# SWP 27/92 MANAGEMENT IN GENERAL PRACTICE - 3
# A SELECTION OF ARTICLES

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# *Management in General Practice 3*

**A selection of articles published in the medical journal Pulse in 1992**

by

Professor Paul Burns and Jean Harrison *



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# INTRODUCTION TO MANAGEMENT IN GENERAL PRACTICE

General Practice is the gateway to the National Health Service. It is responsible for the provision of a comprehensive range of health promotion services and preventative and reactive primary health care. When it operates smoothly there is no better example of multidisciplinary team-work. But patient expectations are rising all the time and the pressure on doctors to become more patient or consumer orientated has never been greater. General practice is no longer just a vehicle to enable doctors to practice medicine. Increasingly practices are becoming community health resources that need pro-active management.

The quality of patient care and service is a major issue for doctors, their patients and the Family Health Service Authority (FHSA). The quality depends on the whole practice team. Recent changes in the National Health Service have made it imperative that good medical care is linked closely to sound management of all the resources of the practice.

At the same time General Practice is becoming more competitive. GPs now have a monetary incentive to increase the size of their patient list. Patients are being encouraged to "shop around" when they move to a new area. They are being encouraged to expect more from their doctor and, if the level of service is not forthcoming, to complain or change doctors. FHSAs not only undertake medical audits, they also undertake surveys of patient service. Those who cannot deliver the appropriate quality of patient care and service will find it increasingly difficult to survive. Those who can will find many opportunities for expansion.

Excellence of patient care and service does not happen by chance, it needs careful planning and continuous management. It needs to be properly organised at all levels of the practice and requires committed team work. It is not a one-off activity but an on-going process that heeds continuous monitoring.

This selection of articles published in the professional medical journals reflects the increasing interest in general practice as a small business. In the past GPs have never needed to develop their skills in managing their professional and support staff. What is more their "style" of management, whilst appropriate to the consulting room, may well be inappropriate when it comes to developing and controlling an effective practice team. These articles reflect the need of doctors to acquire "basic" management skills across a spectrum of disciplines, but particularly in the area of people management. They reflect a statement of best management practice applied to the general practice situation.

# *Planning for a Healthy General Practice*

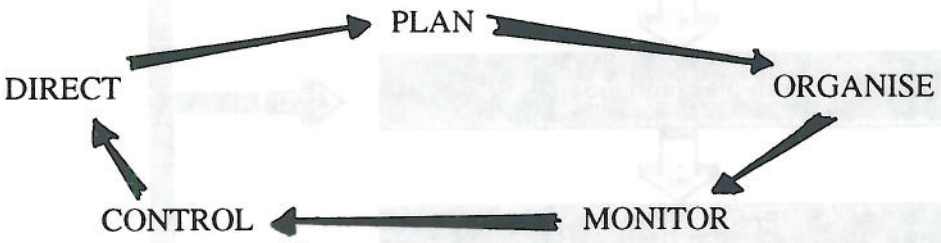
**Business Plans can improve the health of your practice and the service you offer your patients.**

## The Need for Planning

"When a man does not know what harbour he is making for, no wind is the right wind"
- Seneca

In the commercial world preparing a business plan is a regular, routine activity and increasingly general practice is adopting the ways of the commercial world. As the activities of the general practice become more complex or it grows in size, the need for planning becomes greater. The regular preparation of a business plan offers you the opportunity to review the performance of the practice and to develop a strategic plan to take it forward in the way you want. Without a business plan you cannot expect the practice to have any direction and you certainly cannot hope to organise it effectively.

Even if you do not know where you want to go you still need to decide on the road and make certain you get down it. You need to plan your actions, organise the practice resources and direct the practice team to achieve your objectives. Even when they all start moving in the same direction, you still need to monitor and control their progress to ensure they continue to move in the planned direction.It is all a continuous process, as shown below.




