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

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This is a selection of brief articles from Modern Medicine, 1991

Management in General Practice

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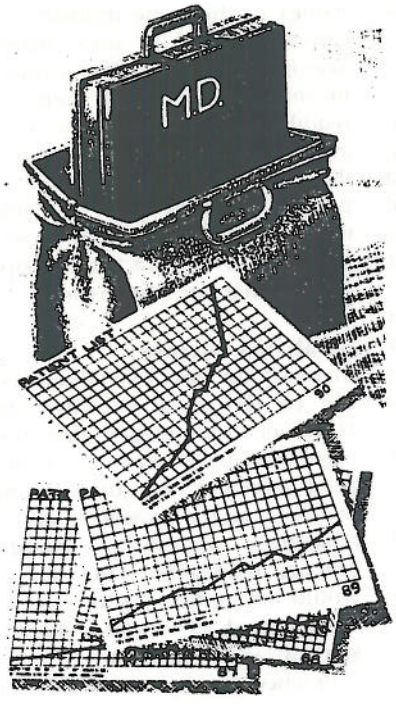
WHO CARES WINS

The customer-centred business and the patient-centred practice both succeed because they care about their clients. Professor Paul Burns argues that a businesslike approach allows the GP to offer a better service to patients



Paul Burns is Professor of Small Business Development at Cranfield School of Management

How can good management improve the service you offer your patients and increase your income? In particular how is it relevant to the 1990 Contract?

The fact is that GPs already practise the core skills which are the basis of good business management. Doctors are accustomed to analysing symptoms, investigating probable causes, applying solutions, monitoring progress and modifying the treatment in the light of experience. These are business skills.

Sound management comes from treating the practice itself as you would a patient. And there is one other quality which is crucial to business success and which GPs possess in abundance: they *care*. The most successful private companies are those which are seen to care about their customers.

So doctors have a head start when it comes to the "businesslike" approach required by the new contract and the White Paper.

A cornerstone in any business management course is the subject of marketing. Contrary to many people's views marketing is not just about selling more. It is concerned with satisfying customer needs.

Effective patient communication, which GPs have pioneered in the medical field, not only improves the efficiency of your diagnosis, it is actually the front line for both marketing and business efficiency. Sales training courses often stress seven golden rules for effective face-to-face selling, many of which translate easily into the surgery:

- Keep it simple—never use two words where one will do
- Don't use jargon—it blocks communication
- Avoid value words—it can cause prejudice
- Avoid using negatives—stress the positive
- Appeal to as many senses as possible
- Provide a suitable environment
- Treat the customer as an equal.

This approach to satisfying your "customers" must go through the whole surgery. In good surgeries the nurses and receptionists explain problems courteously, simply, without using jargon.

The practice environment can be made pleasant, restful and comfortable. How often do you sit in your waiting room and just look around it? Would you feel at ease waiting in it? Think about when you visit your accountant or your solicitor. How do their receptionists stack up against yours? Patient meetings can be a useful means of gathering constructive suggestions about how the practice might be improved. It is

worth remembering too, that improvements to a surgery you own will probably increase the property's value.

The new practice leaflets present you with an opportunity, not only to distribute information about the practice, but also to convey this whole patient-centred approach. The difference in this case is that you are doing it on paper. And the message is the same: "You, the patient, are important, and we'll do all we can to help you."

On the record

A patient-centred approach should help GPs to attract and keep the patients they want—and that should generate the desired income. But the new contract also places great store on achieving target rates of immunisations and cervical smears.

The key to achieving these targets is a good records system. You need to establish who needs which service. You will need to be able to target different patient groups and have a system for sending out call and recall letters. These should be personal letters, not circulars, and they should be strongly worded, giving a firm appointment and clear indication of the risks of not undertaking the smear or immunisation. You may even need to follow up nonrespondents with telephone calls.

Probably the only way you will be able to do all this is with a computer. But there is an old adage about computing; garbage in means garbage out. You will have to continually invest time and effort in keeping your computer databases up to date. You also need to ensure that you have the right sort of data. Data that allows you to target the right group based upon appropriate criteria. What is more, because of the problem of validation, you would be well advised to run regular checks of your database against FPC records.

Demise of the bagman

"Brown paper bag jobs" are legendary in the accounting profession. The bag contains invoices and cheque stubs brought in by a local small firm. Brown paper bags should become a thing of the past for GPs.

Accurate accounting information is important, particularly when it comes to splitting partnership profits. And while accuracy is important, you also need proper systems. For example, how many of your accounts include partners' personal expenses and superannuation? It is always wrong to treat superannuation as a practice expense. And while it is for the partners to decide whether they want to pool expenses, for example for cars, it is generally not a good idea because it can cause so much argument if one GP's expenses are out of line with the others.

A company monitors its financial performance by comparing its actual results to the budgets it prepared at the beginning of the year. Plans and budgets are just as important for the general practice. Cash flow budgets allow you to plan your financing needs in advance and to think through the "what if" situations. Should you refurbish the surgery? Should you change the car or purchase more computer equipment? Planning ahead is one of the keys to business success, and the same principle applies to general practice.

The other thing that a company would do is to compare its actual performance to that of other companies in the same industry. You can also do this, since national averages for many general practice income and expense items are readily available. Differences from averages are to be expected, but the discipline of making the comparison requires you to explain them, and it might disclose a problem for the practice or opportunities that you are missing.

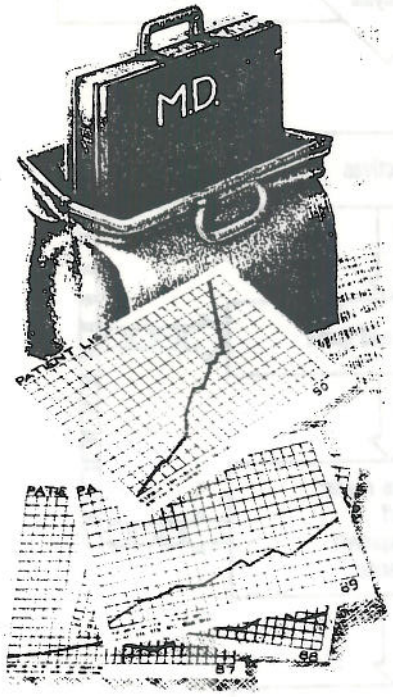
Qualified success

Many of the tasks I've talked about can be delegated to other staff. However, that means that these members of staff have to be managed. And it all takes time. Because of this, larger practices are increasingly appointing qualified practice managers. After all, you would not go to a doctor who was not qualified, so why let unqualified staff run your business?

Practice managers can deal with all the business aspects of running the practice and so free you up to do what you do best and probably enjoy most—practising medicine.

How to give your PRACTICE a check up

Planning ahead will improve the health of your practice and the service you offer your patients. Professor Paul Burns takes you through the process



Paul Burns is Professor of Small Business Development at Cranfield School of Management

How often do you tell your patients to plan their lifestyles—take regular exercise, eat a balanced diet, drink alcohol in moderation? And how often do they take any notice of you? After all, those bodies of theirs have worked perfectly well, so far. So why should they change their lifestyle now? That is unless they have faced some recent medical crisis, in which case they may realise that they cannot go on as before and may appreciate the need for planning the future

Planning is just as important for an organisation. Unfortunately, that advice is often just as unpalatable for an organisation as it is for a patient. And the organisations that are most receptive to the advice are those that are facing some crisis. For a business that crisis is normally commercial, and if they discover it too late it may prove terminal. For general practitioners, the new contract and White Paper may well prove to be the sort of crisis that encourages them to think about the future and plan ahead—an unexpected, and for many unwanted, bonus.

