



**Centre for Research in Accounting, Accountability
and Governance Working Papers
School of Management**

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in an English Hospital**

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November 2006

**Number CRAAG-06-04
ISSN
1356-3548**

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CONTRADICTIONS AND CONFLICTS IN AN ENGLISH HOSPITAL**

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ABSTRACT

The changing context in the New Labour Government policy and legislation to deliver healthcare introduced in England in 1999 reflected a discontinuity in the way that the healthcare organisations are controlled and this represented a new experience for the National Health Services (NHS). This paper examines empirically the effects of the introduction of a compulsory set of performance measures on the management processes of a particular English hospital. It demonstrates the complexities involved in using performance indicators to control activities in health care organisations. It explicates the course of change experienced by a particular organisation by highlighting both the intended and unintended outcomes associated with the pressure to change to meet the demands of a specific set of key targets. This case-study based research indicates that there is the need to pay a close attention to the way that the local-level healthcare organisations are interacting. The theoretically language adopted is informed by Broadbent and Laughlin (2005)'s analysis of organisational change, which draws on Laughlin (1991) and some aspects of Habermas' (1987) critical theory.

Key words: public sector reforms, organisational change, rating system in healthcare.

INTRODUCTION

An increasing concern with organisational performance measurement is reflected in public sector reforms around the world (e.g. Olson *et al.*, 1998, Hood, 1995). The reliance on the use of performance measurements to measure efficiency and effectiveness has become more visibly embedded in the governments' strategies adopted to improve public services (Modell, 2001). In the healthcare sector, critics of reforms argue that large increases in funding have not delivered a comparable increase in performance management (Model, 2004; Mayle *et al.*, 2002). The response to this criticism has overemphasised the adoption of crude throughput measures (Jones, 2002; Eddy, 1998). In the particular case of the (NHS), the main changes introduced since the election of the Labour Government in 1997 reinforce policies concerned with the overall ethos and alteration in structures. The legislation and policies directing the delivery of healthcare services has given greater significance to the use of performance indicators as a control device than preceding governments (1999 Health Act).

This paper adds to the literature on performance management because it builds an understanding of how the UK Government's steering processes have been redefined to steer healthcare systems. Focussing on the micro effects, this study supplements the usual managerialist bias by addressing issues from the perspective of a diversity of the organisational members. The implementation and result of a rating scheme led to radical changes at the hospitals' level and this represented a new experience for the English NHS. For the first time in this country, under-performing hospitals lost their autonomy because they did not fully meet a particular set of performance measures.

The implications of such policy are very broad and have not been sufficiently and empirically researched in their organisational context in the accounting literature. In particular, there is insufficient understanding of how recent approaches to control have affected the way that the general hospital are managed in England. The purpose of this paper is to fulfil this gap.

This case study adopts Broadbent and Laughlin's (2005) analysis of organisational change, which draws on Laughlin (1991) and some aspects of Habermas' (1987) critical theory. This theoretical amalgamation provides a way of theorising the control processes by relating societal and organisational prisms with the purpose of generating an understanding about the interface between both. Whilst Broadbent and Laughlin (2005) and Laughlin (1991) aim to explain and express the effectiveness of such a model, this study intends to adopt this model to build an understanding of the process of change experienced by a particular organisation and it does so by describing particular movements that emerged over time and along the process of change. This is the theoretical contribution of the paper.

The remainder of the paper is organised in five main sections. The first section introduces the theoretical approach. Section two provides a broad overview of how control has been established by the Labour Government. Section three portrays the micro effects. Section four reflects on the findings and the final section concludes the paper with some insights for further research.

RESEARCH APPROACH

Broadbent and Laughlin (2005) and Laughlin (1991) use the concept of steering from Habermas' (1987) critical theory to provide a language to allow discussion of the dynamics of the relationship between the macro and the micro levels. The star-rating systems introduced to control hospitals in England during 1999 and 2004 represented an important element of (macro) steering (Habermas, 1987), because it reflected the Government's intention to tackle variable standards of service at the local level in an attempt to achieve equity (1999 Health Act). The notion of equity defined at the macro level is operationalised at the micro level through the enforcement of a set of key targets to lead to intra organisational comparison. The impact of such an approach at the operational level is represented in this study by the micro effects.

