Covering Paper on
Oldham System Financial Framework

Executive Summary

The purpose of this paper is to outline and gain agreement to “Oldham System Financial Principles” which have been developed by the Oldham DoFs group and the Oldham System Sustainability Group. The Financial Principles will:

1. underpin the delivery of a recurrent and sustainable financial position for the Oldham “Place” integrated care system, and will form part of the Oldham Integration Agreement;
2. Inform decision making processes; and
3. Ensure that financial investment decisions are made at “Place” rather than at organisational level, subject to delegated decision making and the ability of organisations to delegate such decisions as set out in Section 9.

The framework sets out a series of procedures for the system to follow across the following areas:

- Setting the system’s Financial Plan;
- Service changes and associated changes to financial flows
- Openness and Transparency
- Shared Risk and Reward
- Shared Governance and Decision Making

These codify the ways of working in the system but set within the context of the new governance framework that is being agreed.

However, decision making will be as per the Integration Agreement and the Terms of Reference for the system groups within that.

Limitation of Scope

It is noted that ongoing work both at GM and national level may lead to changes to this framework Specifically, the primacy of resource allocation decisions may be mandated at GM “system” level rather than at Oldham “place”, limiting the scope of local decision-making

Recommendation

The group is asked to approve the attached Oldham System Financial Principles for inclusion in the Integration Agreement.

Oldham System Financial Framework

1. Background

1.1 Historically, the Oldham health system has contracted for services using the national rules with only minor changes/variations. For most NHS commissioned services this has meant block/capitated payments, except for ROH which was mainly on PbR contracts.

1.2 The NHS Covid financial regime has enforced a shift to block payments for Acute services as well which has resulted in a consistent approach for all providers. However, moving away from PbR has introduced new challenges such as re-aligning finances following service re-designs that increase clinical productivity / effectiveness; streamline patient pathways; and reduce health inequalities.

1.3 Local Authority health and social care service commissioning and expenditure has, where appropriate, complemented NHS spending/provision but operated within the statutory boundaries of the Local Government finance regime subject to the local framework of the Councils Constitution within which are contained the Councils Contract Procedure Rules and Financial Regulations.

1.4 Over the past two years Oldham DoFs have been working together to improve understanding of the different parts of the health and care system through sharing information and taking a joint approach to service changes. This Framework sets out these principles to support and underpin the wider Integration Agreement.

1.5 Many decisions about the design of the financial system have taken place at a national level. However, as key elements of the future NHS evolve – integrated care systems (ICSs), new provider collaboratives, new forms of contracting – many of these decisions will also need to be taken at a more local level.

2. Principles

2.1 The following principles underpin the financial aspects of our joint working:

1. Our overriding financial objective is to deliver a stable system financial position (“Oldham living within its means”), as well as and not solely focussed on, individual organisational success and failure.

   All parties recognise that Oldham is currently spending £90m more than the recurrent funding available long term and have agreed to work together to deliver a long term sustainable financial plan.

2. System working requires system decision making – i.e. system governance with delegated decision making powers from all organisations

3. Decision making must be informed by clear understanding of the financial implications and funding for each of the partners together with the regulatory framework within which each of the partners operates and the limitations that this may create (mindful that this is an evolving position and may change)

4. Organisations retain freedom to operate and accountability to deliver outcomes within the agreed resources;

5. Each organisation should be fairly funded and seek to manage within those resources within the funding provided; and

6. All organisations agree that funds and resources should be allocated with a focus on reducing health inequalities through a targeted, evidence based approach.

The GM ICS Financial approach is still in development but the following reflects the current thinking regarding how funds would be deployed:

MONIES AND THE REALITY OF THEIR ALIGNMENT AND DISPOSAL

There are four types of monies that we might want to consider in thinking through how and to whom we allocate resources in order to achieve our priorities and objectives

- **Protected** - has to go to the place it's currently spent to recognise fixed costs or on going commitment (long term care packages)
- **Flexible** - money that could be moved from its current place to get better value for every £ spent
- **New/Growth** - money that we now have but haven't had before so can be spent in a place of shared choice to optimise the value of all spend
- **Non health and care money** - money spent that affects health, well being and demand for care that could be aligned to get better value out of existing spend and improve health outcomes

3. Scope of Financial Framework

3.1 It is agreed that this framework should be applied to all budgets across the following areas:

- CCG – all budgets

- ROH / OCO – all budgets
- OMBC – all budgets in scope of Section 75
- PCFT – all Oldham CCG commissioned services

This is based on the current understanding but will be subject to change and development as the system design evolves.