The only people who do not need to plan ahead are those who live in an unchanging world and do not want to go anywhere. Kenneth Clarke has just moved the goal posts for GPs. But even without this upheaval most GPs want to improve the service they offer their patients and need to plan to achieve those improvements.

So, what does planning entail? To plan effectively you need to know:

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

Planning forces you to evaluate the strengths and weaknesses of the practice and the changing needs of your patients—and the FPC. This process is just like a patient check-up except this time it is undertaken on your practice. You need to evaluate how healthy your practice is and how able it is to undertake the job it faces in the future.

Once you do this then you are in a position to start setting practice objectives. These must be consistent with your own and your partners' personal objectives. Once set, you must decide how they are to be achieved, by developing strategies and formulating operating plans. These are quantified in the practice budgets which form the core of the plan. The whole process is shown in the diagram on page 328. The feedback loops represent the changes you might have to make at each stage as you find, for example, that your objectives are

not achievable given your practice needs or resources.

The practice check-up

You should start with an honest evaluation of your own and your partners' motives for being in general practice. Most doctors have a very strong sense of patient and community service. But what are the other motivations that drive you? What are your personal aims, needs, and longer-term objectives? How do they fit with your family obligations and constraints?

The check-list on page 331 should help you consider your motives. It is not meant to be exhaustive, but simply to indicate the type of questions you might ask yourself. Your partners may have different motivations and if these are too diverse it will make it very difficult to arrive at a consensus plan for the practice.

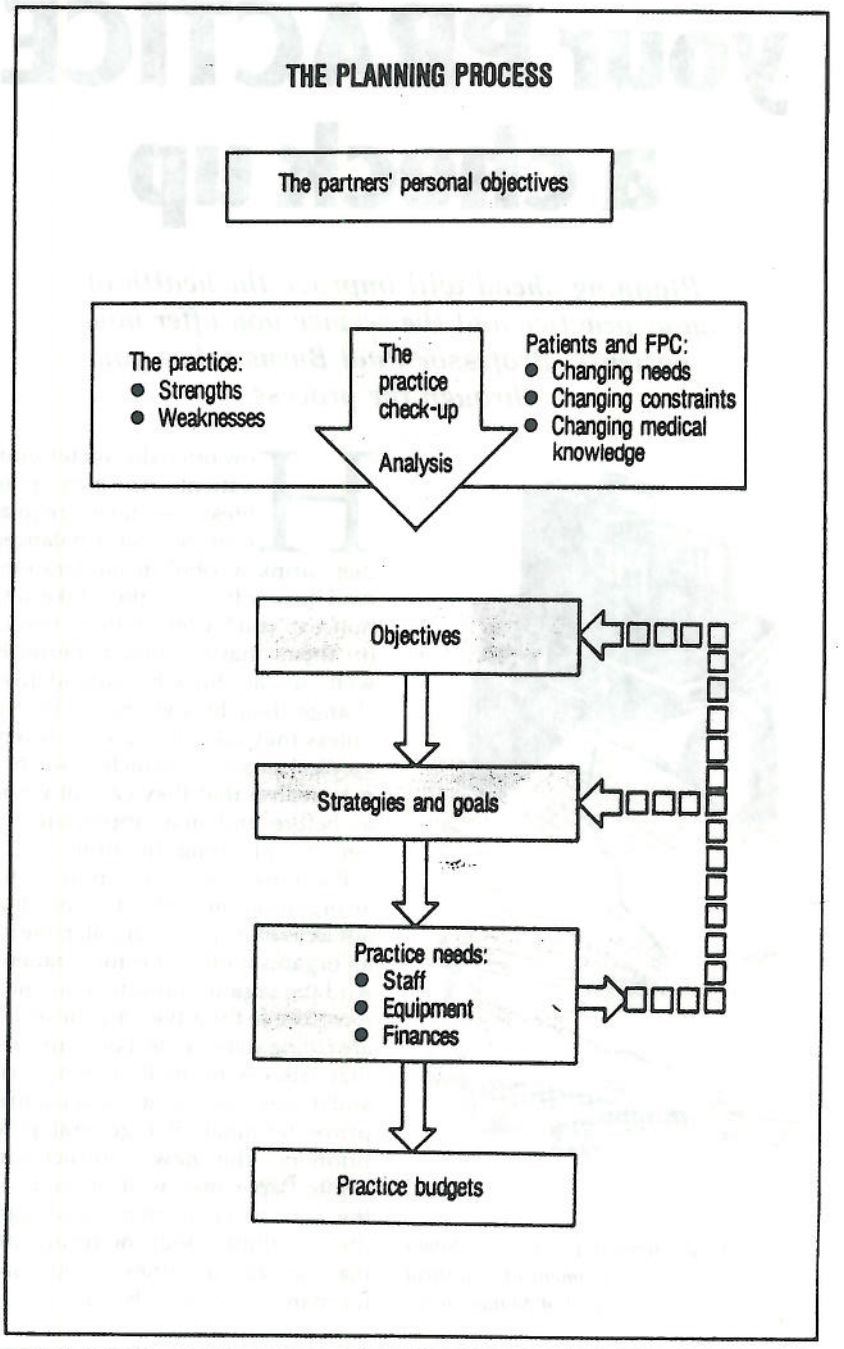
The next step is to look at the practice itself and evaluate its strengths and weaknesses. Try to look at it objectively from the patients' point of view. In fact, why not ask your patients? Customer satisfaction questionnaires are commonplace in better run businesses, so why not in better run practices?

It might help to break the process down into five headings:

- You and your partners
- Your professional and administrative staff
- The practice environment
- Technology
- Administration.

The check-list on page 332 again should help you do this, but remember it is not exhaustive.

Isolating a weakness in the practice is often easier than determining the action needed to remedy it. It is



just like practising medicine in many ways. You need to recognise the symptoms of managerial weakness, but you must then also be able to diagnose the cause and prescribe the treatment. Any patient can tell you about his or her symptoms. The real art of medicine comes with diagnosis and prescribing treatment. Similarly, the real art of management comes from diagnosing the cause of the managerial failure and remedying it.

General practice is about people, and your practice is only as good as you and your professional and administrative staff. You need to make an honest evaluation of what you, your partners and your staff are good, and bad, at doing. Are there gaps in their skills? What do you need to do to fill those gaps? Can they meet the requirements of the new contract?

CHECKLIST

Discover your personal motivations

Are you in practice:
- To serve the community? ☐
- To serve patients? ☐
- To express your personality? ☐
- To maintain your independence? ☐
- To research medicine? ☐
- To achieve status? ☐
- To have an easy life? ☐

What sacrifices are you prepared to make:
- With your family? ☐
- With your time? ☐
- With your other outside interests? ☐
- With your money? ☐
- With your health? ☐

What are your longer-term objectives:
- To serve the community? ☐
- To serve patients? ☐
- To provide a regular income? ☐
- To maximise that income? ☐
- To accumulate a capital gain? ☐
- To maximise your free time? ☐
- To undertake postgraduate research? ☐
- To operate at the forefront of medicine? ☐
- To achieve the high regard of your colleagues? ☐

What is the balance you wish to achieve between:
- Patient service? ☐
- Professional development? ☐
- Income? ☐
- Free time? ☐

Opportunities and threats

You need to build on your understanding of your patients, the new contract and how your FPC will interpret it to develop a "feel" for how your practice might develop and what opportunities and threats it might face. Is your list size increasing or decreasing? Is the age profile of your patients deteriorating? Is the socioeconomic or sex profile changing?

