Do You Track Real Impact?

Traditional analytics shows you if metrics improved. Prescriptive analytics shows you if your specific interventions worked by:

- Tracking cohort-specific outcomes pre/post intervention
- Adjusting for seasonal variation and case mix changes
- Calculating actual vs projected ROI
- Identifying which interventions to scale and which to stop

Real-World Application: The Monday Morning Question

Picture this scenario: It's Monday morning's executive meeting. The COO presents the latest performance pack. Elective activity is down 8%, emergency length of stay is up, theatre productivity has dropped to 71%.
With traditional analytics, the conversation goes: "We need to improve theatre utilisation." "We should focus on discharge planning." "Let's set up a working group to investigate further."

With prescriptive analytics, the conversation goes: "Our analysis shows that late-starting lists could be impacting up to 180 potential procedures per month. By optimising three list start times to 8am, we'd recover 60% of that loss. Here are the three theatre sessions, here's the rota change required, and here's the potential £800k annual impact."

That's the difference between knowing you have a problem and knowing exactly how to fix it.

The Path Forward

NHS trusts need to move beyond RAG ratings to actionable insights. They need analytics that:

- Identifies specific, actionable improvements
- Quantifies the impact in operational and financial terms
- Prioritises interventions based on effort vs impact
- Tracks whether interventions actually work

This isn't about replacing clinical judgement or operational expertise. It's about augmenting those capabilities with data-driven precision. It's about moving from hypothesis-driven improvement to engineered precision with measurable outcomes.

The trusts that master prescriptive analytics won't just perform better. They'll fundamentally change how improvement happens - from experience-based decisions to data-validated interventions that deliver predictable results.

Red Circle Healthcare Advisory specialises in prescriptive analytics for NHS trusts, combining PLICS expertise with advanced analytics to deliver actionable improvement insights.

To learn more about moving beyond dashboards to genuine data-driven improvement, scan the QR code to contact us:

Mr X is the UK's leading proponent of prescriptive analytics.

BEYOND CTP: WHY YOUR COSTING SYSTEM SHOULD DO MORE THAN MEET NATIONAL REQUIREMENTS

Rigid schemas trap trusts in compliance mode—missing the intelligence that could transform care and efficiency

The Compliance Trap

"CTP submission successful." It's a familiar relief—but also a missed opportunity. For many NHS finance leaders, meeting the Cost Transformation Programme's requirements has become the ceiling of what costing systems deliver. But what if it were the floor?

With Local Cost Collection on the horizon, trusts face new challenges—and new possibilities. Yet most costing systems remain locked into rigid schemas designed solely for compliance. These schemas accept only what national submissions demand—nothing more, nothing less.

The result? Vast amounts of valuable patient-level data—frailty scores, quality outcomes, pathway details, innovation metrics—sit unused. Your trust likely holds the intelligence to improve care and reduce costs. But your costing system can't see it.

"We have incredibly detailed data about our patients—frailty scores, co-morbidities, social factors, outcomes," says a Finance Director at a large acute trust. "But our costing system only accepts the bare minimum for CTP. We're making decisions about millions in spending based on a fraction of what we actually know."

The Rigid Schema Problem

Most costing systems are built around predefined schemas: fixed lists of fields tailored to national submission specs. If it's not in the spec, it's not in the schema.
What gets excluded?

- Your EPR's frailty scores, comorbidity indices, and polypharmacy data
- Your quality systems' PROMs, safety incidents, infection rates, satisfaction scores
- Your pathway logs of assessments, handoffs, education sessions, and follow-ups
-

You're surrounded by rich patient-level data—but forced to discard most of it.

What You're Missing: The Individual Patient Story

Take Mrs. Johnson, 78, admitted with a hip fracture. Your schema captures: age, diagnosis code, procedure code.

But your EPR knows more: frailty score of 6, 12 medications, mild cognitive impairment, lives alone, low patient activation, multiple co-morbidities, three falls in the past year.

This isn't academic—it's predictive. Patients like Mrs. Johnson typically require longer stays, more AHP input, and complex discharge planning. Yet she's costed the same as a fit 78-year-old with strong family support.