## The Planning Process

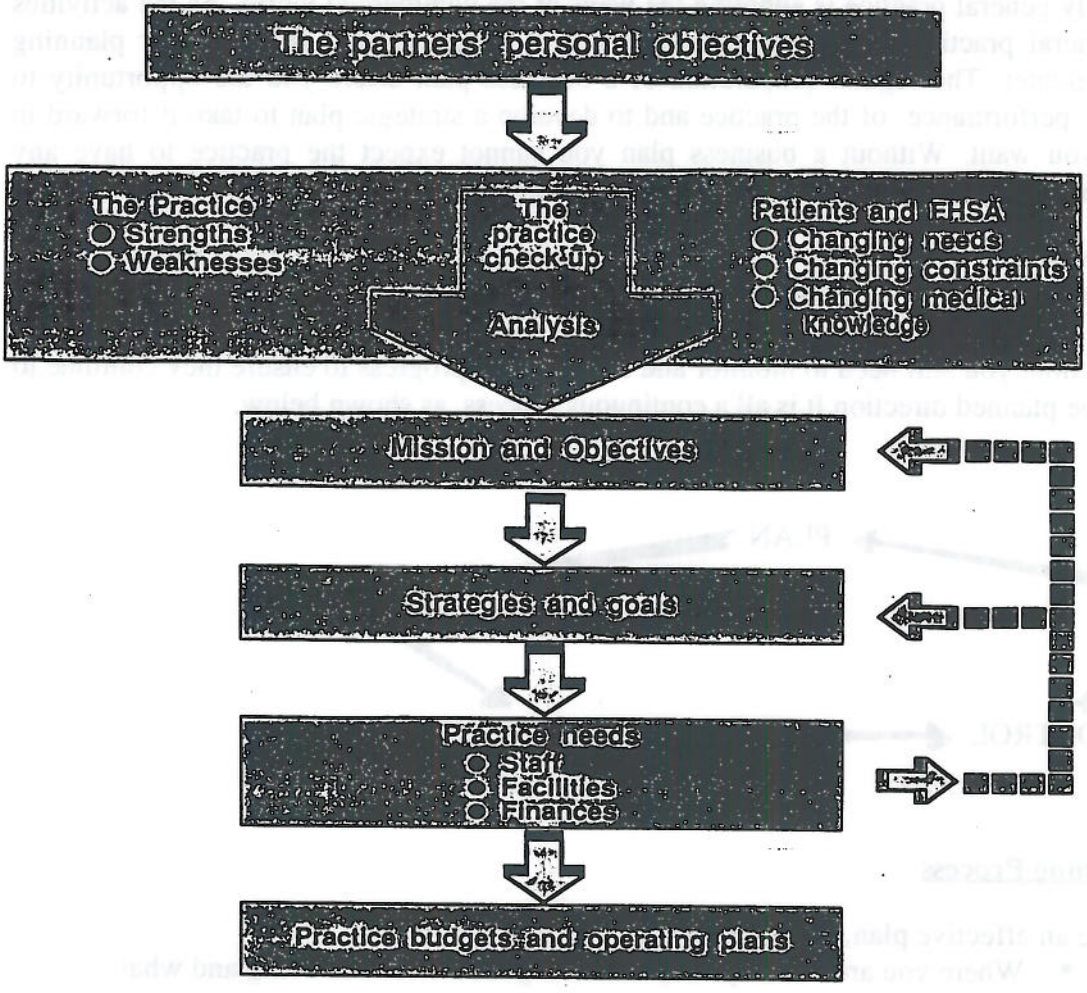
To prepare an effective plan, you need to know three things:

- Where you are - what your practice is good and bad at doing and what opportunities and threats it faces.
- Where you want to go - what you want the practice to develop into in the future.
- How to get there - what you need to do to achieve your goals.

The whole planning process is shown in the diagram below.

(The Planning Process diagram here)

## THE PLANNING PROCESS



## Where you are

You start the process by evaluating the strengths and weaknesses of the practice and the changing needs of your patients and the FHSA. It is just like doing a health check on a patient, except this time it is on your practice. You look at the core clinical services you offer, your partners, the professional and administrative staff, the location of the practice, the accessibility of services, the practice environment and your administration. All the time you are asking the questions what you are good at and what you are bad at. You may have to ask your patients. You will certainly have to ask your staff.

One practice decided its strengths included strong leadership and clear vision, a well equipped practice, financial viability and enthusiastic, dedicated high quality staff. On the other hand, the weaknesses included a building in need of refurbishment, insufficient patient feed-back, no methodology for measuring outcomes and quality and inadequate clinical audit. The idea is that the plan builds on your strengths and addresses the issues raised by your weaknesses. Of course isolating a weakness is often easier than deciding on the action needed to remedy it, but that is the art of management.

The same practice looked at the threats and opportunities that it faced. It decided the opportunities included increased resources through fund holding, better information through computerisation, better management and planning. On the other hand, the changes in the NHS threatened to disrupt the partnership and the increasing workload threatened the staff with stress overload.

