SIMULATED INTERACTIVE MANAGEMENT SERIES

Article 7. Money, money, money. (Where does it come from, how do we control it, and how far should we go to get more?)

J Wardrope, S McCormick

Emerg Med J 2002;**19**:146–148

This is the seventh article in a series on management within the emergency department. This article focuses on financial aspects, including budgets and funding.

To understand this article fully you must read the extra information on the journal internet site, www.emjonline.com

See end of article for authors' affiliations

Correspondence to: Mr J Wardrope, Department of Accident and Emergency Medicine, Northern General Hospital, Herries Road, Sheffield S5 7AU, UK; Jim.Wardrope@northngh-tr.trent.nhs.uk

THE STORY SO FAR . . . . . .

This series has created a virtual accident and emergency (A&E) department to highlight management issues. This "paper edition" is only a summary of the information available and a wealth of background information exists in emjonline.

The "Feedback" section allows reflection on previous problems and the "in tray" section provides a summary of the new papers and problems that have arrived.

The "task" section outlines the management tasks that you are being asked to consider. If you respond to these tasks by submitting your view to the *EMJ*, then one hour of external CME may be claimed and this is registered with the Faculty of A&E Medicine. Many readers have replied, some replies have been posted on the web site and in the near future we hope to include feedback from Australia. This will explore how the different health care, legal, and political systems affect the management of an emergency medicine department.

The "time out" sections explore some of the theory that lies behind management.

Good management practice dictates that we should actively seek the views of our customers, in this case that is you the readers. We welcome any feedback on the series and suggestions of major topics to be covered, especially if you are willing to be an author.

FEEDBACK

The runaway SHO has caused you a number of sleepless nights but was there anything you could have done differently? The case is now with the General Medical Council and out of your hands. Confidentiality was broken on the grounds of patient safety and the health of the SHO. Part of being an effective manager is realising what is your responsibility and what is not. This is no longer your problem and it is time to move on and deal with the active problems of the department.

The offer to sponsor the departmental advice cards has been turned down. The amount of income that this would have generated compared with the perceived hassle involved was considered insufficient. When the letter was brought up at a departmental meeting, there were a number of uneasy voices that were concerned that the sponsorship might be perceived as a direct recommendation of this chemist. Would there be a danger of losing some moral independence or even face pressure about prescribing patterns?

A similar line was to be taken on the school visits as neither Mr London nor Dr York felt they had "spare time" to carry out such public relations. However, Rebecca Devon heard about the letter and has asked if she could try and arrange visits with the school. The consultants have accepted this but they have asked for the visits to occur later in the year, as it will hopefully be quieter then. Remember, even if you are not interested in a project there may be someone else who is interested and to whom you can delegate. When delegating a task to a junior, you still remain responsible and must remain aware of progress and any potential problems that may arise. The degree of freedom given to the junior will depend on their level of training, experience, and your assessment on their management capability. Outline the issues Miss Devon should discuss with her consultants. The school outing to the department may be good public relations but runs the risk of having children in a functioning emergency department.

The personal injury report is on the internet. You may wish to review this and debate the opinion (see "in tray" tasks).

TIME OUT—SPECIALIST SUBJECTS

Finanace—where does the money come from

Maintaining financial balance is one of the key objectives of any organisation and perhaps should be for individuals. A&E is almost exclusively a publicly funded activity in the UK, therefore the financing is fairly straightforward (although always insufficient). This section will look at financial management at the A&E directorate level. How is the service funded? What is the difference between capital and revenue? What is a budget? How do you control a budget? For those interested in the finance of whole organisations such as Trusts, an introduction to the basics of reporting accounts for a large business is included in the internet section. (see St Jude's PLC).