Quality and Outcomes: Invisible

Your trust tracks quality obsessively—PROMs, safety incidents, infection rates, satisfaction scores. But your costing schema accepts none of it.

You can't:

- Link orthopaedic costs to infection rates
- Show ROI on enhanced recovery protocols
- Explore whether pre-op education reduces complications and costs

The data exists. The schema ignores it.

Pathway Details: Lost

Modern care is pathway-based, not procedure-based. Your systems log every touchpoint. Your schema reduces it to: admission date, procedure code, discharge date.

You can't see:

- Who received pre-op optimisation
- Who had coordinated vs fragmented care
- Who engaged with rehab vs who didn't

These variations may drive cost more than the procedure itself.

The Analytics Restriction

Rigid schemas don't just ignore data—they restrict analysis. You can't answer:

- What drives cost variation in diabetics? (Schema lacks activation, comorbidity, social data)
- Why do some surgical patients cost more? (Schema lacks frailty, discharge complexity)
- Does pre-op optimisation deliver ROI? (Schema can't link participation to cost)

Important questions. Available data. Blocked by schema.

The Workaround Culture

To compensate, teams build workarounds—manual joins in Excel, shadow analytics outside audit trails.

"We spend considerable time building workarounds," says one head of costing. "It's inefficient, risky, and we know we're missing insights."

Innovation Restricted

Innovation needs measurement. But if your schema can't accept new metrics, you can't cost new models of care.

"We piloted a community falls prevention programme," says one elderly care consultant. "But we couldn't track participation or link it to costs. So we couldn't build a business case."

Breaking Free: Open Data Schema

The solution isn't abandoning compliance—it's going beyond it. Open schema costing systems accept whatever data your trust collects. They adapt to your intelligence—not the other way around.

Real Patient-Level Intelligence

A respiratory team could upload:

- Patient activation scores
- Self-management assessments
- Medication adherence
- Care coordinator contacts
- Social support ratings
-

They might discover that engaged patients cost less over 12 months—despite similar clinical profiles. That insight could justify investment in activation and coordination.

Quality-Linked Costing

A surgical team could link:

- Enhanced recovery participation
- PROMs and satisfaction scores
- Complication tracking
-

They might find enhanced recovery patients have shorter stays, fewer complications, and lower costs—plus higher satisfaction. That's a business case for scaling.

Open Profile Drivers

With open schemas, you can build cost drivers from:

- Frailty + comorbidity + polypharmacy = complexity index
- Pathway participation
- Infection occurrence
-

You might find your highest complexity quintile costs 3x more—but appropriately so. Or that infection prevention saves thousands per case.

The Business Case

Open schema costing could enable trusts to:

- Build business cases for frailty services based on complexity analysis
- Justify higher tariffs with objective case-mix evidence
- Identify costly pathway variation
- Demonstrate ROI from quality improvements
- Scale innovations with proven cost impact

"The real cost," one finance director reflects, "is in the business cases we can't build because the data is 'unsupported.' We suspect we're leaving significant value on the table."

The Patient-Level Test

Choose a complex patient your clinicians know well. Now ask:

What does your costing system actually know about this patient?

If the answer is just age, diagnosis, and procedure—you don't have patient-level intelligence. You have patient-level identification with procedure-level insight.
Three Questions for Your Current Provider
Before renewing your costing system, ask:

1. Can we cost patients based on their true complexity—not just age and diagnosis?
2. Can we link quality and outcome data to our costs to demonstrate ROI?
3. Can we build custom cost drivers from our own data without waiting for schema updates?
4.

If the answer isn't yes to all three, your costing system may be costing you insight.

Moving Forward

Local Cost Collection is evolving toward genuine patient-level understanding. But the trusts that lead won't wait for mandates. They'll act now—because costing compliance is not the same as costing care.
Your patients are complex. Your care is sophisticated. Your data is rich. Your costing should reflect that reality.

Let me know if you'd like this adapted into a slide deck or briefing note for board-level discussion.