## Where you want to go

The changing nature and role of general practice has caused heated arguments among doctors and disrupted partnerships. It has caused many doctors to re-examine their personal values and motivations. Most doctors have a strong sense of community service, but what are the other motives that drive you? What are your personal aims, needs and longer term objectives? And what are they for the other partners in the practice? The objectives you set the practice must be consistent with your own and your partners, otherwise there will be conflict or paralysis. Deciding on your own and your partners' objectives is just the start of deciding where you want the practice to go.

Central to the whole planning process is the mission statement or statement of core values for the practice. This should do two things:

- Define the boundaries of the practice - its purpose and scope.
- Contain elements of what you want it to become - your vision of what the practice can realistically strive to become.

One practice developed the following mission statement:

> *"To provide excellent, accessible, personal primary care (including health promotion) in a friendly environment, where new ideas from whatever source are considered in a positive light, with the provision of adequate time for professional development fof all members of the practice (accepting the need for the practice to be adequately manned at all times), whilst maintaining a reasonable income"*

Notice that the mission statement contains not only the statement of activity but also many indicators of what the partners want the practice to develop into. Words like "excellent" and "accessible" indicate the quality standards the practice aspires to.However, there are many phrases describing the quality of work such as "friendly environment" , "new ideas" and "adequate time for personal development". Finally, there is the financial motivation "to maintain a reasonable income", although this is more of a constraint than a primary mission.

Based upon the mission statement comes the objectives the practice sets for the year. They are founded in the practice check-up and for most practices reflect elements of patient service FHSA targets and financial performance. Objectives must be:

- Quantifiable and measurable.
- Bounded in time.
- Realistic and achievable.

They should build on the practice strengths and shore up the weaknesses whilst seeking to meet the longer term mission for the practise. They could include refurbishment of practice premesis, recruitment of new staff or improvements in various areas of patient care. For one practice, a major objective for the year was simply to find out more about their patients and what they thought about the service they received from the practice.

**How to get there**

The strategy and plans will detail how the practise proposes to achieve its objectives. A strategy is a course of action that involves detailed plans and actions. It need not be complicated, however, it should consist of a series of simple tasks that together form a means of achieving your objective. At some stage, the tasks will have to be broken down into more detail. For example, if you wanted to attract more patients to replace those who leave the area naturally and to grow your list, you may decide to open a small satellite surgery. Increasing your list size would be an objective, openning the satellite surgery the strategy that would have to be supported by detailed plans.

The next step is to quantify the needs of the practice in terms of staff, equipment and finances. The openning of a new satellite surgery has implications for all three areas. Often, if the resource implications mean that the objectives or plans are not viable, you will have to go back and modify them (shown as feedback loops).The final stage is developing the detailed financial budgets to support the plan. These include income statements, cash flow forecasts and balance sheets and represent the quantified financial implications of the whole planning process.

**Getting help**

If you find this planning process somewhat daunting, you might consider going to the Department of Trade and Industry for help. Under their Planning Initiative all practices are eligible for up to 15 days consultancy help to develop a Business Plan. The DTI will pay at least half the consultancy fee of up to £400 per day. For further information telephone Freephone 0800 500 200.

# *Effective Delegation*

**Delegation will help you develop your practice team - and that means better patient service.**

To run your practice efficiently you need to learn how to delegate effectively. Delegation can speed decision making and implementation. It can help develop individual members of staff and give them a sense of involvement with and commitment to the practice. With effective delegation you can free-up more time to think strategically and to practice medicine.

To delegate you must identify which of your tasks can be done by others and then hand over responsibility and authority to undertake the task. This means that you must **trust** that the person you are to hand the task over to has the ability to complete it. It also means that you must allow the person enough freedom to do the job properly and that probably means giving them greater freedom than they have had in the past. Too much control and you demonstrate that you do not trust them. Poor delegation can be as demotivating as effective delegation can be motivating.

## Barriers to delegation

We have all felt the urge to just get on and do a job ourselves rather than to delegate it. It could be that you worry that the person you delegate to will not do the job as well or as quickly. It could be that you defensive about the possibility that the person just might do the job better or quicker than you. It could simply be that you feel you do not have the time to explain the job. Alternatively, you may feel that you need to be involved in most things just to keep an eye on what is happening.

These are all common reasons or excuses for not delegating. In fact they all have something to do with the person making the excuse. When you delegate you take a risk about the ability of the individual to successfully complete the task. Generally, the benefits of delegation outweigh the possible negative consequences. However, if things go wrong you, ultimately, bear the consequences.