3.2 The initial phase of working will not include services delivered outside of Oldham.

4. Decision making

4.1 All decisions within the scope of the financial framework, with a financial impact will be made at the Oldham System Board in line with its terms of reference, or through such delegation as approved by the Board in line with the regulatory framework within which each of the partners operates and the limitations that this may create (mindful that this is an evolving position and may change).

4.2 Investment/disinvestment decisions will require a business case setting out rationale, timescales, outcomes and benefits. Investments/disinvestments will be reviewed 6 months after implementation to ensure planned outcomes have been achieved.

5. Setting the System Financial Plan

5.1 All organisations remain responsible for setting their own budgets within their own regulatory regimes within financial rules and principles set at a GM level. To reach a balanced budget, it is likely there will need to be an iterative challenge process of Oldham System level conversation to reach defined financial envelopes for each organisation. The Local Authority funding envelope will be subject to the Local Government Finance Settlement, local decision making including local taxation decisions (mindful that the Council cannot delegate the setting of its overall budget).

5.2 The overall funding envelope for each organisation is agreed collectively working through the new Oldham System governance. This envelope will recognise that:-

- Different organisations have different regulatory regimes which must be complied with (including the form and timing of budget decision making and partner/public engagement) and that some Government resources are mandated for specific initiatives and there is no latitude in the utilisation of such resources; and that
- As a system we have historically had a large underlying recurrent financial deficit.

5.3 This is the area in which there is most likely to be rules and guidance provided by nationally and within GM. However, we recognise that historically the NHS has been permissive of local arrangements where all parties are in agreement.

6. Service changes and associated changes to financial flows

6.1 The allocation of finance to support investment will be supported by a business case sponsored by the recipient organisation. It is assumed that the partner organisation will require the assurance of a business case as part of its own governance.

6.2 At system level, each business case will be assessed against system criteria including the reduction of health inequalities; national priorities for investment (e.g. mental health) and benchmarks for productivity, efficiency and outcomes. The development of a business case should set out these parameters and would be required for internal governance within the host organisation.

6.3 Where service pathway changes shift the distribution of responsibilities for patient care between different organisations, then the following principles will be applied to estimate changes to organisational budgets.

6.4 The section below sets out three options for estimating the resource impact on organisations which should be followed to provide the System Board with consistent and equitable financial recommendations.

6.5 Oldham DoFs group will agree which of the three options below is most appropriate for the service change in question. The Oldham DoFs group will be responsible for making a recommendation to the Oldham System Board.

A. Actual cost changes

6.6 Calculated as the changes in costs of the organisation resulting from this service change both directly in delivering the service as well as the support costs. This would include as a minimum staffing, estates, equipment and consumables.

6.7 This method is likely to be most appropriate for Oldham Council, smaller organisations and/or simple/small-scale service changes. For example, changes to services delivered by GP Practices or PCNs.

B. Activity based tariff

6.8 The NHS national pricing tool (PbR) gives prices for all types of activity. Recognising that this is a national tool which calculates an impact across all areas of a provider, including fixed costs such as estate, it would not be appropriate to assume 100% of the costs can be removed where patient flows change and so 50% of tariff should be applied.

6.9 Activity changes should be estimated from proposed pathway at a detailed level using historic activity levels with impacts agreed collectively by the design team, including clinical input.

6.10 There is an expectation that using 50% of the PbR value of the agreed estimated activity impact would be reasonable. This should be considered on a case by case basis for reasonableness.

6.11 This method will only be appropriate for providers where a national tariff figure is available, e.g. ROH/OCO or community elective providers (e.g. Virgin Dermatology service).