David Molyneux is our Chief Technology Officer

INTEGRATED HEALTH ORGANISATIONS - THE CFO PRESPECTIVE

"Finance Leaders hold the key to turning integration into transformation"

From Hospitals to Health Systems

The Government's new policy to establish Integrated Health Organisations (IHOs) marks the next major step in NHS reform - enabling Advanced Foundation Trusts to hold the whole health budget for their local populations.

For finance leaders, this represents both an opportunity and a profound challenge. It is an opportunity to align investment and outcomes; but it also demands a new mindset around risk, accountability, and value creation that reaches far beyond traditional provider boundaries.

IHOs are not simply structural changes - they are new operating models for population health. They shift the NHS from payment for activity to payment for outcomes; from hospital-based treatment to community-based prevention; and from fragmented budgets to integrated system finance. Digital innovation and integration will be a key enabler.

"For CFOs, the IHO model turns the financial architecture itself into a tool for health improvement."

The CFO's new landscape

Under the IHO model, the CFO's role expands in three directions:

1. Stewardship of a population budget – Managing total cost of care across hospital, community, mental health, and primary care services.
2. Investor in prevention and digital transformation – Allocating capital to long-term value creation rather than short-term throughput.
3. System integrator – Aligning financial, clinical, and digital enablers across partners to deliver improved population-level outcomes.

This shift means CFOs will need to move from financial management to financial design and management. They will shape the payment architecture - year-of-care contracts, multi-year budgets, and risk-sharing arrangements - that make prevention and integration financially sustainable.

The most effective CFOs will also develop payor-style capabilities within their organisations; data analytics, actuarial insight, and performance risk modelling. These will be essential to govern the whole population spend and ensure transparency across multiple providers.

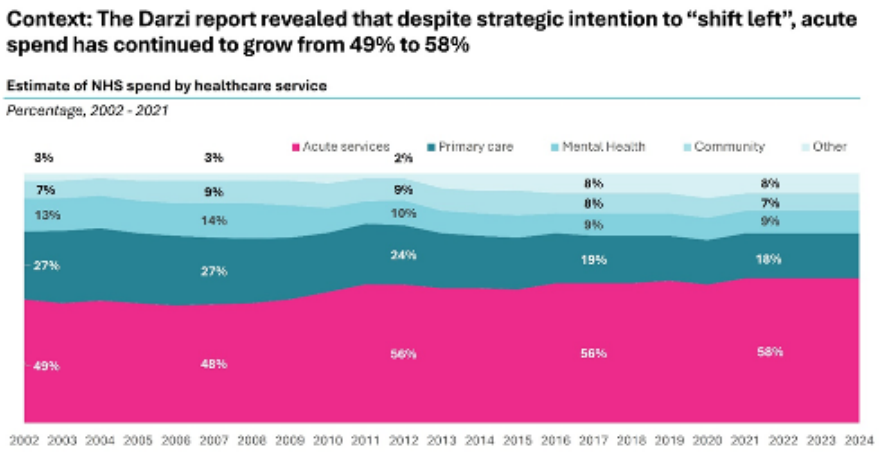
Addressing the system's core problems

IHOs are designed to solve structural weaknesses that finance leaders will recognise only too well:

·The "right drift" of £18 billion from community to acute care since 2007.

- A 12–18% decline in hospital productivity since 2018/19.
- Fragmented data systems and misaligned incentives.
- No single organisation accountable for population outcomes.

IHOs potentially provide the governance mechanisms and financial accountability arrangements that the current system has lacked. They bring investment and savings together in the same place for the first time.



About this diagram
This diagram was created by Carnall Farrar Ltd (CF), a consultancy focused on improving health and healthcare through collaboration, innovation, and investment.

"Integration without financial accountability is collaboration without consequence."