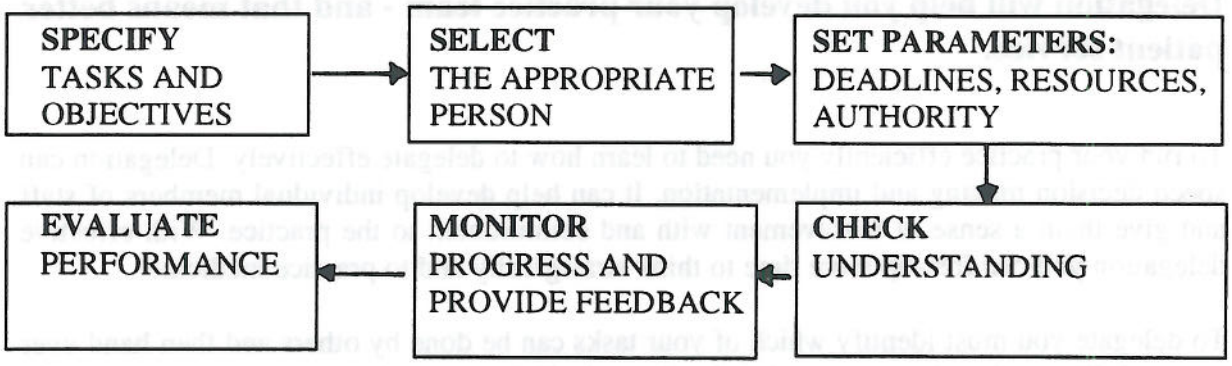
Think about delegating all the tasks you need not do personally, especially those which you are good at and used to doing. Ask yourself what tasks actually could not get done if you were ill. The truth is that there will probably be very few. But if you are still left with plenty then you are probably not delegating enough.

Do not overestimate your ability or underestimate that of you staff. Delegation can create new and better ideas about how problems are solved. Good managers delegate a lot, creating a team that is constantly expanding its skills and experience and moving onto new challenges.

## Masking delegation work

Delegation is not about "dumping" work onto your staff or passing on problems. It needs careful planning. The whole process is shown in the six steps below. Each step needs careful

thought and may involve you developing some new skills. Effective delegation can be quite a challenge.




**Selecting delegates**

Of course you need to select a delegate with the appropriate skills and qualities for the task. However you also need to consider a range of other factors:

- Is timing and quality very important for the task?
- Does the task need previous experience?
- Would it be useful to have someone else in the team acquire this experience?
- Which person would learn most or feel the greatest challenge from the task?
- Who is not appropriate?
- Who is available?
- If time and quality permits, can the task be used as a training exercise?
- Is more than one person needed and, if so, how will they work together?
- What other work priorities does your delegate have?
- How will you monitor progress and evaluate results?

Only when you have considered these factors should you decide on your delegate. For example, if timing is tight you may select a more experienced delegate who has the range of appropriate skills. Make sure you delegate some aspects of the job that stretch your staffs' ability and provide challenges. That way you help in their personal and professional development.

**Briefing the delegate**

There is no point in just telling the person you select to get on with the job. They need to be properly briefed. That means you need to be clear in your mind exactly what the task is and how it is to be carried out. If you are confused you can expect your delegate to be also. The checklist below gives you the essentials of briefing.

BRIEFING CHECKLIST

- Specify the parameters clearly: details of the task, deadlines, resources, authority
- Explain the desired final outcome
- Allow freedom to decide how to undertake the task but get them to justify it
- Continuously check their understanding
- Be enthusiastic and gain their commitment to the task
- Be clear about the reports you need from them as the task progresses
- Review areas of the task that are sensitive to error
- Discuss their other work and how this task might affect it

## Monitoring progress

Monitoring the progress of the project is how you control it. However, you must allow your delegate to undertake the task in the way you have agreed with them and without interference. Otherwise they will feel you do not trust them and become demotivated.

You must be alert to signs that things are going wrong whilst being willing to let trivial mistakes to be made. Encourage frequent informal discussions rather than formal review sessions. This will encourage trust and mutual respect. Be ready with help and advice. Always be encouraging. Resist the temptation to do the task yourself or transfer it to somebody else except when you are certain that otherwise the job will go horribly wrong.