C. Detailed cost and/or service line reporting data (only ROH/OCO)

6.12 Given the complexity of the process and the detailed inputs required, this method would only be appropriate for ROH/OCO for large scale service changes with a material shift of resources. This could use SLR, model hospital, GIRFT or PLICS costing data or a mix thereof.

6.13 The detailed approach is set out in Appendix 1: GM Transformation Programme Financial Guidance, but the key aspects are:

- Uses methodology as per (2) above but at 100% to calculate the reduction in funding; but then
- Calculates transitional funding for up to 3 years on the following basis:
    - Uses actual cost base;
    - Determines which costs can be avoided immediately (e.g. agency staff, TUPE, re-use of equipment, consumables);
    - Categorises each remaining element of expenditure into “variable”, “semi-variable” or “fixed”;
    - For each type of expenditure applies a timeframe over which provider needs to manage out the costs of immediate or 1-3 years;
    - Calculates transitional (temporary) funding based on 100% for year 1, 50% for year 2 and 25% for year 3.

6.14 This methodology can only be applied where organisations have detailed costing information which is likely to only be PCFT and ROH/OCO.

7. Openness and Transparency

7.1 We recognise that to operate as a system we need a core level of understanding and transparency of the key aspects of the system finances, not just of our own organisations. However, this is not about a right to inspect detailed information of other organisations’ finances.

7.2 Financial transparency here is intended to mean that all organisations will share the following information openly in order to allow all parties to work towards the other objectives here and to support wider system working. Explicitly this is expected to include the following as a minimum:

(i) Annual financial plans, including assumptions, risks and uncommitted funds. Both at draft and final stages.
(ii) Cost efficiency plans and performance
(iii) Routine financial monitoring reports, e.g. monthly finance committee reports
(iv) For specific service/pathway re-design work, sharing of relevant detailed staff and financial information

7.3 In some circumstances, the system will need a more detailed understanding of particular budgets and services as determined by the Oldham System Board. This is expected to be the exception rather than the rule.

8. System-Wide Shared Risk and Reward

8.1 This is to recognise:

(i) That all organisations will, at times, have better or worse financial performance for a variety of reasons within and without their control; and
(ii) That as a system, to leave any one organisation in financial failure, will impact on the outcomes that are achieved for Oldham residents.

8.2 We agree to use uncommitted/contingency resources (as described in point 2 (i) above) in a planned way through system conversations and decisions and support organisations in financial difficulties where possible.

8.3 This is not to describe an old fashioned contract bonuses, payments or penalties set of mechanisms, albeit we may seek to develop some form of incentive scheme(s) in the future.

9. Shared Decision making and Governance

9.1 The system integration agreement sets out clear governance and participation of those routes. Decision making without approval of the resources to implement those decisions is meaningless.

9.2 This recognises that each organisation where possible, will either need to formally delegate financial authority to the System Board or run a dual approval process for those decisions deemed to be “in scope” but that the System Board may not enforce a decision on an organisation that is contrary to that organisations own internal constitution/financial regulations or best interests.

9.3 It is recognised that organisations are operating in a complex and changing systems with decision making at many levels, including internal, organisational, locality, NES sector, GM and Provider/CCG/MH fora. Recognising the challenges of this the intention is that organisations ensure that the financial implications of decisions are explicit and reported back explicitly to the System Board which holds the overall responsibility for the System financial position.

9.4 The following describes when decisions require Oldham System Board approval. This will be in addition/parallel to any normal internal financial governance:

a) All recurrent or non-recurrent decisions with incremental financial impact of over:
   - CCG £250k
   - ROH / Oldham Care Organisation £499k
   - PCFT £250k
   - OMBC £250k

   This is based on current approval limits for COO/CE, hence the variation.

   These limits are for individual decisions, but organisations recognise that the cumulative recurrent impact of decisions are subject to system approvals.

   It is expected that organisations will manage the recurrent impact of decisions made based on internal financial delegation, subject to annual planning processes.

b) All organisations will maintain a log of internal decisions made which will be provided for information to:
   - Oldham DoFs group monthly; and
   - Oldham System Delivery Board quarterly.