International insight – What works elsewhere

Internationally, integrated systems have demonstrated measurable financial and clinical benefits:

- **Ribera Salud (Spain)** operates under 15–20-year capitation contracts. With unified clinical directorates and value-based incentives, it delivers 25% lower costs and 38% shorter hospital stays than public comparators.
- **Montefiore Health System (USA)** transformed from near-bankruptcy to an accountable care leader by integrating community clinics and shared-risk contracts. It cut costs versus national benchmarks while preserving physician autonomy.
- **ChenMed (USA)** uses full capitation for older adults, achieving 56% fewer emergency admissions and 38% fewer readmissions than Medicare averages.

All successful systems combine strong payor functions, unified data, and rigorous performance management. Crucially, finance leadership is embedded in clinical strategy - not separate from it.

Critical success factors for Finance Leaders

The transition to IHOs requires CFOs to lead on several fronts:

- **Aligning incentives** – Design financial mechanisms that reward prevention and penalise unwarranted variation.
- **Investing in data and digital** – Ensure integrated patient-level data supports decision-making, risk stratification, and predictive modelling.
- **Building delivery capability** – Develop financial and operational management skills suited to complex system governance.
- **Sequencing investment** – Fund prevention, digital, and workforce changes ahead of acute cost release, using realistic time horizons.
- **Rewiring culture** – Make finance a partner in population health, not just cost control.

What good looks like

CFOs will need to demonstrate:

- Strong financial viability and governance (mirroring Advanced Foundation Trust tests).
- Competent leadership and coalition-building across providers, linking with strong, effective strategic commissioners.
- Transparent reporting and benchmarking at population level.
- The ability to manage both short-term budgets and long-term transformation.

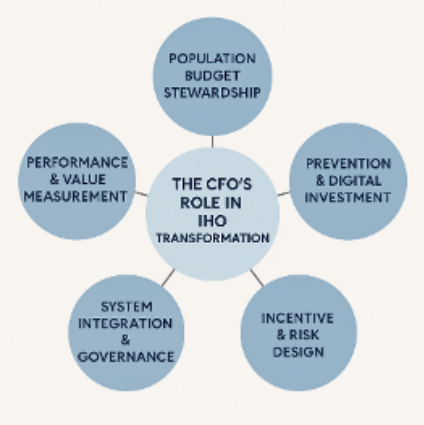
Finance leaders who treat IHOs as a new economic unit — not merely a reconfiguration of providers - will position their organisations for success.

The CFO as System Architect

IHOs will only succeed if CFOs lead a redesign and successful implementation of new financial architecture that underpins them. This means developing:

- Integrated budgets that fund outcomes, not activities.
- Investment models that capture and recycle savings from prevention.
- Performance frameworks that link finance, quality, and population health metrics.

As one international CFO put it: "If the incentives stay in the hospital, so will the money - and so will the patients."



In summary

IHOs mark a once-in-a-generation shift for NHS finance leaders — from balancing books to shaping systems. The CFO voice must be central to this transformation; defining value, enabling integration, and ensuring the financial logic of the new NHS model supports its clinical and service ambition.

**"CFOs will not just fund the journey to integrated health,
they will help design the map."**

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.

THE SONG THAT CHANGED EVERYTHING

Smells Like Teen Spirit

by Nirvana

"Smells Like Teen Spirit" didn't just launch Nirvana into the mainstream—it detonated the hair metal edifice and rewrote commercial radio's rules. Released when the music industry had calcified into glossy production and corporate rock, this deliberately crude anthem became the unlikely catalyst for a cultural earthquake that empowered disaffected youth and proved authenticity could triumph over polish. Recorded for roughly £2,500 in six hours, the track represented an accidental convergence of underground sensibility, major label distribution, and cultural timing that nobody—least of all its creator—anticipated or wanted.

The song emerged from what producer Butch Vig described as Kurt Cobain "trying to write the ultimate pop song," though Cobain dismissed it as a failed attempt to rip off the Pixies' quiet-loud dynamics. By early 1991, Nirvana had secured a major label deal after underground success with "Bleach," their £400 debut. When they entered Sound City Studios in May 1991, Cobain arrived with a four-chord progression that bassist Krist Novoselic thought sounded suspiciously like Boston's "More Than a Feeling"—a resemblance Cobain allegedly acknowledged with dark humour.

