Why your budget doesn't add up

David Bailey begins his series on accountancy for nursing managers by explaining why the NHS system is unfair on nurse budget-holders - and how it could be improved.

Is it right that nurse managers should hold budgets? Should we be holding nurses accountable for spending on their wards, in their departments and for their services?

These fundamental questions demand answers. They are highly relevant to nursing today, as the NHS has more nurse budget holders than ever before and the numbers are steadily increasing.

Devolution of budgets down to ward manager, outpatient department manager and community and day-care service managers has taken place throughout the health service. The NHS consumes vast quantities of public money and needs to manage it with a system which has clear lines of financial accountability. Yet has devolution of nursing budgets worked? Are we right to hold nurses to account?

Over the past decade, the NHS has institutionalised the conflict over budgets. Budgeting has been used to serve the accountant and not the nurse manager. Budgetary control systems have been designed around the needs of accountants to produce annual financial accounts and, more recently, to calculate prices of services for contracting, rather than assisting managers in controlling resources.

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which the ward manager could exercise some control was more than £4,000 underspent. The overspend on the total budget was therefore caused by a £10,000 overspend on non-pay, over £8,000 of which was solely due to drugs.

Figure 2 shows how the overall position of the ward budget differs if drugs costs are excluded. Without drugs, the cumulative financial position is constantly underspent throughout the year. This revised budget position is the one which more closely mirrors the responsibilities of the ward manager.

Clinical budgeting

The concept of clinical budgeting is now long established. The argument goes like this: clinicians are the individuals who cause money to be spent. If consultants never saw patients, there would be no need to employ medical secretaries, nurses or administrative staff. For hospital services, consultants decide which patients should be admitted, how long they should stay and what the treatment regime should be. It is clinicians who spend the money, therefore it should be clinicians who receive the financial information and hold the budgets.

However, to change the views of the majority of consultants so that they agree to be managerially responsible and financially accountable for all the areas within which they work will take a revolution greater than the scale of the change in role of the ward sister.

To compound the problem, budgets are not set for a single purpose. What are the different reasons why you receive financial and budgetary information?

Planning: The NHS needs to ensure that all the proposed changes to its services are properly costed to ensure that they have a firm financial future.

Monitoring: Budget holders need to check that what is happening financially actually matches the plans that were made, and that the reasons for any differences are investigated and understood.

Controlling: Budget reports are designed to highlight areas where control over spending is required.

Measuring your performance as a manager: The performance of nurse managers is being judged, in part, by their budget performance: how under or overspent they are. However, when judging financial performance, the critical area to consider concerns the underlying reasons for variances. There are fundamental flaws in the design of NHS budgetary systems which handicap their use for assessment of managerial performance. The greatest problem is that budgets do not match the responsibilities of managers. Managers cannot control spending on all areas of their budgets and where control can be exercised it is often only partial.

Control of spending is not one-dimensional. Spending can be viewed as the product of the unit cost of goods and staffing and the amount of usage.

A dressings budget, for example, can be controlled by either buying cheaper or using fewer. Similarly the budget can overspend by an increase in price or an increase in usage. The increase in price could be due to a manufacturer's price increase, or a change in the quality or type of dressing used. An increase in usage could be due to wastage because of lack of training or due to an increase in demand. There may be a multitude of different and competing causes behind any over or underspending, each of which may be the responsibility of a different person. Fixed inflexible budgets have helped perpetuate the problem of
responsibility for budgets.

If the major pressure on your budget is the level of activity, any influence of waste, over-ordering, inefficiency or over-stocking will be masked. Similarly, the efforts of budget holders to be more economic and effective in their delivery of care will also be masked.

Yet, here again, the accountancy techniques and principles do exist to solve the problem.

Flexible budgeting is a way of relating the financial budget to the actual activity undertaken. It involves the setting of standard costs, such as dressings cost per patient day or surgical supplies cost per theatre session, and calculating the total budget based upon the actual number of patient days or theatre sessions. When your activity and therefore some of your costs increase, so does your budget.

Any under or overspending on your budget must therefore be due to a change in the unit cost from the standard which was set.

Budgeting methods

The mechanistic application of the equation that overspends equal bad management and underspends equal good management must be avoided. There are currently so many factors within budgets that are outside the nurse manager's control that such simple rules are totally unworkable. Underspends can be the sign of poor management, where services have not been provided, quality standards have not been met or opportunities for non-recurring spending have been missed.

Overspends may have nothing to do with the quality of management and be mainly caused by the method chosen by your finance department to calculate the budget. If mid-point of scale is used to calculate pay budgets, for example, when many staff are near the top of the scale, the resulting pressure to overspend can be considerable.

Managers are not the only ones with a need for information. The same financial information is used for annual accounts and contract prices. This information needs to be constructed in a different way from your information needs but there is only one financial system with which to do it.

What we are left with is a compromise which serves no individual purpose perfectly. Few nurse managers would support the widespread appointment of more accountants in order to improve the quality of their financial information.

It is right that nurse managers should hold budgets, but the budget should only contain items over which nurse managers have direct control if they are to be used for assessing managerial performance.

Unless there is an impetus at board level to change budgetary systems to match more closely the responsibilities of managers, budgeting will continue to fall into disrepute. Nurse managers are the ones most affected by the lack of responsibility accounting and so they have the most to gain by pressing for improvements.

In the next article in this series, I will be looking at the range of budgetary control policies used by trusts and asking: Do you know the rules of the game? ■

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