Appendix 1: GM Transformation Programme Financial Guidance

Greater Manchester Health and Social Care Partnership

Financial Planning Guidance

"Son of Scampion"

1. INTRODUCTION

Service changes and developments have been a feature of the NHS in Greater Manchester for a number of years and major changes involving multiple Commissioners and multiple Providers have been guided by principles that where codified into what has become known locally as "The Scampion Rules".

The Scampion Rules essentially where a framework by which the financial consequences of any major service changes where planned. Following the Devolution agreement and the establishment of the Greater Manchester Health and Social Care Partnership, who manage the Transformation Fund on behalf of Greater Manchester, the Scampion rules have been cited as having relevance within the financial planning that will underpin the transformation agenda and projects therein.

The GMHSCP Themes cross cut all providers and commissioners and the process for developing financial plans follows the appropriate governance route and underpinned by a Business Case, along with governance approach that supports bids to the Greater Manchester Transformation Fund.

The emerging work within the GMHSCP Themes all require sophisticated financial planning that underpin the new clinical models of service delivery. The individual projects will all be subject to the business case approval process but this must be within the context of the whole picture of service change across GM.

The Directors of Finance of both Commissioning and Provider organisations have agreed that the time is now right for the Scampion rules to be "refreshed" and brought up to date for application in Financial plans going forward.

The purpose of this paper is to propose the updated rules that will be utilised across Greater Manchester.

2. Applicability

It is intended that these rules apply for major strategic change involving multiple commissioners and multiple providers. Within this context this would mean that the projects within Theme 2,3 and 4 would all have the stranded costs calculated on the basis of the rules within the guidance.

Where there are changes within a single health economy it is anticipated that the local health economy will come to its own agreements about applicability of this guidance.

3. Rules of Last Resort

It is expected that the guidance set out in this document are applied in any major strategic change. However, it is also expected that the financial stability of the organisations included within the strategic change have to be considered and, where possible, mitigation should be put in place through other service changes before Transformation Funding or recurrent support funding is provided. This would enable any organisation who is deemed a loser (either lost income or retained costs) to be able to offset these costs with new income from new service delivery.

It is expected that once the stranded costs are identified, using this guidance, that those stranded costs are mitigated through other service changes and / or developments.

Any stranded costs identified through this guidance are non recurrent in nature, as its expected that cost savings (from elsewhere) will be identified to offset the costs, or other service changes will be put in place to utilise these services and costs.

4. MITIGATION BEFORE RULES APPLY

Whilst the application of the Son of Scampion rules will be deployed within major service redesigns across the Greater Manchester health economy and sectors this does not mean that transformation funding will be made available to the Trusts requesting it.

It is expected that the commissioners and providers undertaking the strategic redesign will have looked at a mitigation plans to provide sustainability to the providers affected by the planned changes. It is the strong expectation of the TFOG process that health economies / localities / sectors / services / pathways (or whatever are the natural collaborations) have made every effort to provide alternative services and therefore income, to mitigate the need for any funding for stranded costs.

The likely mitigations that should be considered before Transformation Funding can be made available is as follows:

Strategic Service changes – There are a number of major strategic changes planned across Greater Manchester in the coming years and the impact that these changes will have on each provider (and economy) needs to be assessed alongside any individual bids to the transformation fund. Where there are clear linkages between the planned changes the net impact on each provider should be assessed as part of any bid. Where there are no linkages directly between bids, the net impact on providers

and commissioners needs to be established to ensure that costs are funded as part of the service changes before any bids for transformation monies are made.

Activity Growth – Given the increase in the age of the population and the changing nature of referrals into some services it is possible that activity may continue to rise in certain services. Given that this is likely to be funded at PBR National tariffs it is expected that marginal costs are applied to this increase and that costs identified as stranded would be offset by the income received at tariff. It is likely that services in the future are funded on a basis other than PBR tariffs, which are more cost focused, the stranded costs can be mitigated through inclusion within the funding of the new services.