A rehearsal room revelation transforms underground rock

The breakthrough came when Cobain demonstrated the song's structure to his bandmates. What made it work wasn't complexity but brutalist simplicity—four power chords (F-Bb-Ab-Db) played with downstrokes, creating a monotonous drone that exploded into the chorus.

Drummer Dave Grohl, newly recruited from hardcore band Scream, brought ferocity that transformed Cobain's mid-tempo conception. Grohl's opening drum fill—four bars of tom-heavy thunder—became one of rock's most recognizable introductions, essentially a condensed version of "Get Down On It" by Kool & The Gang, filtered through punk aggression.

The musical structure was deceptively straightforward whilst containing subtle sophistications. The verses employed "tonal ambiguity"—the F5 power chord functioning in either F Phrygian or F minor, creating unresolved tension. The chorus exploded into F minor proper, with Cobain's distorted guitar creating a wall of sound through "power chord arpeggiation"—strumming the full chord rather than palm-muting individual notes. The bridge's guitar solo was deliberately sloppy, rejecting 1980s technical virtuosity.

The song employed what Vig identified as the "Pixies formula"—extreme dynamic shifts between whispered verses and screaming choruses, creating sonic violence that punk had promised but never achieved with such precision. Cobain's vocal melody followed the guitar riff almost exactly, treating voice as another instrument. The lyrics, famously nonsensical and written for phonetic qualities, paradoxically captured teenage alienation more effectively than literal narrative.

Lo-fi aesthetics meet major label resources
May 1991 marked a collision of underground values with professional recording infrastructure. Sound City Studios, despite its legendary history (Fleetwood Mac's "Rumours"), operated with modest equipment—most crucially, a vintage Neve 8028 mixing console that imparted warm, compressed sound. Vig brought a philosophy of capturing raw performance rather than perfecting takes.

Basic tracking took approximately six hours across two days, with the band playing live. Grohl's drum sound—arguably the track's most distinctive element—resulted from extreme close-miking with liberal compression. The famous introduction employed "gating," where ambience gets cut between hits, creating unnatural but powerful clarity.

Cobain recorded rhythm guitar through a Mesa/Boogie amplifier with a Boss DS-1 distortion pedal and Electro-Harmonix Small Clone chorus effect—creating the swimming, detuned quality characterising the verses.

Vocal recording proved problematic. Cobain, self-conscious and reluctant to do multiple takes, delivered what Vig called a "rough and raspy" performance that perfectly suited the material. The doubled vocal effect on choruses—borrowed from John Lennon—was achieved through actual double-tracking. The guitar solo was recorded in one take, with Cobain deliberately using the wrong pickup setting on his Fender Mustang to achieve a thin, piercing tone.

Crucially, the "Nevermind" album budget totalled approximately £45,000—roughly a tenth of typical major label rock albums in 1991. This constraint enforced a work-quickly aesthetic that paradoxically maintained underground credibility through evident spontaneity whilst sounding expensive enough for commercial radio.

Cultural exhaustion meets authentic rage

The September 1991 release came at a precise cultural inflection point. American rock radio had ossified into predictable hair metal rotation—Mötley Crüe, Poison, Warrant. MTV functioned primarily as a promotional vehicle for corporate rock. Generation X teenagers, facing economic recession and cultural vapidity, had no mainstream outlet for genuine disaffection.

Alternative rock existed as vibrant underground but remained commercially marginal. Industry assumption held that underground aesthetics couldn't achieve mainstream success. DGC initially projected sales of perhaps 50,000 copies.
The music video, directed by Samuel Bayer for approximately £30,000, became the unexpected catalyst. Filmed in a gymnasium with hired extras instructed to "go wild," it created a visual representation of underground concert culture mainstream audiences had never witnessed. When MTV added it to "Buzz Bin" rotation in November 1991, response proved overwhelming, forcing the video into heavy rotation.

