Making finance work for you—strategic issues in clinical directorates

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This is the fourth in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson

The NHS has a long history of underinvestment interspersed with periodic bouts of overspending to relieve the ensuing crises. Strict cash limits make it unlikely that funding will match the multiple demands of an increasingly aging population, rising drug prices, and advancing technology. In this context it is difficult to perceive the finance function as a "flexible friend."

The restructuring of the NHS, with the formation of budget holding clinical teams (directorates) and self governing (trust) status for hospitals, and especially contracting, which brings together activity and financial data, means that clinicians now have the opportunity to influence the use of revenue funds in a more imaginative way than before, to improve patient care. Yet, many doctors view financial management as yet another mechanism for restricting clinical freedom. But doctors who participate actively in financial management within a sufficiently large clinical directorate can make finance work to achieve a clinical service of more uniform quality.

To illustrate the point, we have compiled a case history (box) which is not based on any one hospital or health authority. We begin with a clinical service directorate (surgery) and follow with a support service directorate (laboratory medicine).

Case study

Bottomless Memorial Hospital is a large district general hospital in an urban health authority which also contains one other general hospital and a specialist hospital for the elderly. The three hospitals have recently amalgamated to achieve self governing NHS trust status (Bottomless Trust Hospitals). There has been little or no collaboration between the hospitals in the past, but a new management structure with clinical directorates extending across all three hospitals has now been established by a new chief executive. A computerised clinical information system is also being developed as part of the NHS resource management initiative. Serious financial difficulties in both clinical and support services have yet to be resolved.

Clinical services (surgery)

The financial difficulties within Bottomless Trust Hospitals include surgery, which, for the current financial year, was funded by a contract for £3m (on a historical basis this would treat 3000 patients) that was not sensitive to workload (block contract). Six months into the financial year 1600 patients had been treated and actual expenditure was £1.7m.

The new surgical directorate was asked to rectify the situation by adjusting surgical activity to within budgetary guidelines. The availability of known costs for different patient categories or case mix enabled the surgical business manager to identify several factors that had contributed to the £0.2m deficit.¹ One hundred more patients than intended were treated in the six months—an extra cost of £100 000 above anticipated income. Case mix did not match that predicted, with more expensive patient categories predominating to create an unanticipated cost of £81 400.

Finally, one consultant led surgical team was more expensive (£18 600 additional cost over six months) than the others; this team also had a length of ward stay 1.5 days longer than average and a longer waiting list despite a similar case mix.

The following strategy was therefore devised by the surgical directorate.

Rationalise the surgical service—The service was rationalised across the two general hospitals, with the major surgical specialties transferred to Bottomless Memorial Hospital to allow the other hospital to concentrate on general surgery and day case surgery. Costs were reduced by converting some of the inpatient beds to day beds.

Calculate accurate costs—Streaming of surgical cases across hospitals in this way facilitated the calculation of the cost per case for laboratory tests, consumables, and length of stay. The surgical business manager was thus able to plan a better mix of high, medium, and low cost cases for contracting purposes, and proposed a move towards a new (cost and volume) contract which would be sensitive to workload.

Investigate variance in performance—Investigation of the cause of the longer than average ward stay of one consultant's patients revealed overcommitted junior staff and a consultant with insufficient sessions on that site. As a result, meetings of the clinical team to plan patient discharges and maximise throughput were irregular. Costs for drugs and consumables were also disproportionately high. Surgical sessions were rescheduled to reduce the consultant's commitments on the other site, and more frequent patient review rounds were agreed. The business manager also identified that the appointment of a part time laboratory phlebotomist from 7 am to 9 am would result in earlier blood count results and facilitate patient discharges.

The surgeons supported these proposals for rationalisation across the hospitals because they addressed their own concerns for clinical priorities, including quality of service to patients and advances in day case surgery, as well as addressing financial concerns.

Support services (laboratory medicine)

Laboratory services in the three hospitals had suffered from underinvestment, resulting in a build up of aging equipment and reliance on labour intensive work practices; staff accounted for more than 80% of costs. The chief executive had declared that a 10% savings target (recurring) was required from the revenue budget of £5m for the combined laboratories. The following financial strategy was therefore adopted by the pathologists.

ESTABLISHING THE CORRECT START BUDGET

While £5m accurately reflected the sum of each of the laboratory budgets, the pathologists identified hidden support costs within the finance, personnel, and other management services of each hospital. It was therefore agreed to transfer a further £0.1m to the new laboratory medicine directorate. The first financial objective, of maximising the start budget by accurately identifying all components, was therefore achieved.

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BMJ 1995;310:244-6

The pathologists realised that they would have to free sufficient income not only to meet the savings target but also to raise service quality in the future. This, they realised, could be achieved by amalgamating the historically separate analytical services of the three hospitals.