For most practices, the new contract will mean substantial changes. It has implications for every general practice in terms of patient records (age, sex, location, morbidity and mortality), use of hospital services and personnel information (training, qualifications, availability and activities). It also means that general practitioners need to know more about the availability of local hospital and community services, the contract arrangements by the District Health Authority and the impact on the practice population of work carried out by other agencies. The checklist on page 332 should help you evaluate the changes you face from your patients and the FPC.

Ends and means

Objectives reflect not only what you want the practice to achieve but also what you think it can achieve. For most practices they reflect patient service, FPC targets and financial performance. Objectives must be quantifiable and bounded in time as well as being achievable.

The new contract has set immunisation, screening and other targets that have financial implications. You must decide whether you wish to adopt them as part of your practice objectives. However, you will certainly wish to add your own patient service and even financial objectives. You should also include your own personal objectives.

Objectives tell you where you want to go. You need a strategy to tell you how to get there. A strategy is a course of action that involves detailed tasks designed to help you achieve your objectives. If you wish to achieve the new contract's immunisation and screening objectives,

Check your practice's strengths and weaknesses

You and your partners
- Professional skills ☐
- Professional competences ☐
- Communication skills ☐
- Age range ☐
- Outside commitments ☐
- Management skills ☐
- Interests ☐
- Workloads ☐

Your professional and administrative staff
- Professional skills ☐
- Professional competences ☐
- Communication skills ☐
- Workloads ☐
- Dedication and motivation ☐
- Ability to take delegated responsibility ☐
- Staff turnover ☐
- Staff illness and absenteeism ☐

The practice environment
- Waiting room condition ☐
- Access ☐
- Consulting rooms—condition, size, facilities offered, etc. ☐
- Children's toys/play area ☐
- Clinic facilities ☐
- Patient information ☐
- Telephone facilities ☐
- Building repair, maintenance and replacement ☐
- Practice location ☐

Technology
- Medical equipment ☐
- Computers—patient records, screening, immunisations etc. ☐
- Telecommunications ☐
- Word processors ☐

Administration
- FPC payments ☐
- Financial records ☐
- Patient records ☐
- Division of partners' responsibilities ☐
- Patient waiting time ☐
- Patient visits ☐
- Prevention and screening arrangements ☐
- Indicative prescribing budgets information ☐
- Internal market information ☐
- Medical audit information ☐
- Annual practice report ☐

Spot the opportunities and threats

Patients
- List size ☐
- Socioeconomic changes ☐
- Demographic changes ☐
- Age and sex profile ☐
- Patient loyalty ☐
- Clinic attendances ☐
- Prevention and screening coverage ☐
- Other practices in the area ☐
- Patient registrations/ deregistrations ☐
- Medical advances ☐
- Trends in diseases and disorders ☐
- Trends in services requested by patients ☐
- Trends in private health care ☐

FPC
- Prevention and screening targets ☐
- Indicative prescribing budgets ☐
- Internal market ☐
- Medical audit ☐
- GP budgets ☐
- FPC information compatibility/ accuracy ☐
- FPC manager's attitude ☐
- Postgraduate training ☐

you need to consider the implications for information generation, technology and even staff organisation.

Try writing down your practice strengths and weaknesses as well as the changes in patients and the FPC that can generate threats and opportunities for the practice. Alongside these, write down the tasks you need to undertake to build on the strengths and shore-up the weaknesses, so that you can achieve your objectives. Assign different tasks to different partners and give each task a priority. Finally, start to plan when these tasks will take place.

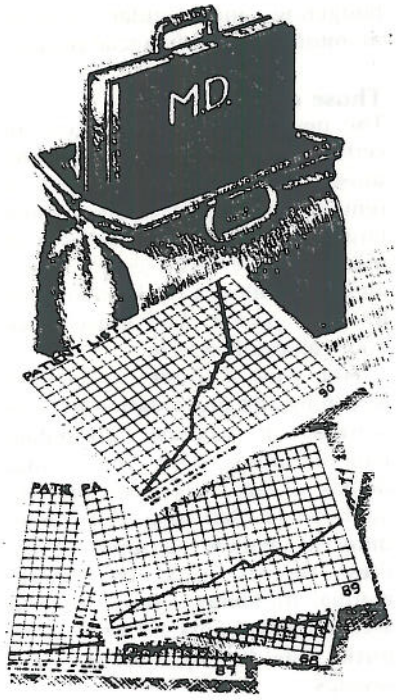
This will tell you who in the practice will do what, and when. You now need to quantify the needs of the practice in terms of staffing, equipment and finances. Often you will have to modify your original plans to reflect what is achievable, given your resources. Once you have this the plans can be translated into budgets.

Planning is never an easy process. It involves a degree of introspection; an element of crystal ball gazing. But you need to ask yourself the "what if?" questions every year. Once you have done this you can relax to some extent and manage the practice with the help of the resultant budgets. However, unless you speculate and look into the future your practice will never improve and you will always be reacting to circumstances beyond your control. Planning ahead will improve the health of your practice and the service you offer to your patients. ☐

Next month's article will look at the business health warnings that the typical practice might face.

An unhealthy practice?

Practices, just like patients, can exhibit early warning signs of poor health. Professor Paul Burns takes you through the business symptoms, diagnosis and treatment



Paul Burns is Professor of Small Business Development at Cranfield School of Management

Doctors are used to analysing symptoms, making a diagnosis and prescribing a cure. You can apply the same discipline to the management of your practice. Any ailing business will exhibit symptoms. If they are ignored the condition will worsen. The practice check-up outlined in last month's article should help you spot the symptoms. But how do you go on to make the diagnosis and prescribe the cure?

The four examples that follow are just some of the management problems that can face any practice —the symptoms. The diagnosis and treatment needed to solve the problems are not always obvious.

Here today, gone tomorrow

General practice is about people and your practice is only as good as you and your professional and administrative support staff. Absenteeism or high staff turnover is a sure sign that something is wrong in the practice. If not acted on quickly, this symptom will start to affect other aspects of the performance of the practice. There are two possible causes: working conditions or your own management and supervision of staff.

Pay and conditions are normally externally determined in the health service. However, many management studies reveal that pay is rarely a prime motivator for any level of staff. Only if it falls below a certain acceptable level does it become a demotivating factor. The conditions in which people work are important because they indicate to them how much you care for their welfare. If you expect people to work in a poor environment you need to compensate them in some other way.

Keep them motivated

Most people want the chance to practise skill or to use intelligence at work. Intelligent, skilled employees are happy to accept responsibility and authority. They want to move on to more challenging situations and will continue to make increased efforts to cope with them. If you cannot provide this your staff might be getting bored.

However, most people are motivated by achievement—the satisfaction of making a meaningful contribution—and recognition when they make that extra effort. As the manager of your professional and administrative team, it is your responsibility to ensure that your staff are well motivated and content, while making certain that they work hard and effectively and are prepared to put in extra time and

effort when needed. If you fail to motivate your staff, they may vote with their feet. To avoid this, check whether:

- You are doing all you can to make their work interesting, challenging and demanding
- They know what is expected of them and when they are meeting your own high standards
- Rewards are linked to effort and results.

Doctors are often very good at communicating with patients. It pays to extend the same principles to dealing with staff. If you encourage participation you will generally improve the sense of involvement with the practice and cut absenteeism and labour turnover.