Alternative use of existing assets – where material service changes liberate existing assets both equipment and buildings alternative use of these assets should be sought, assuming they are not required as part of the initial service change. The alternative use will depend on the type and nature of the assets, where alternative use by the existing trust is not possible, them these assets should be offered to other providers who may be looking for assets to provide new services in that locality.

Where alternative use is not possible then providers should look to dispose of the assets as soon as possible to liberate costs and sale proceeds.

STP - Within the context of STP and Health Economy Financial sustainability. Where plans for service change leave providers with spare capacity that cannot be utilised or sold it is expected that within the context of local economy STP that provision is made to fund providers who are burdened with assets that cannot be reused or sold.

Site rationalisation - Site rationalisation across a Health Economy or within a site. District Valuer rationalisation of the asset value held by Trusts.

Local CIP Plans – It is anticipated that Trusts who have assets that they are unable to reuse or sell off must contribute to the funding of the costs associated with the surplus assets, which should be part of the Trusts Cost Improvement Plans going forward. Clearly there is a reasonableness test that needs to be worked through as providers will be unable to add significant costs to their CIP requirement, if this is already a material sum in the context of turnover.

Joint Working – Plans to include Local Authority service provision and utilisation of assets where possible.

5. PROPOSED APPROACH

5.1 INCOME

5.1.1 NHS Contractual

Providers and Commissioners will have NHS contracts in place that cover the services that are subject to the changes planned within the strategic change. The majority of contracts are on a Payment By Results basis, with local agreements where applicable. It is expected that Payment By Results would continue to operate until such time as

the Strategic change commences and patient flows are changed from one provider to another.

Where planned reductions in patient numbers are agreed (as part of the strategic change) it is expected that Trusts should start to plan to reduce costs (where applicable). This has the effect of focusing the attention onto cost reduction rather than having a change to NHS Contracting and protecting income.

5.1.2 Other Income

Health Education Income – income to providers is based upon the education and training tariffs recently implemented, along with the transitional arrangements to ensure financial stability as part of that process. It is anticipated that tariffs would flow around the system based upon the student (and other numbers) within the Health Education England contracts. It is anticipated that the transitioning arrangements in place would be adjusted to take account of the changes within the service reconfigurations.

Other Income – Where services sell products as part of their service delivery, it anticipated that this income will transfer to the new provider of services where appropriate. Where income received for sales of services provides a contribution to overheads, where this is a material value this should be agreed by the respective providers with a tapering arrangement where required.

Private Patient Income – As per other income.

5.2 EXPENDITURE

The NHS has placed a much greater emphasis on costing and both NHS England and NHS Improvement have published a range of guidance documents to help providers to produce more robust costing information. The costing submissions to NHSI have, therefore, been of a higher standard across the board in recent years, which ultimately helps with the development of PBR National tariffs but also provides a more robust framework for assessing changes in cost base within any Strategic Change.

Integral to this improvement has been the publication of the HFMA Costing standards which have been adopted by NHSI and NHS England as being the definitive standards that providers should use when developing costing within their organisation. The HFMA Costing standards can be found at the following web address.

https://www.hfma.org.uk/docs/default-source/our-work/costing/Clinical-Costing-Standards/acute-standards-201617.pdf?sfvrsn=16

Costing Standard 4, within the HFMA document gives guidance on cost classification, allowing costs to be allocated into Fixed, Semi Fixed and Variable costs. The following is an extract from Costing Standard 4:

- Fixed costs – fixed costs will not change as activity changes over a 12-month period. Fixed costs are absorbed across the patients treated in a period and therefore the amount absorbed per patient will change as volumes of patients ex through the year. Fixed costs may also change if a contracted service is removed or added – therefore fixed costs are not just time-de ned.
- Semi- fixed costs – semi- fixed costs do not move with activity changes on a small scale, but ‘jump’ or ‘step up’ when a certain threshold is reached. Defining the threshold, and the materiality of the step change, is at the discretion of individual organisations.
- Variable costs – variable costs will be directly affected by the number of patients treated or seen. They are an incremental or marginal cost. One more unit of activity will generate an extra cost. It is important to note that the very nature of patient-level costing means that this cost may differ from patient to patient, but the nature of the cost is that it is triggered by the quantity of patients.