The primary analysis of the organisational change in this paper is examined in the light of a range of environmental 'disturbances' (Broadbent and Laughlin, 2005, p.9; Laughlin, 1991, p.209; see also Morgan, 1986, p.249 and Bartunek, 1984, p.356), which surfaced as result of the pressure to change to meet the demands of a macro-steering mechanism (the key targets). From a micro perspective, the disturbances that emerged and travel along the process of change take dissimilar forms in terms of their nature. Some of them are of more controllable nature than others are. The demands of a rating regime introduced to control hospitals (added, for instance, to increased demand of patients), represent examples of macro (external) environmental disturbances. These events are of non-controllable (unintentional) nature, because they are externally imposed onto the micro level (for whatever reason). In contrast, the micro (internal) environmental disturbances that surface along the changing process are, to a certain extent, of controllable (intended) nature, because they (as are the events that resulted from them) are a result of the organisation's management strategies, implemented within the organisation in an attempt to accomplish the macro demands (key targets).

The analysis supported by this notion permits the identification of possible 'pathways' through which organisational controllable and non-controllable disturbances travel resulting in different levels of organisational change, which can be classified in 1st or 2nd order change (Laughlin, 1991:209; see also Greenwood and Hinings, 1988). Such categorization will depend on the level of intensity that the macro demands affect the micro level and this is reflected into the organisations' design archetypes, interpretative schemes and sub-systems (Broadbent and Laughlin, 2005:16). From this analysis, it is possible to determine whether the pathways of change take the state of 'colonisation' or 'reorientation', respectively (Laughlin, 1991:209).

In line with the theoretical language adopted to address the themes that surfaced at the micro level, reaction and actions by what Laughlin (1991:210) refers to, 'design archetypes' represent the formal controls that the organisation under consideration attempts to use to meet the key targets. The organisational 'interpretative schemes' correspond to the organisational members' values, which are

likely to be reflected in the design archetypes. The ‘sub-systems’ are tangible ways and resources used by this particular organisation to organise itself in order to meet the design archetypes’ demands (Broadbent and Laughlin, 2005; Greenwood and Hinings, 1988). The assumption is that an organisation can contain and be represented by its interpretative schemes, design archetypes and sub-systems, and organisational change can be understood by examining these (Laughlin, 1991, p.211).

This study builds an understanding about organisational change by examining the organisation’s interpretative schemes, design archetypes and sub-systems and the way that they interact with each other. This approach provides a language to explore individuals’ interpretations and responses to institutions, in a way that it develops a structural or processual linkage between these aspects and the organisational system. This paper aims to reflect the manner that organisational actors deal with such functions.

Data Collection

This empirical investigation took place during twenty-one months period^[1]. In line with the theoretical approach, several methods were employed in the data collection process. Formal and informal interviews were conducted. A sample of respondents was initially selected based on their position in the organisation. A large number of documents were gathered and analysed. These included the Department of Health (DoH)’s documentation, in particular the inspection of the legislative records regarding the Labour Administration’s legislation and policy directing the delivery of healthcare. This analysis set the context for understanding the organisational perspective. Documentation regarding the NHS hospital under consideration was also analysed (e.g. Financial and Activity Reports, Quality Reports, Board Meeting Reports). The organisation setting allowed an understanding of the Hospital’s profile and the actual value given to the documents that presented the organisation.

Observation permitted an understanding of the organisation’s design archetypes and sub systems. It also allowed the description of tangible elements, which were related to the functional or physical

aspects with which the organisation presented itself. The researcher attended the Hospital's internal and public Board meetings^[2], which allowed the evaluation of the debates about how the issues were portrayed by the organisational actors. The analysis of the empirical investigation is a result of the examination of all the data collected with the triangulation of this (Yin, 1999, 2003; Ryan *et al.*, 2002). Views about the nature of the organisational interpretative schemes emerged from the analysis of the design archetypes as well as the values claimed by organisational members (Morgan and Sturdy, 2000; Bartunek, 1984). The theoretical approach adopted permitted both to discuss the issues that emerged from the empirical investigation (in the light of the language offered by a prior theoretical framework) and to embrace the richness and diversity inherent in the empirical situation. The control mechanisms established by the Government represent the macro steering.