Cash flow problems

Every business needs to guarantee sufficient cash to pay creditors and staff and make some income for the owner. General practice is no exception. Partners like to have a regular monthly income and if there is insufficient cash flow in any month to ensure this they are likely to spot this symptom fairly quickly!

The problem could lie with a lack of financial planning or inadequate controls over income and expenditure. Every practice should prepare a cash flow budget annually. So, if you can predict fluctuations in your monthly cash flow—due perhaps to purchasing some large fixed asset like a computer or a car—you can plan to do something about it, even if it's just by borrowing from the bank. As overdrafts become not only more expensive, but also harder to get the need for accurate cash flow planning becomes even more essential.

Once you have your budget you need to keep to it. And if a cash flow crisis still creeps up on you, the problem needs to be investigated further. What is the cause of the budget variance? Are you claiming all your allowances from the FPC? Are you claiming them as soon as you can? Is the FPC slow in paying up? If it is expenditure that is out of line with your budget you need to find out what the expenditure is. Is it worth while? Can it be reclaimed from the FPC? Is it a one-off payment or is it likely to be repeated in future months and therefore cause cash flow to deteriorate further?

However, sorting out this month's problem is only the start. You need to put in adequate controls, sufficient to ensure that the problems don't surface again. Unless you do that, all you have succeeded in doing is disguising the symptoms rather than prescribing a cure. The real answer is good budgeting and regular, prompt monitoring of the financial results.

Those elusive targets

The new contract sets targets for certain services like childhood immunisations and cervical smears. It remains to be seen whether these targets are actually achievable in many practices. However, if they are, then failure to meet them will hit your pocket. You must check your call/recall system.

You cannot hope to deliver screening and preventative services without an accurate, up-to-date patient index. This must hold details of age, sex, location and address so that you can target different patient groups. While these records could be entirely manual, the ability to store, sort and access this information on a computer yields significant time savings.

Computer-based systems are only as good as their operators. You need to ensure that one member of staff has responsibility for updating

Prescription for an unhealthy practice

	Diagnosis	Treatment
Absenteeism or high staff turnover	Poor working conditions	Check: Pay and conditions Working environment Job definitions Career progression
	or	
	Poor staff management	Check: Communication Motivation Management attitude
Cash flow problems	Poor planning	Check: Budgeting procedures
	or	
	Poor controls	Check: Financial controls and monitoring procedures FPC income and expenses
Inability to meet screening and preventative services targets	Poor call/recall system	Check: Accuracy of records, systems and procedures
Support service breakdown and bottlenecks	Work overload	Check: Volume of work Staff selection, staff training, staff control

the information and sending out the call/recall letters regularly. It's a good idea to review these letters. They should be personal letters, not circulars, and they should be strongly worded, giving a firm appointment and a clear indication of the risks the patient might face if they do not attend the appointment, or the health advantages offered if they do. Patients, just like doctors, receive dozens of circulars every week. The point is to ensure that your letter does not go the same way as most junk mail.

Poor support?

Have you ever faced the situation where your support system starts to go wrong—patient records go missing, appointments are double-booked, vital supplies are not ordered? Symptoms like these can rapidly lead to chaos in a general practice. The diagnosis is simple—work overload—but is the cause simply too much work or is it more to do with staff selection, training and control?

Recruitment is a vital management task because you will usually have to live with the results for a considerable time. See last month's *Briefcase* for a useful guide to the process.

Once staff are in post they still need to be developed. People learn to perform well from close observation of role models and being in challenging situations that require initiative. However, doctors often cannot give staff the close supervision and personal training that is needed, particularly when the member of staff has just joined the team. Also, the skills needed for a new job may be ones that are not already present in the practice. This is where formal training comes in.

There are a variety of management training courses both for GPs and for practice administrators. These are often run by local colleges of higher education but also by private sector organisations. The national series of conferences, "The Healthy Management of General Practices", (run by BUPA) attracted over 2,000 GPs and practice managers last year and will be repeated in autumn this year. The Association of Health Centre and Practice Administrators offers a Diploma in Management using distance learning material from the Open University School of Management. The Small Business Programme at Cranfield offers distance learning material to help with management development within any small organisation.

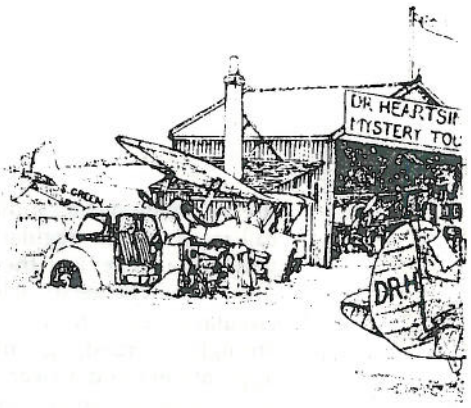
Choosing a training course involves analysing the needs you and your staff have, and their career objectives. If training courses match these objectives, needs and timescales, then they might be appropriate. But check their content, quality and practical relevance first. You can augment formal training with work discussions and development projects. Even getting staff to read articles like this will help!

Staff development is not a one-off activity. It must be worked at continuously. Your staff need to have new work challenges, but they also need to have the tools to help them cope with the challenges.

Next month—The Pound-Watcher's Guide to Practice Budgeting

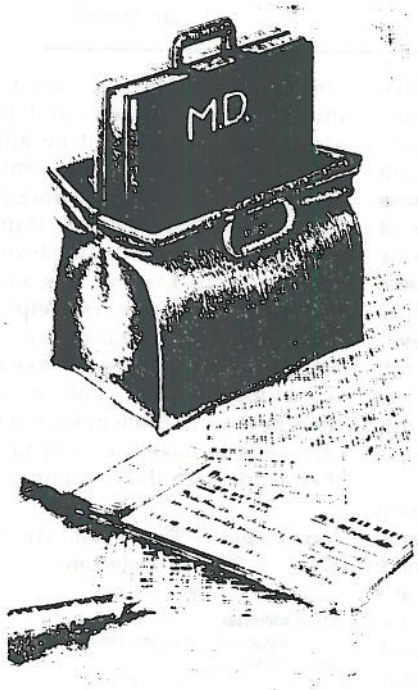
Useful addresses:

1 The Association of Health Centre and Practice Administrators
14 Princes Gate, London SW7 1PU
2 BUPA (Provider Affairs), Provident House, Essex Street, London WC2R 3AX
3 The Small Business Programme, Cranfield School of Management, Cranfield, Beds MK43 0AL
Tel 0234 750414



Dead reckoning beats flying blind

Budgets can do far more than simply record transactions: carefully kept and suitably projected, they can control the direction in which the business moves, and when it can do so. Professor Paul Burns provides the navigational aids



Paul Burns, Professor of Small Business Development, Cranfield School of Management