Up until 1990 finance in the NHS was relatively straightforward. Money was allocated to district health authorities who in turn financed individual hospitals. This system had the value of simplicity but gave very little ability to control expenditure and to ensure value for money. It also

Table 1 St Jude's annual budget position at end of December. (–) indicates an under spend. The current position is an overspend of £112606 or 5.5% over budget

	Year budget	Budget to date	Cost to date	Variance	Establishment	In post
Medical						
Consultant	264100	198001	130687	–67214	3	2
Registrars	80318	60106	61004	1102	2	2
Staff grade	100467	75145	78341	3204	2	2
SHO	328399	246299	210900	–35701	9	8
Locum	0	0	85230	85230	0	
Total	773284	579551	566162	–13379		
Nursing						
grade H	36000	27000	26890	–110	1	1
grade G	180923	135692	136700	1008	5	5
grade F	98727	74450	72350	–2500	4	4
grade E	245799	184349	143300	–41049	8.5	7
grade D	281912	211434	167300	–44134	13	10
Support worker	0	0	0	0	0	0
Bank	0	0	108567	108567	0	5
Total	843361	632925	655107	21782	31.5	32
Admin						
Grade 4	43506	32629	33124	505	3.3	3.2
Grade 3	74421	55815	64820	5005	6	7.2
Grade 5	0	0	5689	5689	0	0.4
Total	117927	88444	103633	11199	9.3	10.8
Other						
Drugs	79240	59430	69850	10120		
Dressings	33740	25305	24200	–1105		
Sterile supply	56255	42191	42005	–186		
Appliances	4383	3287	4085	802		
Stationary	3860	2810	3040	230		
Travel	2892	2124	7604	5220		
Other	54774	41080	40980	100		
Training	4700	3525	1500	–2005		
Radiology	650000	487500	505000	17500		
Labs	130000	97500	114000	16500		
Total non-pay	1019844	764752	812264	47176		
Total	2754414	2065810	2137166	71356		
Cost improvement	–55000	–41250	0	41250		
Current position				112606		

bred inequalities in the system in that large expensive institutions were given more money and smaller DGH units might receive proportionately less. The NHS reforms of the 1990s tried to apply normal market ideas to health care. Health authorities became the "purchasers" of health care and acute Trusts the "providers". Contracts were set so that a certain number of operations/admissions/outpatient attendances were supplied to agreed standards by acute hospitals. Capital was no longer "free" but had to generate a "6% return" as Public Dividend Capital Dividend.

The effect was to put the NHS onto a psuedo-business footing. This made sound business and political sense and achieved greater equity in the distribution of resources and greater control. However, the cost was a step change in the numbers of staff required for contracting/accounting/monitoring and the new emphasis on costs might be a factor in staff demotivation. The trend towards the NHS being run as a business is likely to increase with more and more "Private Finance Initiatives" (PFI). One of a manager's major responsibilities is to remain within budget and financial discipline will be an increasing burden on all clinical managers.

Capital and revenue

Capital expenditure is usually characterised by "one off" purchases. Technically it is money that is spent on items that are going to benefit the business for more than one year. In practice in the NHS the lower limit for capital expenditure is usually regarded as £5000. Such money is usually needed to provide buildings and equipment. Up until recently this money all came from the government. Most capital in the NHS is meant to generate a "6% return" on the "investment". Trusts receive an annual "block allocation" for small capital items. Major capital projects are subject to a detailed business planning process and increasingly the private sector is involved through the PFI.

Revenue expenditure is the money used to pay for items used within one year. This includes staff pay, drugs, costs of tests, consumable items.

Revenue income is generated by operating the business, in the A&E department this is mainly the income from treating patients. At present this money comes from district health authorities. It is not yet clear how A&E services will be delivered when commissioning is devolved to Primary Care Trusts (PCTs). Each locality might have a different system but PCTs are going to be much more influential in budget stetting in the future. There will be some allocation for providing teaching and research through the Service Increment for Teaching and Research (SIFTR), perhaps some grant research income. There are small amounts from other sources such as recharges to insurance companies for the care of road traffic accident victims or for the provision of copies of notes to solicitors.