By January 1992, "Nevermind" had displaced Michael Jackson's "Dangerous" from number one—a symbolic changing of the guard journalists immediately recognised as historically significant. Cultural impact extended beyond music: flannel shirts became fashion statements, "slacker" aesthetics achieved cache, and expressing disaffection became socially acceptable. Teenage audiences found permission to reject conventional success narratives.

Accidental revolution creates industry upheaval

The commercial numbers tell a story nobody predicted. "Smells Like Teen Spirit" reached number six on Billboard—remarkable for minimal initial radio play—whilst "Nevermind" has sold over 30 million copies globally. DGC scrambled to press sufficient copies, with the album eventually going diamond (10 million US sales).

The anthem that nobody wanted

"Smells Like Teen Spirit" succeeded because it arrived when audiences desperately craved authenticity after a decade of manufactured excess. The combination of underground credibility, major label distribution, and perfect timing fundamentally altered popular music's commercial calculus. Cobain himself famously grew to despise the song, refusing to play it or deliberately sabotaging performances, uncomfortable with having accidentally created exactly the arena rock anthem he'd opposed.

More than three decades later, the track remains what music critic Rob Sheffield called "the song that made it okay to be a loser again"—a testament to how three musicians from Aberdeen, Washington accidentally demolished an entire musical era whilst proving audiences would embrace authenticity over polish. That Cobain never reconciled himself to this success makes the impact somehow more poignant—a reluctant revolutionary who fundamentally transformed popular music whilst desperately wishing he hadn't.

Smoked Haddock Risotto with a soft poached egg

- **300g smoked haddock fillet (undyed), skin removed**
- **1 onion, finely chopped**
- **1 celery stick, finely chopped**
- **1 garlic clove, finely chopped**
- **300g Arborio or risotto rice**
- **1 litre fish or vegetable stock**
- **100ml dry white wine (optional)**
- **50g butter**
- **50g Parmesan cheese, grated (plus extra for serving)**
- **2 tbsp chopped fresh parsley**
- **Olive oil**
- **Salt and freshly ground black pepper**
- **egg**
- **Lemon wedges, to serve**

Pour half the stock into a wide pan and bring to a gentle simmer. Add the smoked haddock fillet and poach for 5–7 minutes until the fish is opaque and flakes easily. Remove the fillet from the stock and set aside. Flake the fish into large chunks and strain the stock, reserving it for the risotto.

In a separate large pan, heat a splash of olive oil and 25g butter over medium heat. Add the chopped onion, celery, and garlic, cooking gently for 5 minutes until softened but not coloured.

Stir in the Arborio rice and cook for 1–2 minutes until the grains are glossy and slightly translucent. Pour in the wine, if using, and allow it to bubble away.

Begin adding the reserved poaching liquid and remaining stock a ladleful at a time, stirring regularly and waiting for most of the liquid to be absorbed before adding more. Continue this process for about 20 minutes, until the rice is creamy and just tender.

Fold through the flaked smoked haddock, the remaining butter, and most of the Parmesan. Season to taste with salt and pepper. Cook for a further 2–3 minutes to warm the fish through. Serve with a soft poached egg on the top.

Stir in the fresh parsley and spoon the risotto into warm bowls. Scatter over the remaining Parmesan and serve with lemon wedges on the side for a zesty lift.

Useful Apps: Loom

Our occasional series on productivity apps that we love

Why Loom Transforms Asynchronous Communication and Corporate Learning

In an era where remote and hybrid work have become standard, asynchronous communication tools are no longer optional—they're essential. Loom, the video messaging platform, has emerged as a particularly effective solution for companies seeking to improve communication efficiency whilst building lasting knowledge repositories.

The Power of Asynchronous Video

Traditional synchronous communication—meetings, video calls, instant messaging—demands that everyone be available simultaneously. This creates scheduling conflicts, interrupts deep work, and disadvantages team members across different time zones. Loom sidesteps these issues entirely by allowing users to record their screen, camera, or both, then share the link instantly.
The beauty lies in its simplicity. Rather than crafting lengthy emails or documentation, team members can show and tell simultaneously. A developer can walk through code changes in three minutes. A designer can explain creative decisions whilst clicking through mockups. A manager can deliver feedback by reviewing work on-screen whilst narrating their thoughts. The recipient watches when convenient, can pause, rewind, and absorbs information at their own pace.