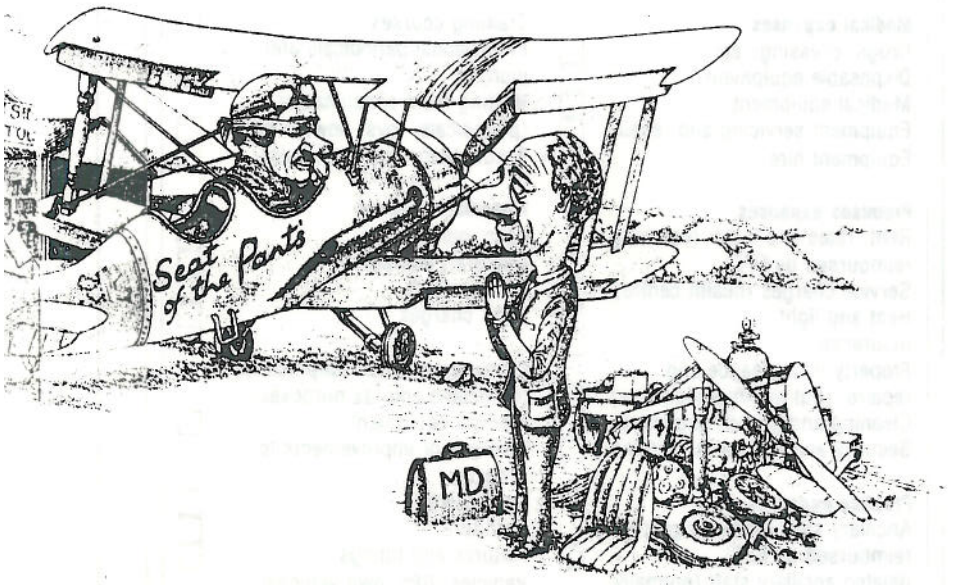
If you don't know where you are going any road will do. Good budgeting forces you to consider where you want to go and how you are going to get there. We all do it instinctively, even as children: "I've got £1.50 today. If I go to town, the bus fare is 35p each way. That leaves me 40p for sweets and 40p for a comic." A more sophisticated child might have tried out the "what-if" questions on the budget: "What if I walk to town but get the bus back. That would give me an extra 35p and, rather than sweets and a comic, I could buy that toy for £1.15".

The business budget

So what changes as adults? Firstly, things get more complicated, often because there are certain conventions to be followed about how budgets are drawn up and laid out. Secondly, business budgets tend to stretch further into the future than day-to-day household budgets. The latter is especially important for GPs, who are notorious for running their practices on a 'fire-fighting' principle, lurching from one minor (hopefully!) crisis to the next and dealing with each one on an *ad-hoc* basis. In other words, there is often a complete failure to distinguish what is *important* from what is *urgent*. The point is that, had you done your budgeting a year ago, these problems might never have arisen; even if they had, you would have been better prepared to cope.

So, should you get a professional accountant to prepare your budgets, leaving you free to practice medicine? The answer is definitely "no". An accountant can certainly put the framework together; no doubt it will be well presented, and the bill for it will be large. But the GP still has to provide the basic information: you must tell them how you want to run your practice.

A computer can help, if you invest in a "spread-sheet" programme. But time must be invested in learning how to use the programme, and you must still provide the basic information, which means working out what the computer needs and how to supply it. Ordinary pencil and paper are usually the best hardware for putting together the first budget.



The computer comes into its own only once you have grasped the essential principles.

Finally, budgeting is not an academic exercise. It is pointless to prepare a budget and then to tuck it away in a drawer as if it were an end in itself, with no further use. You constantly need to check your prediction against actual results, and possibly revise your projections in the light of what happens.

Practice income

FPC income (quarterly)		**FPC reimbursements (quarterly)**	
Capitation fees	☐	Surgery rent	☐
New registration fees	☐	Surgery rates and water	☐
Basic practice allowance	☐	Ancillary staff (including NIC)	☐
Seniority payments	☐	Related ancillary staff	☐
Immunisation and screening payments	☐	Locum fees	☐
Training allowances	☐	**Other income**	
Teaching medical students	☐	Hospital and other part-time appointments	☐
Allowance for minor surgery payments	☐	Life assurance examinations	☐
Child health surveillance payments	☐	Cremation fees	☐
Health promotion clinics fees	☐	Private patient fees	☐
Night visits fees	☐	Special reports and medical services	☐
Rural practice supplement	☐	Dispensing drugs	☐
BPA deprivation supplement	☐		

Putting the budget together

Management textbooks on budgeting all point out the need to draw up three documents:

- A cash flow forecast, which is concerned with day-to-day money coming in and going out
- A profit and loss 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 highlights the assets and liabilities of the practice and points out the sources of purchasing funds.

In fact, most GPs are safe drawing up only a cash flow forecast because, in business terms, their activities are relatively straightforward and, except for one major item the difference between their cash flow and profit is likely to be relatively minor. The major item that often causes problems is capital expenditure—computers, cars, improvements and so on. With profit estimates you allow for depreciation of an asset over its useful life. Cash flow recognises the cash expenditure immediately and is the more prudent method of assessment.

Budgets are especially useful in one respect; they allow you to calculate how much you and your partners can safely draw out of the practice each month. Most GPs want a regular monthly income and, given the current rates of interest, prefer not to go into overdraft. If, after using a cash flow budget projection, you still need to borrow money, you can approach your bank manager to arrange a facility and, possibly, negotiate a more attractive rate of interest.

The cash flow forecast

A cash flow forecast gives a month-by-month account of the cash that should be coming into the practice and the cash that should be going out. It is essential to estimate not only the amounts of cash income and expenditure, but also their timing. Normally, this should be relatively straightforward, since the main items of cash income and expenditure can be predicted with some certainty. However, most GPs have experienced some problems predicting FPC income this year under the new contract. Start by predicting your practice income. This falls into three broad headings: FPC income, FPC reimbursements (both received quarterly) and other income. Checklist 1 can help ensure that all income is included in the estimates.

Next, you predict your cash expenditures. These fall into eight broad headings, as outlined in Checklist 2. Most expenditures are fixed costs that can easily be predicted. When it comes to capital expenditure, "what-if" questions are worth trying: What if I delay purchase? What if I lease or hire rather than purchase? You may need to take professional advice before making your decision.

Taxation is a major cash expenditure for any practice. Staff PAYE and NIC must be paid monthly, but partnership taxation is paid in two instalments—on January 1st and July 1st. These payments relate to partnership profits in previous years. They are likely to be large, and it might be prudent to avoid further large expenditures, such as on capital items, in these months.

The whole exercise can be pulled together using the cash flow forecast worksheet, with a month-by-month projection over the coming year. Each month, you should be able to work out the surplus (or deficit) of receipts over expenditure. If you add that to (or subtract it from) the balance in the bank at the beginning of the month, you will arrive at an estimate of the balance at the end of the month.

Most GPs would perform this exercise at least twice. The first time—without inserting a figure for partners' drawings—allows them to make a judgement about the level of drawings that is appropriate to each month, and to look at any expenditures that might be avoided or postponed. Having made these decisions, they complete the final cash flow forecast.

The advantages of budgeting

Be warned that some people become preoccupied with the detail of budgeting and fail to realise that the process of thinking systematically about the future of the practice is important, as is planning to make the most of the resources you have. The process causes you to question and re-evaluate your original plans.