Budget setting

If we were starting St Jude's as a business we would need buildings, equipment, supplies, services, and people. All of these elements require money. We would have to estimate how many staff we need, costs of that staff, and the costs of supplies and services. All of these costs have to be paid on a continuing basis and thus would be recurring costs. Some equipment purchases might be recurrent, but buildings and larger items of equipment would normally be regarded as capital costs. Adding up all our recurring costs along with the "mortgage payments" and devaluation cost on capital would allow us to develop an estimate of the amount of money we

Box 1 Common additions/subtractions used in yearly budget setting

Inflation—each year costs of employing people and buying goods increases and NHS budgets are adjusted by a set amount to allow for pay and non-pay inflation.
Cost pressures—increases in budgets may be given to allow for increases in expenditure over which the manager has no control, for example increased costs due to a national agreement on rates of pay for out of hours work by junior doctors.
Service improvement—increases in budgets may be given to allow an increase in the level of service, for example the appointment of a new consultant.
Cost efficiency savings—all NHS trusts are expected to reduce budgets each year by a set percentage, typically 1% or 2% per year. This is a common business practice and is designed to ensure that any unnecessary expenditure is removed from budgets. However, in service with chronic under resourcing problems this logical device can mean cuts in the level of service provided.

Box 2 Summary of information on the internet

Internet intray

St Jude's diary
Note of conversation with Sister Oak
Letter from paediatrician
Clinical problem—a patient has arrived unconscious with an advanced directive!

Internet information

Medical report
Paper on financial reporting

would need annually to provide our service. This type of "bottom up costing" is the logical way to start a budget setting process. However A&E budgets are almost never derived in this way. The commonest model is that of "top down" budget setting. That is the previous year's budget is used as a baseline with additions for inflation, cost pressures and service improvements minus "cost efficiency savings".

There may be increases for *cost pressures* but these are often subject to negotiation. Each trust has to add up all the cost pressures from different directorates and then go to purchasers of services to try and obtain further funding. This is not an easy process and the amounts obtained seldom cover the increased costs. *Service improvements* usually have to be fought for over a prolonged period, unless there is a legal need (for example Health and Safety) or a major political need (for example, cutting waiting lists). *Cost efficiency savings* are extremely difficult to find in A&E budgets. Fortunately these are subject to negotiations within Trusts and some A&E clinical directors spend a lot of time arguing about this part of the budget. It is critical that departmental managers become heavily involved in the yearly budget setting process, currently known as "Service and Financial Framework".

Budget control

Having derived the budget the next step is to *manage* the budget. There is some possibility of being proactive and using the budget in slightly different ways but most Trust's Standing Financial Instructions leave little room for manoeuvre. Most of the management of the budget is really just monitoring the expenditure against the budget and looking for variance. Table 1 shows a typical budget statement showing the expected expenditure, the actual expenditure and the variances. The reasons for variance must be explained. St Jude's seems to be overspending. What are the reasons for the overspend? How are you going to explain these to the chief executive? Can any action be taken to correct the overspend? These are some in tray tasks for this month.

Summary

The control of finance is a key part of the A&E manager's role. We have introduced some very basic ideas in budget setting and control. Fortunately the financial management of a UK A&E department is relatively simple compared with that of similar departments in the USA. However, we have only scratched the surface. Other financial issues will surface form time to time and you may wish to tell us if you want any other boring areas covered in the series!

TASKS

- Review your department's own budget
- Review your Trust's annual accounts, is there a balance sheet, income and expenditure statement, and a cash flow statement?
- Review the personal injury report. Examine the evidence base for period of disability after a simple neck sprain after a road traffic accident
- What action do you take when an SHO goes off sick? How do you fill the rota? How do you document it?
- How do you handle delegation of a task?
- How are you going to handle the paediatric management problem?
- How are going to handle the unconscious overdose patient with a living will?

ACKNOWLEDGEMENTS

We would like to thank Mr P Driscoll and Mr C Perez Avila for their helpful comments.

Disclaimer

Most of the characters and situations in this series are entirely fictional and any resemblance to any person of institution is coincidental. A few situations are based on real life but all the names have been changed.

FURTHER READING

Cole GA. Financial aspects of management. In: *Management theory and practice.* 5th ed. London: Letts Educational, 1996:411–23.
Williams RM. The real finances of the emergency department. In: Rosen RA. *Managing to get it right. The ACEP users guide to emergency department management.* Dallas: American College of Emergency Physicians,1998:67–74.
Donaldson C, Gerard K. *Economics of health care financing*. London: Macmillian, 1993.