The Audit Commission has stated that laboratory savings can best be achieved by centralising the staff and equipment required for specialist tests.² As an acute laboratory service on the two district general hospital sites was an agreed quality requirement, there was no plan to centralise all diagnostic services to one hospital. It was therefore agreed to centralise to Bottomless Memorial Hospital those specialist and routine tests that did not require a result within four hours. A motorcycle courier service was contracted

"Support services need financial protection from unplanned and unfunded increases in demand by clinicians."

to provide a rapid transport link. To process the remaining work on the other district general hospital site the previously separate pathology disciplines were amalgamated into a single multidisciplinary laboratory which was relocated next to the outpatient-casualty areas and linked by a dedicated pneumatic tube delivery system to the intensive care unit. This improved the turnaround time of the results service, produced revenue savings, and eliminated the cost of additional instruments for near patient testing. The small laboratory at the hospital for the elderly was closed and the service thereafter provided from the central laboratory, making use of the courier service.

IMPROVING PREANALYTICAL AND POSTANALYTICAL SERVICES

Laboratories often lack control over their pre-analytical (blood collection, specimen transport) and postanalytical (return of test reports to clinicians) services. Both phases are critical determinants of laboratory response time, particularly when services are centralised; the completion time of test requests is becoming an increasingly important measure of quality for diagnostic laboratories. It was agreed that the laboratory medicine directorate would now hold the budget for phlebotomists and laboratory porters and drivers. This is a further example of correct identification of the start budget.

Computer systems are essential in laboratory medicine: benefits range from modification of the requesting behaviour of clinicians by the use of expert systems³⁻⁵ to the rapid return of results. Funds from the health authority's information technology budget were therefore allocated for a standard computer system to link all laboratories on the two sites and to link the laboratories with the hospital clinical information system. These improvements to the preanalytical and postanalytical phases of laboratory testing improved service quality.

INTRODUCTION OF ZERO BASED, FLEXIBLE BUDGETING

Support services need financial protection from unplanned and unfunded increases in demand by clinicians. This can be achieved for selected services by a combination of zero based and flexible budgeting. This entails a move from a fixed budget, allocated according to historical levels of demand, to a budget that can change according to the level of clinical

activity but which starts at zero. The required income is then recovered from each clinical directorate in proportion to use of the service. The blood and blood products budget and the on call service were therefore selected for zero based, flexible budgeting because the pathologists anticipated that they would have little control over demand; the budget holding clinical directorates, on the other hand, could audit their own use of these services.

LEASING RATHER THAN BUYING EQUIPMENT

In this case there had been no capital investment to replace the aging equipment and thereby increase efficiency through automation. The alternative was to lease equipment. Capital equipment funds have been eroded so frequently in the NHS that the leasing of equipment is becoming the favoured option in many instances. The pathologists found that the financial terms offered by instrument manufacturers were highly negotiable and favoured lease over purchase as capital charges were required to be paid on any equipment purchased by the directorate.⁶ Lease of equipment also included an attractive price for consumables. Thus the intrinsically higher costs of leasing were largely offset within the financial package, as well as by future revenue savings arising from automation.

Thus, by imaginative restructuring, the laboratory directorate created new financial opportunities. Investment in the laboratory service was provided by the chief executive for information technology and for refurbishing the laboratories, in view of the clear financial and quality benefits of the strategic plan. As staff costs still consumed more than 80% of revenue costs in the main laboratory a reduction in staff numbers by cross discipline working patterns and an alteration in skills mix was planned. This would generate further savings, facilitate a move towards a 24 hour laboratory service (replacing on call), and justify the cost of a pneumatic tube system to replace in part the portering service. Market testing of the laboratory service was not imposed by the chief executive as it would not have been timely to introduce this further variable during the agreed restructuring process.

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Conclusion

The strategies outlined in this case study incorporate several general principles that allowed finance to be used more effectively. The principal gain arose from the opportunity to rationalise services between previously separate hospitals and clinical teams. Such opportunities are now possible as a consequence of the restructuring of the NHS and should be used to correct the erosion of quality which often occurs when an inadequate budget is spread over too many cost centres. Unfortunately the formation of multiple self governing trusts within some health authorities limits such rationalisation, and as yet there is little experience of collaboration between trusts. Rationalisation does require team work, as opposed to the freedom of independent clinical units, but working as a team within a large directorate can achieve the critical mass required to maintain, and make more uniform, the quality of the service.