## Giving feedback

If the project goes well give praise and credit to the people responsible. Apart from anything else, it is not fair to take credit for other people's work. Consider the effect that recognition will have on their motivation.

If things go wrong do not blame staff in public. Conduct the post mortem in private. Find out what went wrong. Was there a misunderstanding? Was the delegate the wrong person for the job? Did they make a mistake? Was the mistake preventable? Were there unforeseen problems? Everybody makes mistakes. The important thing is to learn from them and then not to repeat them.

## Taking time

Effective delegation means you must invest time in many activities to achieve better results or to save time in the long run. The time that you will free up through delegation is time that you can use to think strategically about the development of the practice. You need to continuously review your own activities and anticipate changes that it may be appropriate to make in the practice to improve the quality of patient care.

Coping with change is now almost part of everyday life. By delegating you can organise yourself and your practise to cope with it effectively and efficiently. You have more time to think and plan. Your staff can have the delegated authority to cope with problems at the point they occur. They are better motivated and will develop their personal and professional skills. Effective delegation will help you develop your practice team - and that means better patient service.

# *Budgeting in General Practice*

**Budgets can help you direct and control the practice and regulate your own, personal finances**

## The Need for Budgeting

You might be forgiven for thinking that these days general practice is as much about managing resources as it is about practicing medicine. You are probably correct. These resources are inevitably measured in financial terms and that means that you need to ensure that the practice maintains adequate financial records and that you understand the information they provide. Not only should this help the practice run more efficiently and effectively but it should also ensure that you can withdraw a regular, monthly salary without having to worry whether the practice can afford it.

Financial control starts with budgets. Budgets are just part of the Business Plan your practice should produce. They force you to consider, in detail, the income and expenditures generated by your plans, and these days this can be far less certain than under the old contract. Income now depends far more on what the practice actually achieves - list size, targets, clinics etc.. And that means you have to plan ahead. What is more, you need to control your costs. Overheads have a habit of increasing at a faster rate than income, to the detriment of profits. If you want to withdraw a steady monthly salary, you need to budget.

Budgets also allow you to ask "What if" questions like: "What if we take on a new practice nurse?" They allow you to decide *whether* you can afford to employ them and *when* you can afford to employ them. They allow you to plan for contingencies such as not making your cervical smear targets. They can even save you time in the long run by allowing you to "manage by exception", only taking action when your actual financial results differ significantly from your budget. They can even help you delegate responsibility for certain expenditures to key members of staff who control them. If done properly this can improve the accuracy of your budgeting, the control you have over the practice and the motivation of your staff.

## Putting the Budget Together

Text books on budgeting speak of the need to draw up three documents:

- A cash-flow forecast, which is concerned with the day-to-day money coming in and going out.
- A profit and loss account forecast, which is concerned with the long term viability of the practice as a business and will be used as a basis for a tax computation.
- A balance sheet forecast, which list the assets and liabilities of the practice and points out the sources of its funds.

In fact, most general practices are safe drawing up only a cash flow forecast because, unlike most businesses, their activities are relatively straight forward and except for one item, there is likely to be little difference between cash-flow and profit. The item that causes the

problem is capital expenditure - medical and office equipment, cars etc.. with profit you allow for depreciation of the asset over its useful life. Cash-flow recognises the cash expenditure immediately and is in many ways a more prudent method of assessment.

## The Cash Flow Forecast

The cash-flow forecast gives a month by month estimate of the cash receipts and expenditures of the practice; their timing and amount. It is essential to estimate not only the amounts of cash income and expenditure, but also their timing. Normally practice budgets are set for one year, starting April (the start of the NHS financial year). In this way you should know the fees set for the period.

The easiest way to start the process is to use last year's accounts and change the figures to reflect changes in circumstances. You start by looking at your practice income. This falls into three broad categories: FHSA income, FHSA reimbursements and other income. Check-list 1 gives you some indication of the income to be included.