THE MACRO-STEERING MECHANISMS

Whilst previous performance measurement policies in England were heavily contained in the approach introduced by the Conservative Government (Smith, 1993,1995; Baggott, 1998), but subtly imposed onto the NHS local organisations, a compulsory set of measures was introduced by the Labour Government (1999 Health Act). For example, while preceding initiatives comparing hospitals' performance intended only to disclose such information to the public (e.g. League Tables); a particular set of key targets was legally enforced as a control device (NHS Performance Ratings – Acute Trusts, 2000/1). The new and robust emphasis on performance measurement was partially operationalised through the introduction of a series of institutions, which set standards of healthcare to be delivered across the country. This proposal intended to pursue the modernisation and reform policy of the English NHS for the following 10 years (The NHS Plan, July 2000).

As part of a broad model of control, the Labour Government introduced a national performance framework, in seeking to monitor the NHS organisations (1999 Health Act). Such a scheme established an extensive set of key targets to assess the performance of the English hospitals. It is within this framework that the Department of Health took forward a new emphasis on performance

measurement to reflect aspects that they believed were of significance to public sector organisations.

The first compulsory steering mechanism introduced a star-ranking scheme.

The compulsory set of key targets

The first star-rating system introduced in England covered only the acute hospital – the so-called general hospitals (NHS Performance Ratings - Acute Trusts, 2000/01). This scheme aimed to assess these hospitals against new broad-based measures during the period of 12 months (between 2000 and 2001). This initiative aimed to improve healthcare outcomes and pursuing a more open accountable NHS to provide patients and the public with comprehensive, easily understandable information on the performance of their local health services (NHS Performance Ratings - Acute Trusts, 2000/01). A commission of health improvement was set to complement the rating approach and it was considered a crucial feature in determining the evaluation of each hospital, as it was intended to oversee the quality of the clinical services delivered (Scully and Donaldson, 1998).

The first rating scheme consisted of two sets of key targets (table I), which integrated non-financial and financial indicators. The broader range of indicators compiled a ‘balanced scorecard’ approach to refine the judgment on ratings (Aidemark, 2001; Chow *et al.*, 1998; Kaplan, 2001; Modell, 2001).

These indicators were chosen to provide a balance across areas such as clinical, capacity and capability, and patient focus.

Table I: Key targets as applied given the macro steering demands

1st SET	
Target 1	Shorter inpatient waiting lists
Target 2	No patients waiting more than 18 months for inpatient treatment
Target 3	Reduction in outpatient waiting
Target 4	Fewer patients waiting on trolleys for more than 12 hours
Target 5	No patients with suspicion of breast cancer waiting more than 2 weeks to be seen in hospital
Target 6	Less than 1% of operations cancelled on the day (as a percentage of elective admissions)
Target 7	Commitment to improving the working lives of staff

Target 8	Hospital cleanliness
Target 9	A satisfactory financial position
Target 10	Not receiving a critical report from the Commission for Health Improvement (CHI)
2nd SET	
Clinical Focus	
Target 11	Low risk of clinical negligence
Target 12	Emergency re-admission rates
Target 13	Deaths in hospital within 30 days of surgery for non-elective patients (admitted on non-planned basis)
Staff Focus	
Target 14	Compliance with junior doctors working a maximum 56 hours per week
Target 15	The sickness/absence rate for directly employed NHS staff
Target 16	The rates of vacancies for consultants, qualified nurses, midwives and health visitors; qualified allied health professionals
Patient Focus	
Target 17	The percentage of inpatients waiting less than 6 months for treatment
Target 18	The percentage of outpatients seen within 13 weeks
Target 19	The percentage of patients in A&E who wait for more than 4 hours on a trolley before being admitted
Target 20	The percentage of complaints resolved within 4 weeks

Source: NHS Performance Ratings System -Acute Trusts, 2000/01, page.4

The Government's commitment to reduce the number of patients on elective (planned) waiting list/times became a central focus of the local healthcare programmes (the Waiting-List Action Team Handbook, August 1999, DoH) and this policy was explicitly reflected in the rating system (see targets nos. 1,2,3,4,5, and 17,18,19, Table I).