This approach typically conveys information more efficiently than written alternatives. Tone and nuance—often lost in text—come through naturally in voice and expression. Complex concepts that would require paragraphs of explanation become clear through visual demonstration. Research suggests video can communicate certain information up to 60% faster than text, though effectiveness varies by content type and individual learning preferences.

Building Company Learning Portals

Where Loom truly distinguishes itself is in creating searchable, scalable learning libraries. Every recorded video becomes a reusable asset. Companies can systematically build knowledge bases covering:

- Onboarding processes and company culture introductions
- Product tutorials and feature demonstrations
- Standard operating procedures and workflow explanations
- Technical training and software walkthroughs
- Best practice examples from top performers
- Compliance and regulatory training content

These videos can be organised into playlists, embedded in learning management systems, or linked within company wikis. New employees access comprehensive training without monopolising senior staff time. Team members revisit procedures without repeatedly asking colleagues. Knowledge doesn't disappear when employees leave—it's captured permanently.
Loom's built-in analytics show who's watched which videos, helping identify knowledge gaps and measure engagement. The platform's transcription features make content searchable, allowing users to find specific information within video libraries quickly.

Practical Considerations

Whilst Loom offers significant advantages, success requires intentionality. Companies should establish guidelines about when video communication serves better than text, how to structure recordings for clarity, and how to organise their video library effectively. Not every communication warrants a video—quick updates often work better as text.

Privacy and security considerations matter, particularly for sensitive content. Loom offers various sharing settings and enterprise security features, but companies must ensure appropriate usage policies are in place.

The platform works best when embedded into existing workflows rather than added as another separate tool. Integration with Slack, Notion, or project management platforms helps ensure videos reach their intended audiences.

Michel Fagot Sélection des Clos Premier Cru 2004

The Michel Fagot Sélection des Clos Premier Cru 2004 is a Champagne for those who value nuance over noise. Produced in Rilly-la-Montagne, a respected Premier Cru village in the Montagne de Reims, this cuvée reflects the house's traditional approach: low yields, meticulous vineyard work, and extended ageing that allows the wine's character to unfold slowly and gracefully.

The 2004 vintage in Champagne is regarded as one of the quietly great years — generous, balanced, and built for long-term development. Two decades on, the best examples are entering a glorious drinking window, combining mature complexity with enough freshness to stay vibrant. Michel Fagot's 2004 offering is firmly in that camp.

Tasting Notes

The wine pours a deep, burnished gold, an immediate sign of its age and time on lees. The bubbles are fine and measured. On the nose, it delivers an inviting mix of brioche, toasted almond, baked apple, dried apricot, and honeycomb, all tied together by the chalky minerality typical of Premier Cru vineyards in Rilly-la-Montagne.

The palate is rich and textural without ever becoming heavy. Flavours of almond pastry, pear tarte tatin, candied citrus peel, and light spice unfold in layers. That subtle oxidative note — the good kind — gives the wine warmth and depth. A saline thread carries the finish, adding precision and keeping the wine lifted.
Despite its age, the structure remains intact: acidity still present, mousse still elegant, the overall balance remarkably harmonious.

Food Pairings

A Champagne of this maturity is extremely food-friendly. Ideal pairings include roast chicken, lobster, scallops, mushroom risotto, aged Comté, or lightly seasoned sushi. Warm, nutty and savoury dishes bring out the best in its autolytic richness.