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## Check-list 1: Practice Receipts

**FHSA Income**

* Capitation fees
* New registration fees
* Basic Practice Allowance
* Deprivation supplement
* Rural practice supplement
* Seniority payments
* Immunisation payments
* Cervical cytology payments
* Minor surgery payments
* Health promotion clinic fees
* Night visit fees
* Training allowances
* Teaching medical students
* Child surveillance payments

**FHSA Reimbursements**

* Surgery rent, rates and water
* Ancillary and related staff
* Locum fees
* Computer reimbursement

**Other Income**

* Life assurance examinations
* Hospital appointments
* Cremation fees
* Private patient fees
* Drug dispensing
* Special reports and services
* Other appointments

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Next, you predict the cash expenditures. These fall into eight broad categories: medical, premises, practice, administration and financial expenses, capital expenditure, taxation and finally partners' drawings. Check-list 2 gives you some indication of the expenditures to be included. Most major expenses are fixed and relatively easy to predict. Capital expenditures may often be deferred. So you need to consider the timing of the expenditure carefully. Taxation is a major expenditure for most practices. Staff PAYE and NIC must be paid monthly, but partnership taxation is paid in two instalments on 1st January and 1st July. These are likely to be large payments and it might be wise to avoid any other major expenditures in these months. They are based upon partnership profits in previous years. Your accountant will tell you how much to expect to pay.

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## Check-list 2: Practice Payments

**Medical Expenses**

* Drugs, dressings etc.
* Disposable equipment
* Equipment hire, servicing etc.

**Premises Expenses**

* Surgery rent, rates and water
* Health Centre service charges
* Gas, electricity etc.
* Property maintenance and repairs
* Cleaning, gardening, security etc.

**Administrative Expenses**

* Telephones and paging service
* Printing and stationary
* Training expenditure
* Professional subscriptions
* Professional journals
* Waiting room consumables
* Accountancy and legal fees

**Practice Expenses**

* Ancillary and related staff
* Locum fees
* Staff pensions

**Financial Expenses**

* Loan and overdraft interest
* HP and lease payments
* Bank charges

**Capital Expenditure**

* Medical equipment
* Computer equipment
* Furniture and other fixtures
* Property
* Vehicles

**Taxation**

* Partnership taxation
* Partners' NIC
* Staff PAYE and NIC

**Partners' Drawings**

You work out the surplus (or deficit) of income over expenditure for each month and add it to (or subtract it from) the balance in the bank at the beginning of the month. You might try doing this twice. The first time you do not insert any figure for drawings. This allows you to make a judgement about expenditures that can be avoided or postponed and allows you to decide on the appropriate level of drawings each month. The final forecast would include all figures.

Of course this whole process is considerably easier if you have a spreadsheet programme. It allows you to, quite literally, play with the figures. When just one figure is changed, the rest of the figures on the spreadsheet will automatically change to accommodate it. This allows you to try out those "what if" questions without the pain of recalculating all the figures in the cash flow.

Fund holding practices face particular problems. They can control and allocate their funds over three areas: hospital services, prescribing costs and the cost of practice staff. They need to keep their fund holding completely separate from the practice budget. That means they need a separate bank account, cash book and cash flow forecast. The fund budgets are set by the Regional Health Authority but paid and monitored by the FHSA.

Once the cash flow forecast is in place, you can use it to manage the practice on an exception basis. As long as the results are correspond to the forecast then, *prima facie,* no corrective action or indeed further investigation, is needed. This saves you time and helps you concentrate your management effort in the areas that need it. You can only manage your practice effectively if you plan ahead. Budgets are an essential part of the planning process.

# *Practice Accounts*

## You need to understand your practice accounts to use them effectively

As a partner you are required to sign the partnership accounts which will be used to determine the profit attributable to individual partners, the amounts they are able to draw and their tax liability. You need to understand the information contained in them and how they are produced.

### THE BALANCE SHEET

In accounting terms, any business is simple. Money comes into the organisation and money goes out, although not necessarily in that order. The balance sheet is the most important part of a set of accounts. It lists the assets that the partnership owns and the liabilities that it owes at any point of time. The difference between the two is called the partnership balances - surplus assets owned by the partners or liabilities they are legally obliged to pay. In other words the balance sheet tells you where the money went (the assets) and where it came from (partners or outsiders).

The assets include fixed assets - those you mean to keep for a long period such as property or equipment. Some assets used by a practice, such as health centres, are not owned by the partners and are therefore not shown in the balance sheet. The assets also include current assets - those that can be turned into cash quickly such as drug stocks, debtors and cash itself.