Once the budget is in place, it can be used to manage the practice on an exception basis. As long as results correspond to the plan then, *prima facie*, no corrective action, or indeed further investigation, is needed. This saves you time and helps you concentrate your managerial effort in the areas that need it. Without a budget you are flying by the seat of your pants, reacting to problems—real or otherwise. You can only control your practice if you plan ahead, and that involves preparing budgets. ☐

CHECKLIST 2

Practice cash expenditures

Medical expenses
- Drugs, dressings etc ☐
- Disposable equipment ☐
- Medical equipment ☐
- Equipment servicing and repair ☐
- Equipment hire ☐

Premises expenses
- Rent, rates and water (normally reimbursed by FPC) ☐
- Service charges (health centre) ☐
- Heat and light ☐
- Insurance ☐
- Property maintenance and repairs (but not improvements) ☐
- Cleaning and garden expenses ☐
- Security and fire alarm systems ☐

Practice expenses
- Ancillary staff (normally partly reimbursed by FPC) ☐
- Related ancillary staff (normally partly reimbursed by FPC) ☐
- Staff pension schemes ☐
- Deputising service fees ☐
- Locum fees ☐

Administration expenses
- Telephones ☐
- Answering services ☐
- Paging equipment ☐
- Printing and stationery ☐
- Professional subscriptions ☐
- Training courses ☐
- Professional periodicals and journals ☐
- Waiting room consumables (periodicals, toys, flowers etc) ☐
- Accountancy and legal fees ☐

Financial expenses
- Loan interest ☐
- Overdraft interest ☐
- HP payments ☐
- Bank charges ☐

Capital expenditure (depreciated for income and tax purposes)
- Medical equipment ☐
- Changes or improvements to property ☐
- Computers ☐
- Furniture ☐
- Fixtures and fittings ☐
- Vehicles (GPs' own vehicles are best left as individual expenses) ☐

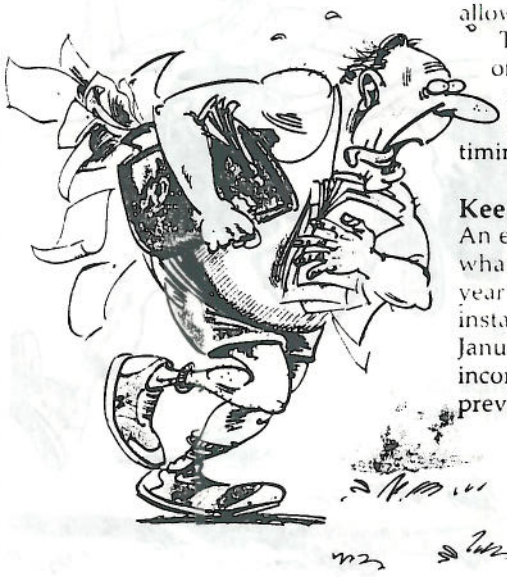
Taxation
- Partnership taxation (Schedule D) ☐
- Partners' NIC ☐
- Staff PAYE and NIC ☐

Partners' drawings ☐

TAXATION How to get the timing right

Tax returns are best approached as a carefully prepared marathon, rather than a desperate sprint. Paul Burns goes over the timing, recording and attention to detail that make for an easy—and profitable—run

Paul Burns is Professor of Small Business Development at Cranfield School of Management



As self-employed, contracted sole traders, GPs enjoy a familiar range of tax allowances not available to employees on PAYE. The main points to remember about allowable expenses are:

- All practice and personal expenses must be properly recorded
- Claim all the allowable expenses and capital allowances you can
- Time expenditure carefully; purchasing equipment towards the end of the accounting year means that you get the benefit of capital allowances more quickly.

These are all part of the routine of a well-run practice. However, one aspect of the tax regulations is easily overlooked: the timing of payments.

Keeping good time

An established practice pays tax on what is known as the 'preceding year' basis. This means that the tax instalments that are due every January 1st and July 1st relate to income earned at least nine months previously.

The income tax year runs from April 6 to April 5. The Inland Revenue assesses the taxable income over the *accounting year* ending in the previous tax year. The table shows that the most advantageous accounting year end, from a tax point of view, is April 30. Twenty months will pass before the first half of the tax due must be paid. The worst year end is March 31, as this gives only a nine-month delay. For GPs receiving quarterly FPC income the most practical year end is probably June 30 (a delay of 18 months); it could be too time-consuming to estimate income for April. At current interest rates, it is of obvious benefit to keep the cash needed to pay your practice's tax bill on deposit for a few extra months!

Changing partners

An opportune time to consider changing the tax year end could arise when a change in the partnership occurs. Normally, if an existing partner leaves or a new one is taken on, the old partnership is deemed to have ceased and a new one started. The 'preceding year' basis does not apply for the tax year in which the old partnership ceases. The taxable income earned from April 6 to the date of cessation is assessed. What is more, if the change means that you might have to pay more tax, the Inland Revenue may review the two previous tax years and reassess them. Whatever they

decide, the effect is that one year's profit will not be assessed to tax.

In the first four tax years of the new partnership, tax will be assessed on profits earned in the same tax year. However, if all the partners in both the 'old' and the 'new' practices agree, an election can be made to tax the practice as if there had been no change in partnership, ie on a 'preceding year' basis right through the period of change. Accountant's advice is invaluable for this process.

Allocating tax to partners

Taxable income is allocated between partners according to the profit-sharing agreement for the year in which the income is assessed, not as income was shared in the year when the income was earned. When a tax election for continuing the partnership is made, the new partner could be taxed on profits earned before he or she joined.

It is a good idea to plan partnership changes very carefully. It is worth taking professional advice to ensure that arrangements are made to minimise the tax bills of all concerned, while ensuring that the practice can pay its tax bills on time without unfair burden on any partners. Generally speaking, an election to continue on a preceding year basis would be worthwhile, if practice profits are rising and can be expected to do so after the change. This keeps up the element of delay on a rising tax bill. If, however, income is expected to fall after the change, a cessation is preferable; the cash could be made available to pay the higher tax bills straight away instead of trying to finance them later from lower income.

When do you pay tax?

Accounting year ends in tax year 6.4.89–5.4.90

Practice assessed for tax in year 6.4.90–5.4.91

Tax paid January 1st and July 1st 1991

How much delay in paying tax

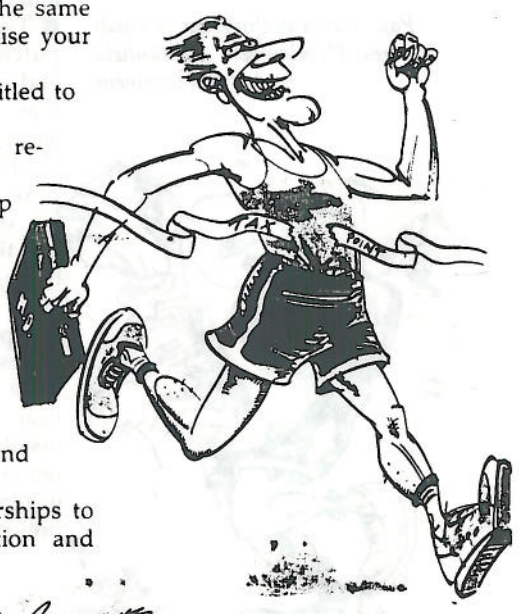
	Accounting year end	First tax payment	Delay (months)
Practice A	31. 3.90	1.1.91	9
Practice B	31.12.89	1.1.91	12
Practice C	30. 6.89	1.1.91	18
Practice D	30. 4.89	1.1.91	20

Secrets of taxation

One secret of partnership taxation is to tackle the problem in the same way as you would maximise your practice income:

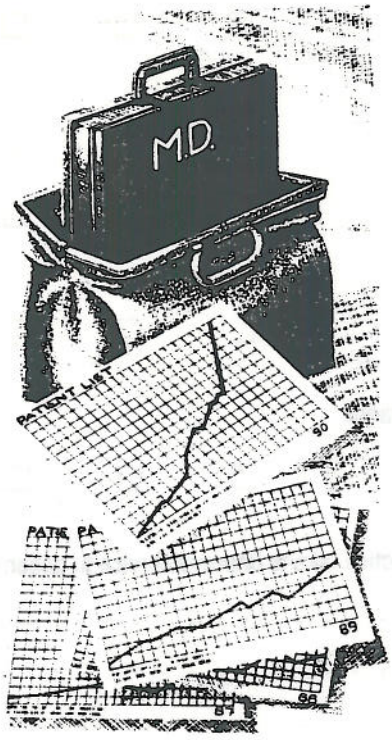
- Know what you are entitled to claim for
- Keep full and accurate records, so that your tax accounts can be drawn up correctly and, if the Inland Revenue wish to investigate, everything is clear and above board
- Check that you have claimed all expenses and allowances
- Plan carefully when you purchase equipment and your car
- Plan changes in partnerships to take advantage of cessation and recommencement rules. Consult the accountant in advance
- Plan the year end to benefit cash flow—select April 30 or, for administrative convenience, June 30.