The star-rating methodology

The tenth targets established in the first set were regarded as the most significant factors in deciding on the hospitals' overall performance. The second set meant to refine the judgement between those hospitals which performed *very well* (performance rating of three stars) and *well overall* (performance rating of two stars). The performance of the three other scorecard areas (the clinical, patient and staff focus) was categorised into one of five performance bands, with 5 (five) points awarded for the best performance and 1 (one) for the worst. Individual band scores were combined to produce an overall score per area. All indicators were equally weighted except the vacancy rates, where each vacancy rate

had 2/3 weight, and the clinical focus indicators which had 4/3 weight. These weights were chosen to balance the impact of each of the three areas (NHS Performance Ratings System-Acute Trusts, 2000/01, 2000). This balanced scorecard approach adopted allowed a broad range of areas to be measured within a single methodology. Therefore, the hospitals that presented high performance rating performed well against a rounded set of indicators. However, the approach used high level summary data and did not involve every area in depth.

The star-rating result

The report presenting the result of the first star-rating indicated that such scheme aimed to provide the public with the ability to compare one hospital to another using a standard evaluation process as well as to serve as an important device for concentrating management attention on key strategic priorities and national targets. The performance against each key target was assessed in terms of whether each target was *achieved* or whether there was *some degree of underachievement* or whether the target was *significantly underachieved*. The key targets were placed within one of these three categories (DoH, Regional Office, Indicators, Methodology, 2000:1) (see appendix 1 for an example).

Without providing further details, the Government's Report indicated that hospitals' performance was regarded as being of concern if there was (NHS Performance Ratings - Acute Trusts, 2000/01: 3):

- a *sizeable number* of targets with some degree of underachievement; or,
- a *smaller number* of targets against which there has been *significant* levels of underachievement; or,
- a combination of both.

Following the result of the star-ratings system^[3], the general hospitals were placed into one of four categories below (NHS Performance Ratings - Acute Trusts, 2000/01: 3):

Three stars – were awarded to hospitals that demonstrated high standards of performance against both 1st and 2nd sets of targets. A three stars hospital was also reported as having good clinical governance by the commission of health improvement.

Two stars – were awarded to hospitals that performed well overall, but did not achieve the highest standards.

The hospitals that achieved high performance in the 1st set of targets were classified as definite two or three stars on the basis of their performance in the clinical, patient and staff focus areas. The second set of measures was simply used to distinguish between those hospitals that were awarded a three-stars mark in the core target assessment. The hospitals that achieved an overall score equal to or above the average (median) in each and every of the clinical patient and staff focus areas were given a performance rating of three stars, the others received two.

One star and Zero stars – were awarded to hospitals where there was some cause for concern regarding particular key performance indicators, which means that they performed worse than expected against some key targets. A zero stars hospital either failed against the key targets or was assessed as having very poor clinical governance by the commission of healthcare improvement. The hospital under consideration in this study was awarded zero stars. The next section examines how the pressure to change to meet the demand of the first ratings scheme affected this particular empirical context.

THE MICRO EFFECTS

The Organisation Profile

The organisation subject of this study is named Green Hospital^[4], which is the largest non-specialist (general) acute hospital in the South of England. This aspect was significant in justifying the selection of this particular organisation. Green Hospital covers a population of approximately 450,000 and it employed 2,692 people (as at the end of March 2001). This organisation presented particular problems, not perceived in the two other hospitals located in the same region. For example, it presented the worst financial situation and it faced a budget deficit of £ 4.747m in 2002/03 (anticipated in the Activity and Finance Report as at 31/03/01). Its main overspending directorate was in the A&E Department, which was the most directly affected by increased activity, recruitment and retention problems. Green Hospital's attempts to change to accomplish the star- ratings scheme proved complex.