Liabilities are the amounts owed by the practice to other organisations or individuals for goods or services not yet paid for. They might also include loans and overdrafts. Liabilities are classified as either current - those due for payment within one year such as trade creditors or long-term - those due for payment after a year such as a business development loan. The whole relationship is shown below:

| **ASSETS** | | **LIABILITIES** | | |
|---|---|---|---|---|
| Fixed Assets: | | Long-term Liabilities: | | |
| Land and buildings | | Loans | | |
| Computer equipment | | Income tax | | |
| Medical equipment | | Lease and hire purchase | | |
| Office equipment | - | | = | **PARTNERSHIP BALANCES** |
| Current Assets: | | Current Liabilities: | | |
| Debtors | | Creditors | | |
| Bank balances | | Lease and hire purchase | | |
| Cash | | Income tax | | |
| | | Overdraft | | |

## FIXED ASSETS

All assets, with the possible exception of land and buildings, are shown in the balance sheet at their original cost. Fixed assets are depreciated over their expected useful life. Depreciation is a method of allocating that original cost over the asset's life. There are many methods of depreciation but the simplest is called straight-line. This allocates the original cost, less the expected salvage value, over the expected life of the asset in equal amounts each year. For example, if the office computer costs £2500, has an expected life of 5 years at the end of which it will have a salvage value of £500, the straight-line depreciation wold be:

$$\frac{(£2500 - £500)}{5 \text{ years}} = £400 \text{ per annum}$$

Each year for 5 years, £400 would be taken off the balance sheet cost of the computer and charged to the profit and loss account. At the end of 5 years the depreciated cost in the balance sheet would be £500 - equal to the expected salvage value.

Generally, freehold land is not depreciated at all and freehold buildings only by a small amount. Indeed, both may be revalued regularly. This reflects the fluctuations in the UK property market and the very long term nature of the asset.

Notice depreciation has nothing to do with cash flow. You normally part with the cash when you buy the asset. Depreciation just allocates the cost over its life. Also, the expectations about useful life and salvage value may prove to be wrong necessitating an adjustment to the accounts. Finally, the depreciation rates used in your accounts are normally different to those you must use to calculate your tax liability. Tax depreciation rates can change each year and do not reflect the assets' expected life. In the past these rates have been as high as 100%!

## PARTNERSHIP BALANCES

As you have seen, the partnership balance is the accumulated amount owed to or by individual doctors. It does not necessarily represent cash, just the surplus of assets over liabilities (or visa versa). Profit sharing proportions may change from year to year and are laid down in the partnership agreement. Partnership balances are calculated by adding profit shares for the year to the balances brought forward from previous years and subtracting drawings. This calculation is made for each partner and the cumulative figure is shown in the balance sheet.

## PROFIT AND LOSS

Profit is simply the difference between your income and your costs. However, it is not the same as cash. You might not have been paid all the income you are owed by the FHSA. Similarly, depreciation is an allocation of cost which does not represent a cash flow. Profit represents an increase in **all** the assets of the practice.

Frequently, partnerships have problems deciding whether certain expenses should be charged to the partnership or to individual doctors. Such thing as motor expenses and spouses' salaries can vary significantly from doctor to doctor and therefore can generate disagreement and ill-will if charged to the partnership. Charging them to individual doctors generally does not affect their tax deductibility. The checklist below shows those expenditures best charged to individual doctors rather than the partnership.

Checklist: Doctors' Personal Expenses

- Spouses' salary and pension
- Locum and deputising fees
- Motor expenses
- Medical expenses
- Journal expenses
- Laundry and cleaning
- Use of home as office:
  Proportion of -
  - Rent
  - Mortgage interest
  - Heat, light, water etc.
  - Repairs and cleaning

## DRAWINGS

Whilst drawings technically come out of profit, they are actually paid in cash and it is important to understand the difference. It is your cash flow forecast that will tell you how much you can safely withdraw from the practice without having to borrow to make the payment. In drawing up the cash flow forecast you will need to make an allowance for the taxation liabilities that the practice faces. That is usually complicated and advice should be sought from your accountant.

Practice accounts are not difficult to understand. They become a lot more interesting when you remember that it is your money they are dealing with and if they are wrong it could affect both your personal tax liability and your personal income.

# *Controlling your Practice Finances*

**Controling practice finances becomes an imperative when you realise you are dealing with your own money**

## Financial Records

Most practices rely on their accountant to draw up a full set of accounts. However, that does not remove the need to produce financial information about the practice on a monthly basis if you want to run it effectively. You need to keep proper records. These comprise:

- Bank Cash Books
- Petty Cash Books
- Purchase Book
- Salaries Book
- Asset and Drug Register
- Fees and Claims Book

Together, these records collect all the financial information relating to the practice. Invoices for purchases are recorded in the Purchases Book. If they represent drugs, they also go into the Drugs Register. If they represent assets, they go into the Asset Register. When paid, the payment is recorded in the Bank Cash Book. Salaries are calculated and recorded in the Salaries Book and also recorded in the Bank Cash Book. Fees and claims are similarly recorded in a separate book and, when payment is received, in the Bank Cash Book. All cash receipts and payments are recorded in the Petty Cash Book. Even computer-based accounting systems use a process of recording based upon these records.