These cost classifications can then be applied in providing guidance as to how costs can be managed within any strategic change.

Costing Standard 1, within the HFMA costing standards guidance provides guidance onto allocations costs into Direct, In-direct and Overheads. The following extract is applicable:

- Direct costs relate directly to the delivery of patient care. These costs can be directly linked to the delivery of patient care and costs are caused/arise as a result of individual patient episodes of care.
- Indirect costs are indirectly related to the delivery of patient care, but cannot always be specifically identified to individual patients. Indirect costs can usually be allocated on an activity basis to service costs.
- Overhead costs are the costs of support services that contribute to the effective running of an NHS provider. They are costs, such as the costs of the payroll service that cannot be traced or easily attributed to patients.

5.2.1 Use of Service Line Reporting and PLICS Data

Most provider organisations have implemented some form of SLR and / or PLICS within their organisations, as these will be used to feed the annual reference costs exercise. It is expected that the SLR / or PLICS data for the services that are subject to the change or transfer be the starting block for the preparation of the stranded costs calculations. The SLR data will have been constructed using the NHSI / NHS England guidance and be underpinned by the HFMA Costing Standards referred to above. This will ensure a degree of commonality of construct prior to the application of the stranded costs guidance.

The following table sets out the broad principles that apply to the cost types within NHS Costing standards.

Cost type	Comments	Timelines
Variable Costs	Costs can be released immediately as this cost is directly related to the patients transferring within the strategic change. Examples include Drugs costs, patient specific non pay (hips and knees).	Costs released at Day 1.
Semi Fixed Costs - Direct	1. Within a major service reconfiguration these costs can be released immediately as the whole service will be transferring to a new provider or reconfigured service. Examples include direct ward based Nurses and Support Staff. Consultants / Junior Doctors – it is anticipated that where the whole service is to transfer that the Medical staffing compliment would move with the service and therefore the costs of these staff would be saved. 2. Where Medical staffing cover is provided across multiple specialties, for example at night it is likely that staff will not move with the service, it is anticipated that proportions of costs are allocated as stranded. 3. Pathology / Radiology – costs of these types of services will be based upon the usage made of these by the Service Line. It is anticipated that that these costs will taper as there will be an immediate saving on consumables and then plans will need to be put in place to reduce the cost or be replaced by other activity from service developments. 4.	Costs released at Day 1. 3 Years tapering (100%, 50%, 25%) 3 Years tapering (100%, 50%, 25%)

Semi Fixed Costs - Indirect	It is anticipated that costs within this category would be managed in a similar way to the Semi Fixed Direct costs:	
	1. Costs such as capital charges on directly allocated capital equipment would be saved on transfer of that equipment to the new service.	Costs released at Day 1.
	2. There are costs within this category that will be saved but these won't be available in the first year, for example CNST premium, which are based upon assessments by NHSLA using data around numbers of doctors and activity within specialties. The data, and therefore premiums, are on an arrears basis, therefore costs will be reduced after the first year.	1 Year (100%)
	3. Patient Catering / Pharmacy / Sterile Services – costs of these types of services will be based upon the usage made of these by the Service Line. It is anticipated that that these costs will taper as there will be an immediate saving on consumables and then plans will need to be put in place to reduce the cost or be replaced by other activity from service developments.	3 Years tapering (100%, 50%, 25%)
Semi Fixed Costs - Overheads	There are elements of these costs that can be saved immediately, for example catering where reductions in patient numbers would reduce the requirement for provisions etc. However, where the costs are not releasable immediately plans need to be put in place to reduce staffing etc. as and when these opportunities arise. Examples of the costs in this heading are:	

Fixed Costs - Direct	It is not anticipated that there will be any material costs within this category.	
Fixed Costs - Indirect	Costs of these types of services will be based upon the usage made of these by the Service Line. It is anticipated that that these costs will taper as there will be an immediate saving on consumables and then plans will need to be put in place to reduce the cost or be replaced by other activity from service developments.	
Fixed Costs - Overheads	The overheads of the provider relating to the buildings, plant and equipment are the most difficult costs to saved. This includes maintenance, insurance, capital charges, energy and utilities etc. Providers should look to minimise these costs through negotiation with the service providers to reduce them to an absolute minimum until such time as an alternative use is identified or the building etc. is demolished. The core costs of managing an organisation (the Board or equivalent) are considered tbe "unsaveable". For this purpose this is considered to include the costs of: • Chairman • Non Executives • Chief Executive • Finance Director • Medical Director • Nurse Director • Other Executive Directors • Secretary to the Board • Plus costs to cover secretarial and administrative support to the above indicative estimate 30%).	