Finally, plan ahead to ensure cash will be available to pay the tax bill. Even if all opportunities to put off the evil day are taken, tax must be paid in full on the due dates; otherwise interest, and even penalties, will become payable. Prepare a cash flow budget. Take steps to ensure that sufficient funds will be available in the practice to meet the partnership's tax bill. Set up a deposit account if cash flows allow, or at least ensure that the practice's overdraft facility is sufficient. □



PATIENTS Are they being served?

Customer care has found a new lease of life in the business community of the 1990s; Paul Burns applies some basic principles to surgery logistics, with the emphasis on facilitating communication



Paul Burns is Professor of Small Business Development at Cranfield School of Management

At the heart of the new contract is a belief that patients should have more say in how health care is delivered in the surgery. It introduces changes that are designed to allow patients to exert greater influence over GPs:

- Changing doctors is now easier
- GPs now have to issue practice leaflets
- FHSAs must publish local directories of family doctors
- FHSAs must conduct consumer surveys to highlight how services can be improved.

These changes will make it easier, not only to attract more patients (if you want to) but also to lose them if they are dissatisfied with service. The contract gives GPs monetary incentives to increase their practice lists and to offer a range of health services. It is only a matter of time before FHSAs start monitoring the level of service offered by local practices and add the "stick" to the financial "carrot".

What patients want

It is an ancient truism that business success often depends on understanding what the customer wants. A consumer survey in *Which* magazine last year asked over 2,000 patients about their consultations with GPs. These "customers" were far from "satisfied". Five out of the top six responses involved better communication:

- 91 per cent wanted more time explaining illness
- 89 per cent wanted more time listening to patients
- 84 per cent wanted more information about hospitals
- 82 per cent wanted more time explaining drugs
- 80 per cent wanted more helpful receptionists.

These figures seem to suggest that, for all the progress that has been made in communications skills within the consultation, there is still some way to go. Unfortunately, listening and explaining consume large amounts of a precious commodity: consultation time. If the patient must be satisfied as well as treated, it would be as well to consider whether "outside" factors contribute. If they do, perhaps the process can be streamlined before patient actually meets doctor.

Developing attitudes

Service starts at the telephone. It is important to have enough phone lines available to ensure that patients are not frustrated by finding all their calls engaged. A helpful response from the receptionist is the next essential. It is easy to forget that patients phone when they are "not at their best", as well as being worried, and that not all of them are

used to the telephone. They need to be put at their ease as well as dealt with efficiently.

Most patients prefer an appointments system, but unfortunately illness seldom waits for a gap in the diary. The key to making waiting acceptable is information. Patients' time is also precious; their impatience can be eased by letting them know how long they may have to wait, and any reasons for an unexpected delay. The receptionist can make the world of difference by being attentive to the needs of the patients. For example, judicious queue juggling can address the "bored child frustration effect" to the satisfaction of child, parent and other waiting patients.

Running a patient-centred practice requires a commitment to customer care by all the staff. They need to be motivated and trained to undertake the task. If they believe you mean it, they will come up with suggestions as to how the practice can be improved. It could prove very useful to ask patients what they think of the level of service. If they fill out cards on each visit, rating practice performance in certain key service areas, it will highlight strengths and weaknesses, and encourage staff to maintain standards. The checklists opposite and on page 712 could lay the foundations for such feedback.

Computer databases

Computer programmes and databases can offer the chance to improve patient service. They are beginning to prove valuable in helping to achieve targets for immunisations and cervical smears, by allowing personal letters to be sent

CHECKLIST

Practice services: patients' views

	Good	Average	Bad
Communication			
How good is the practice at listening to patients and explaining problems?			
Doctors	☐	☐	☐
Nurses	☐	☐	☐
Reception	☐	☐	☐
Telephone			
How easy is it to get through to the practice to make an appointment?	☐	☐	☐
Is the receptionist courteous and helpful on the telephone?	☐	☐	☐
Seeing patients			
How easy is it to see the doctor?	☐	☐	☐
Is the receptionist courteous and helpful face-to-face?	☐	☐	☐
The practice environment			
How would you describe the waiting room?	☐	☐	☐
How would you describe the waiting room facilities?	☐	☐	☐
Practice leaflet			
How would you describe the practice leaflet?	☐	☐	☐
Other services			
How would you describe the range of other services offered by the practice/health centre?	☐	☐	☐

Suggestions

What other steps could the practice take to improve service to patients?

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LEADERSHIP
Doing it in style

GPs have a perceived authority that goes with being a doctor. But this can work against you as a manager. The key to effective leadership and management is flexibility—the ability to adapt your style to suit the circumstances. Paul Burns and Jean Harrison outline the options and the consequences

Paul Burns is Professor of Small Business Development, Cranfield School of Management
Jean Harrison is Deputy Director of the Small Business Programme at The Open University

General Practice is all about people: staff as well as patients. The quality of patient care is determined by the quality of the health care team. This team has to be nurtured and developed. Members cannot always be allowed to just do as they please. As Peter Drucker, a well-known management guru, said: "The only things that evolve by themselves in organisations are disorder, friction and malperformance." The modern GP must be a leader, a team-builder and a manager of a local health resource. Yet how many GPs are trained in managing people?

If you believe your health care team is important, you need to organise your staff properly. That means recruiting the right people for the right jobs, ensuring that they know what is expected of them, and then monitoring performance. It also means that you build a positive relationship with them, helping the individual to develop into, and perhaps beyond, the job. Try answering the 'Do people matter?' checklist on page 36. It will give an indication of whether you are organising your staff effectively.

Problems with communication and continuity of care inevitably arise, compounded by a range of factors, from conflicting opinions to poor interpersonal skills. Organising the people in the team has a direct bearing on the quality of patient care provided by the practice. In a climate in which it is fast becoming impossible for the GP to have a detailed input into all the functions of the practice, time spent on planning how to organise practice resources to maximise efficiency may have a considerable effect, both on patient care and on the doctor's personal health and well-being.

The management cycle

The tasks involved in managing people are often seen as a series of separate topics. Indeed, they are generally treated as such in many management training programmes, mainly so that the material can be conveniently organised. Ignoring the interrelationships of the activities often means that some tasks are given less time than others, with potentially disastrous effects. It is safer to look at the whole process as a continuous loop system (diagram, page 35) which features interconnecting activities of equal importance. If any one part of this system fails, the whole thing rapidly grinds to a halt.

Implementing this approach will normally require reorganisation, as opposed to organisation, a reap-

praisal of existing attitudes and a restatement of the objectives used to assess the efficiency of the service currently provided. This is true for the practice, the team and the individuals involved.

The doctor as manager

No matter how effective the service provided by a GP inside the consulting room, much good work can be ruined, in the eyes of the patient, by inept service outside it. The whole health care team needs to develop the doctor's 'bedside manner' and exercise discipline and objectivity, tempered with sympathy and understanding. It seems to be the doctor's responsibility to provide the role model, both as leader and as manager; sadly, many GPs have had little or no formal training to deal with this.

