# Service briefing: the financial context

A one-page briefing for a first conversation with your clinical manager and finance business partner. It is not a business case.

| Service: | Prepared by and date: |
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| **Need**<br>Which problem are we solving, for which patients? What evidence shows it? | |
| **Current pathway**<br>What happens now: activity, outcomes, costs, and who funds each part? | |
| **Proposal**<br>What changes? Separate one-off (capital or set-up) costs from recurrent revenue costs. | |
| **Commissioning and income**<br>Who commissions this service (ICB, NHS England, council)? Under which contract? Does income change, and for whom? | |
| **Benefits and risks**<br>What would we measure, clinically and financially? Who gains and who bears the cost? What could go wrong? | |
| **Questions for finance**<br>Which assumptions need checking before we go further? | |

**Watch for:** beds freed ≠ cash saved · projected income ≠ confirmed funding · capital buys it, revenue runs it · the saving may land in another organisation's budget

# Worked example (fictional): perioperative medicine service

All figures are illustrative teaching assumptions.

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| **Need**<br>Which problem are we solving, for which patients? What evidence shows it? | About 300 emergency laparotomies a year; an estimated 35% (about 105) may benefit from specialist perioperative review. Frailty and delirium care is currently reactive. |
| **Current pathway**<br>What happens now: activity, outcomes, costs, and who funds each part? | Ad hoc referrals to existing teams. Length of stay above the national benchmark (local data to be confirmed). |
| **Proposal**<br>What changes? Separate one-off (capital or set-up) costs from recurrent revenue costs. | Option B: extend the existing frailty and perioperative team. About £80k a year recurrent (staff); minimal one-off cost (training, IT set-up). |
| **Commissioning and income**<br>Who commissions this service (ICB, NHS England, council)? Under which contract? Does income change, and for whom? | Emergency surgery is paid through the urgent and emergency care blend, so extra activity changes income little. Possible best-practice tariff income: eligibility to check, not yet assumed. |
| **Benefits and risks**<br>What would we measure, clinically and financially? Who gains and who bears the cost? What could go wrong? | Measure: review within an agreed time, length of stay, complications, readmissions. Benefits mostly freed bed capacity, which is not cash. Risk: recruitment. |
| **Questions for finance**<br>Which assumptions need checking before we go further? | How is this activity paid in our contract? Is any best-practice tariff income achievable? Can freed beds be used for elective work? |

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