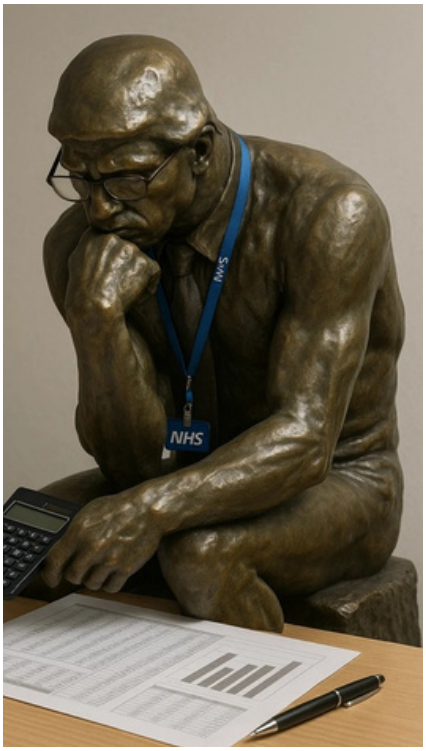
Verdict
This is a Champagne that rewards attention. It's mature, layered, textural, and quietly luxurious — the kind of bottle suited to intimate dinners or thoughtful celebrations. If you enjoy vintage Champagne with generous autolytic character and a long, savoury finish, the Michel Fagot 2004 offers exceptional pleasure and terrific value for its age and pedigree.

Rating: ★★★★☆ (4.5/5)

A beautifully evolved Premier Cru Champagne showing power, finesse, and real craftsmanship.

The Last Word... on Meetings in the NHS

Do you really have to attend?



Nearly twenty years ago I didn't have a smartphone. If I'd had one on that windy February afternoon in 2007, stuck in a meeting room at the Christie in Manchester, I might have actually got some work done.

There were fifteen of us crammed into that modern meeting room. A commissioner and a CFO did all the talking whilst the rest of us – junior finance folk, commissioning apparatchiks, well-meaning but ultimately surplus to requirements – sat there trying to look engaged. I was a finance manager in my early thirties with a heavily pregnant wife at home and a desk piled high with work I wasn't doing.

The meeting lasted an hour and a half. Then we all had to leave early because of a weather warning. The M62 was closed. The M56 was chaos. The M53 was gridlocked. What should have been an hour's drive back to Liverpool took three.

So here's what puzzles me: if the technology has moved on so dramatically since then, why are NHS CFOs still trapped in the same meeting hell?

The Culture Hasn't Caught Up

These days I use Notion to record meetings and prepare transcripts afterwards. I've watched hours of Tiago Forte and Ali Abdaal on YouTube talking about productivity. I've listened to Tim Ferriss interview Sam Corcos, the CEO of Levels, who explained how his entire company runs asynchronously using Notion and Loom. No one sits in pointless meetings. Everyone gets the information they need when they need it.

The technology exists. Right now. Today. You can record any meeting, generate a transcript, summarise the key points, and share it with everyone who needs to know. The people who actually need to make decisions can attend. Everyone else can catch up in five minutes rather than waste ninety.

But we don't do this in the NHS, do we? We invite fifteen people because we've always invited fifteen people. We sit through meetings where we don't contribute because that's just what you do. We accept every meeting invitation because saying no feels awkward. Meanwhile, the commercial income work doesn't get done. The strategic thinking doesn't happen. The analysis sits on your desk, waiting.

Two Simple Questions

How many hours are you spending in meetings? What could you achieve if you got your time back?
I'm not talking about revolutionary change here. I'm talking about two straightforward principles:

First: default to asynchronous. Before you schedule a meeting, ask whether it could be a Loom video and a Notion doc instead. Most meetings can.

Second: record and summarise everything. If you do need a meeting, record it. Summarise the key points. Share it with everyone who wasn't there. Stop inviting people just to keep them informed.

That's it. Those two changes would transform how NHS finance teams work.

The Tools Are Here

I know you're busy. I know you've got a million other priorities. But protecting your time isn't a luxury – it's essential. You can't focus on commercial income generation if you're stuck in meetings all day.

The irony is that the very technology that could free you up is the same technology everyone's talking about. AI can transcribe meetings. Notion can organise information. Loom can replace face-to-face updates. You just need to actually use them.

I'm a bit of an evangelist on this stuff, so reach out if you want to have a chat about any of it. Just because you've always done something doesn't mean you have to keep doing it.

... and that's the last word.

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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.

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