Management style

Few people possess all of the skills needed to undertake the activities listed on page 45 and our personalities and idiosyncrasies often hamper the objectivity needed to control and direct management activity. While there is a strong link between personality and management style, they are not the same. Attitude towards the people who work for you is always an important factor in determining your management style.

Consider these alternative views of people:

- Most people require incentives to work for others, dislike authority, are slow to exercise self-discipline or self-control and are basically lazy. They need to be persuaded and pushed.
- People are self-motivated, are proud of their skills and keen to use and develop them. They like to have a level of autonomy, but work better if they are organised effectively to make maximum use of those skills.

These two extreme views are taken from a recognised study of worker motivation—McGregor's theory X (the former), theory Y (the latter). The majority of managers have elements of both views in their own style, and will shift emphasis depending on the situation—the individuals involved, the type of task, the objectives, the time-scale, etc. Your own style will almost certainly have at least two interpretations: yours and your employees'. Different types of workers tend to operate more effectively under one approach than the other. For example supervisory, professional or specialist tasks are often carried out by people who prefer a degree of autonomy and need scope for personal and job development. Studies of routine clerical jobs have shown that a theory Y approach does no less and no more than a theory X approach in terms of increasing productivity, since this type of employee typically works to support outside interests, and may not be concerned with how his or her performance affects the unit as a whole.

The appropriate managerial style depends not only on the workers and their situations, but also on your personality and the style of management with which you are most happy

McGregor's simplistic approach is over 20 years old. It is now recognised that the appropriate managerial style depends not only on the workers and their situations, but also on your personality and the style of management with which you are most happy. There are a number of models designed by organisational theorists, identifying four styles:

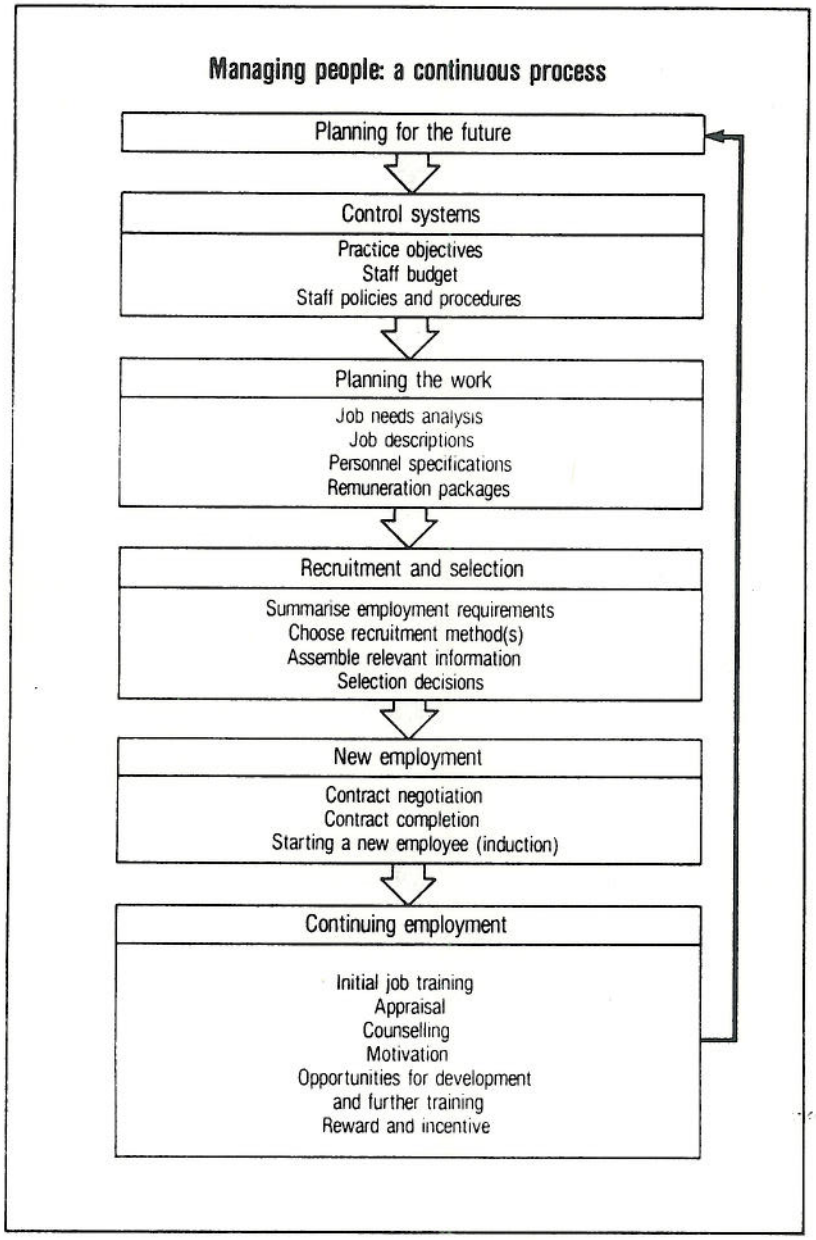
- Autocratic: the manager makes all the decisions and tells the employees what they will do
- Paternalistic: the manager makes all the decisions, but sells them to the work-force
- Consultative: the manager discusses the decision with others who may be concerned with the issue, and listens. The manager alone then makes the decision
- Participative: the manager discusses the decision with the workforce and they take the decision as a unit.

These styles reflect both the level of autonomy given to employees and the level of flexibility in the hierarchy of your organisation.

Matching style to task

The autocratic and paternalistic (also known as directive), styles are useful for managing routine tasks in which procedures are not subject to frequent change, or for situations in which fast decisions need to be taken. Neither offers employees much individual freedom of action, and both must be based on accurate information.

More complex situations, requiring an analysis of a range of different information and input from a variety of skills, are often best approached by a consultative



or a participative style. These styles are supportive and generally encourage co-operation and flexibility.

The participative style is best suited to professional partnerships —but beware: decisions still have to be reached. Guidelines help the complex process of reaching consensus. Each manager will have a style that is reflected in how the organisation works and how employees relate to the manager. A general practice is likely to adopt a participative style between the doctors, a consultative style with other professional groups, and a consultative or paternalistic (and often autocratic) style with administrative personnel, depending on the nature of the decision and level of competence of the individual. It becomes clear that management style involves a high degree of flexibility.

The doctor as leader

Management is about efficiency. Leadership is about setting goals, inspiring the team to achieve goals and ensuring that everyone is moving in the right direction. Leadership has to take account of the leader, the people who are led, the job to be done, and the environment within which the whole practice operates. Effective leaders change their styles and approaches as necessary.

Leadership has three key roles. These often conflict and overlap, but an effective leader must combine all three, albeit in differing proportions to suit different circumstances:

- Setting work objectives for the whole unit; promoting new ideas and work patterns (*Directional*)
- Ensuring that objectives are met through teamwork (*Organisational*)
- Championing the cause and providing a focus for the whole unit (*Inspirational*).

Leadership style

Power and authority are often associated with leadership, but both are difficult to define exactly. Power is a vague concept that implies physical or psychological superiority. By implication, it is a directive, compelling and sometimes threatening ability. Having authority, on the other hand, involves being in a position to get people to accept and act on your views willingly. Leadership has to rely on authority as a power base.

It is not difficult to imagine the doctor as leader. Traditionally, the doctor figure is seen as authoritative, eminent and expert. This view, although typical of the role, is often