The strategy behind making finance work for you at clinical directorate level is not complex, the more

Key point summary

- Services can be rationalised (amalgamated) to address financial concerns, while still maintaining and even improving quality of service
- A start budget needs to be accurate: identify all component costs, including hidden support costs
- Centralise or rationalise staff and equipment for specialist tests
- To increase efficiency, computerise where possible, and consider lease rather than purchase of equipment
- Introduce zero based, flexible budgeting for selected services instead of a fixed budget allocated on the basis of previous demand
- Reduce staff costs, often one of the largest overheads, by cross discipline working patterns and a change in the skills mix of staff

detailed aspects of budget management being the responsibility of the directorate's business manager. What is more demanding at clinical director level is the

management skill required to implement change and achieve a synergy between the directorate and hospital management to ensure purposeful implementation of agreed strategy.

- 1 Perrin J. *Resource management in the NHS*. Wokingham: Van Nostrand Reinhold, 1988:86-141.
- 2 Audit Commission for Local Authorities and the National Health Service in England and Wales. *The pathology services: a management review*. London: HMSO, 1991.
- 3 Gama R, Nightingale PG, Broughton PMG, Peters M, Ratcliffe JG, Bradby GVH, *et al*. Modifying the requesting behaviour of clinicians. *J Clin Pathol* 1992;45:248-9.
- 4 Mutimer D, McCauley B, Nightingale P, Ryan M, Peters M, Neuberger J. Computerised protocols for laboratory investigation and their effect on use of medical time and resources. *J Clin Pathol* 1992;45:572-4.
- 5 Peters M, Broughton PMG. The role of expert systems in improving the test requesting patterns of clinicians. *Ann Clin Biochem* 1993;30:52-9.
- 6 Cook AN. The NHS reforms and the finance function. In: Spurgeon P, ed. *The new face of the NHS*. Harlow: Longman, 1993:46-71.

"Every Doctor is a Manager" is a conference being run by the BMJ, BMA, and British Association of Medical Managers to explore the issues around doctors in management. It takes place on 16 February 1994 in London; details from the BMA Conference Unit, BMA House, Tavistock Square, London WC1H 9JR. Tel: 0171 383 6605.

A book of the series, entitled *Management for Doctors*, will be published on 16 February to coincide with the conference; price UK £12.95; Overseas £14.00 (BMA members £11.95; £13.00). Order from the BMJ Publishing Group (tel 0171 383 6185/6245; fax 0171 383 6662).

Controversies in Management

Chemotherapy for solid tumours

Routine treatment not yet justified

G M Mead

This is the eighteenth in a series of articles examining some of the difficult decisions that arise in medicine

Most patients with advanced or metastatic cancer will at some point be considered for chemotherapy or, occasionally, biological therapy—for example, interferon. These treatments are of limited specificity and commonly result in short term toxicity; they may also be expensive. If cure or increased survival is a realistic possibility these considerations are important but do not alter the treatment approach. However, most cancers are incurable once metastatic and often respond poorly to chemotherapy, which can result in side effects, inconvenience, and financial costs without improvements in symptoms or survival. In practice, partly because of the limited resources available in Britain, chemotherapy is often not discussed with, much less given to, many such patients. Increasingly, however, patients demand access to all available options, and the issue then is should treatment be considered, and if so with single or multiple drugs (with of course variable toxicity and cost) given intensively or non-intensively? Common examples of these diseases include metastatic non-small cell lung cancer, colorectal and upper gastrointestinal cancer, and renal cell cancer. The table shows some of the treatments used.

Though no systematic reviews have been published, anecdotal experience suggests that management policies for these diseases vary widely between surgeons, radiotherapists, and oncologists and also within these groups. Approaches vary considerably between institutions and nations, and in the public and private sector. Desperate patients who seek second opinions may also expose these differences, as will enthusiastic forays into the media by patients or colleagues. The media often highlight new and

untested therapies without the tempering effects of peer review or trials. How should we judge treatment efficacy, and is it possible to achieve a consensus with regard to standard therapy for these diseases?

Assessing efficacy

Medical oncologists assess chemotherapy regimens by measuring clinical and radiological response rates together with "time to treatment failure" and survival. Additional and potentially very important end points are control of symptoms and quality of life, as assessed by the patient, and financial cost. In practice all of these variables require interpretation—and naturally patients and their families will have their own views on treatment goals.¹

Response rates are perhaps the most commonly used method of assessing efficacy of chemotherapy. Though these give data on the proportion of patients receiving treatment with no benefit, radiological shrinkage of solid tumours should not be overinterpreted, as it often has little or no survival benefit.² Toxic, expensive drugs such as aldesleukin for renal cell cancer³ and,

Treatments for metastatic cancer

Metastatic cancer	Standard therapy	Common alternatives used with uncertain advantage
Non-small cell lung	None	Any chemotherapy
Stomach	Fluorouracil	Cisplatin containing combination
Pancreas	None	Fluorouracil or combination
Colon	Fluorouracil	Fluorouracil plus folinic acid with or without interferon
Kidney	None	Interferon
		Interleukin 2

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BMJ 1995;310:246-8