	Clinical representatives on management teams (unless the post becomeunnecessary as a recall of the service change) are considered to be unsaveable. Chaplains costs are considered to be unsaveable. The remaining Overhead Departments will have elements of costs that relate to the service lines, with staff working exclusively for those services. Where this is the case it is anticipated that these costs would transfer with the service along with the staff involved. The remaining elements of the Overhead Departments will have costs of service delivery relating to the service lines but these will not work exclusively for those service lines. In this case a re-structure of the teams within these departments would be expected to be carried out. This, of course, can only apply where a material value remains (both staff and costs) where only small values remain these should be subject to wider structural change programmes within the provider, where staff would be required to be part of change management within providers.	

6. Applying This Guidance in Practice

It is expected that the strategic mitigation set out in this paper is concluded before the application of this guidance is utilised.

It is expected that all provider organisations now have implemented, some form of, Service Line Reporting, which should enable the services affected by the major strategic change to be identified financially and the total (fully absorbed cost) cost of delivery of that service identified.

Once this has been concluded and the service line(s) has been financially identified each cost heading should be separated using the guidance set out in this paper.

A suggested layout has been included with this paper to help Providers and Commissioners work through what can directly transfer as part of the transfer and what will need further work to ensure costs can be released over time.

7. Transformation Funding Request

The major service changes that this guidance envisages will be subject to the widest governance scrutiny and business case process. Any costs that Providers and Commissioners feel are “unreleasable” (stranded) at the point of service transfer should apply this guidance with the application for funding support to follow the standard Transformation Funding approach.

Revised Scampion Rules

Illustrative Example Service Line Analysis

Heading	Total Cost £000's	Total Service Line Cost			Releaseable Costs			Non Releasable Costs			Notes
		Fixed £000's	Semi Fixed £000's	Variable £000's	Fixed £000's	Semi Fixed £000's	Variable £000's	Fixed £000's	Semi Fixed £000's	Variable £000's	
Direct Costs											
Senior Medical Staffing	850		850			850					
Junior Medical staffing	250		250			250					
Ward Costs	2,050		1,750	300		1,750	300				
Critical Care Unit Costs	780		700	80			80		700		
Operating Theatres	1,125		1,000	125			125		1,000		
Imaging (Radiology)	375		325	50			50		325		
Pharmacy	650		300	350			350		300		
Therapies (AHP's)	250		220	30			30		220		
Pathology	480		400	80			80		400		
Out-patients	300		280	20			20		280		
Sub Totals	7,110		6,075	1,035		2,850	1,035		3,225		
Indirect Costs											
CNST	640		640						640		
Clinical Coding	100		100						100		
Divisional Management	150		150						150		
Caterinng Services	285		100	185			185		100		
Portering	200		200						200		
Sterile Services	190		170	20			20		170		
Sub Totals	1,565		1,360	205			205		1,360		
Overheads											
Building Maintenance	275	275						275			
Building Insurance	110	110						110			
Capital Charges	1,250	1,250						1,250			
Domestics and Cleaning	600		570	30			30		570		
Rates	300	300						300			
Energy and Utilities	740		740						740		
Administration	250	250						250			
Board Costs	100	100						100			
Finance	450		370	80			80		370		
IM&T	750	750						750			
Human Resources	550		450	100			100		450		
Organisational Development	270	270						270			
Strategic Planning	75	75						75			
Sub Totals	5,720	3,380	2,130	210			210	3,380	2,130		
Grand Totals	14,395	3,380	9,565	1,450		2,850	1,450	3,380	6,715		