## Accuracy

Any accounting system, however, is only as accurate as the information fed into it. You must have a system that ensures *all claims* are made, as soon as possible, and then payment is actually received. Similarly you need a system for accurately recording and paying all liabilities. Your administrative staff need clear responsibilities. For example, one person should have responsibility to ensure that all claims are properly made and then checked against FHSA quarterly statements and any differences investigated. This can prove time consuming since some FHSA statements are broken down by doctor, others are simply lists of patients receiving certain services and some simply show numbers of claims paid. If you follow the checklist below you should control your claims effectively.

FHSA CLAIMS

- ☐ One person should have responsibility
- ☐ Claims should be accurately recorded
- ☐ Claims should be made promptly
- ☐ Use the correct claims forms
- ☐ Check claims against FHSA statements

## Monitoring Performance

How do you know whether your practice is performing well? The answer to that is if it is performing according to your plan and budget. You need to monitor your performance against budget on a monthly basis. That means monitoring the figures in your Bank Cash Book against your cash flow forecast. You therefore need to ensure that the account headings used in your cash book are the same as those used in your cash flow forecast. You also need to monitor your level of outstanding fees and claims as well as unpaid invoices. These figures come from your Fees and Claims Book and Purchase Book respectively.

The difference between actual and budgeted results is called a *variance*. Variances are always likely to exist and it is a question of judgement whether they are large enough to warrant investigation. But it is only if there is a large variance that you need to investigate the reasons. If you use budgets in this way they allow you to "manage by exception", only taking corrective action when things deviate from your original plan. However, variances must be tread with some caution as they are not always what they seem. For example, a positive variance, or underspend, on postage may be because somebody has forgotten to send out immunisation letters and, whilst you may underspend on this account, the result is a loss of income to the practice.

What you need is a *budget comparison statement* which allows you to compare each heading in your cash book with your budget on a month by month basis. It is also advisable to compare your actuals to your budget on a cumulative basis as small variances can add up over 12 months to a significant amount of money. A possible format for these statements is shown below.

BUDGET COMPARISON STATEMENT

MONTH: _____

| | | MONTH | | | YEAR TO DATE | | |
|---|---|---|---|---|---|---|---|
| A/C No. | Heading | Actual | Budget | Variance | Actual | Budget | Variance |
| | | | | | | | |

## Effective Delegation

Budgets can help you delegate authority for the day to day administration of the practice and then control it effectively. The principle is simple. You assign responsibility for different accounts or groups of accounts to individual members of staff who have effective control over that expenditure. You can then monitor their performance using the Budget Comparison Statements.

Of course, you will have to involve them in the process of setting the budgets, but they will probably have a better grasp of what that expenditure is likely to be in the future and involving them is an integral part of gaining their commitment to the budget. Remember only to assign responsibility for expenditure to those members of staff who actually control it. There is nothing more frustrating that to be held responsible for something that you do not control. Remember also that your budgets must be realistic and attainable if they are to gain the commitment of your staff.

**Control**

So what do you do if things go wrong and you deviate from budget? The answer is to talk to people. You find out what the problem is and why it has happened. If you have problems with your cash receipts from the FHSA, talk to your FHSA manager. Find out why they are not paying. Is there a dispute? Do they have administrative problems? You need to have effective personal relations with the FHSA at all levels in the practice.

You should talk to your bank manager regularly also and they should be one of the first people to be alerted if you start to deviate from your budget. They will know what is happening any way because of the state of your bank account. Explain what has happened, why and what you are doing to put it right.

You should also keep on top of the fees for outside work that you are owed. Make sure you undertake the work promptly, deliver any reports immediately on completion of the work and issue an invoice at the same time. Chase up outstanding payments. Remember also to take any credit offered. Most suppliers allow at least 30 days for payment. Use it. Consider using HP or leasing to purchase assets. Only as a last resort do you want to reduce the level of drawings for the partners!

Controlling the finances of the practice should not be difficult as long as you have the proper records, the appropriate systems and have assigned responsibility to appropriate members of staff. Remember, it is your money you are dealing with.