The changing process

The operationalisation of the rating system within Green Hospital led to a series of intended and unwanted 'disturbances' (Laughlin, 1991:209). They surfaced and travelled along the pathways of change in an intricate, sometimes not in a successive fashion. Some disturbances (as were the effects resulted from them) were perceived by the organisational members as 'noisier' than others were in the context of the hospital's daily activities. It is within this perspective (and in the light with the theoretical approach adopted) that they are portrayed, as it follows.

Controllable disturbances: the intended pathway

The hospital's management team initially implemented several strategies in order to accomplish the demands of the key targets. Initiatives such as focusing on day-case procedure, controlling the number of admissions and closure of wards are examples of the management approach to tackle the key-targets achievement. Managers and medical personnel were initially able to control some disturbances (as some of its effects) that emerged as consequences of the strategies initially implemented. As they primarily assumed, this pattern of control would persist along the (intended) process of change and, thus, the original (intended) pathway would lead to the intended outcomes (the achievement of some targets), as it is explained bellow.

Focusing on day-case procedure

Evidence indicated that the focus on day-case practice was a strategy initially adopted by the Green Hospital's management to accomplish the demand of some key targets. For example, it was the method used to shorten the length of inpatient-waiting list (target 1), since this target can be met simple by reducing the number of patients included in the inpatient waiting list. Day case was also an alternative adopted to alleviate the pressure on A&E's trolley waiting, as it implies no over nights, which means that more beds could be available in the wards to accommodate A&E incoming patients. Therefore, Green Hospital was able to present fewer patients waiting in A&E trolleys for more than

12 hours (target 4). The focus on day-case procedure was also intended to improve the hospital's capability to present less than 1% of operation cancelled on the day (target 6). Cancellations usually occur due to the shortage of beds. Day case was as well proposed to alleviate Green Hospital's financial difficulties and to improve its ability to present a satisfactory financial position (target 9), since it is considered a rapid and economical method to tackle the waiting-list achievement. Day case does not usually entail the costs relating to hospital staying such as accommodation and staff (30th Board Meeting Report, 2001). During the course of this empirical investigation, Green Hospital presented a day-case rate of 74%, which was considered excessive (and, thus, a reason for concern), compared with the national standard peer group rate of 65% (30th Board Meeting Report, 2001).

Controlling the number of admissions

Reducing the number of patients to be added to the waiting lists/times was another initial strategy adopted by Green Hospital's management in an attempt to balance the Hospital's existing resources and meet the demands of the waiting list/time targets (targets 1–6 and 17-20). Evidence indicated, for instance, that elderly patients were frequently impeded from being included in the inpatient-waiting list, because they were perceived as having multiple health problems, which implies longer staying and constant staff attention during and after experiencing an operation (36th Board Meeting Reports, January/2001; see also Harrison and Dowswell, 2001).

“One way of dealing with the waiting-list targets is by reducing demand. Therefore, very often we choose not to increase the length of waiting list! In some cases, we wait until the patient health condition becomes worse to include him/her in emergency case. Sometimes, I would rather not keep adding patients on waiting. Part of the reason is that they [the Government] restrain activities. They [the government] make doctors feel uncomfortable about adding more people on the waiting list.” (Consultant 2).

....Yesterday, for instance, I saw a 86-years old woman and she needed an operation^[5]. I thought that if I added her to the waiting list, a younger patient would wait longer for an operation. I spoke to the Hospital's Clinical Manager and I said that she should stay in the hospital until they [the Hospital's surgeon] could operate on her. We would not have had this conversation if she was a 30-years old patient! We do this naturally! This is what the healthcare system in this country imposes! At the end of the day, the waiting list is one way of rationing health care in the UK NHS, where there is no payment at the point of the delivery...” (Consultant 3) [Emphasis added]

Closing wards

Closing wards was another initial managerial strategy adopted by Green Hospital to attempt to accomplish the demand of some key targets. For instance, it was intended to reduce the general increase in expenses and, in particular, the high cost associated with bank and agency staff^[6] as well as to alleviate the pressure on nurses and carers. Two wards were closed in this hospital in the first semester of January 2001(32nd Board Meeting Report).

However, despite the Hospital's management effort towards implementing initiatives in an attempt to meet the demands of some key targets, a series of further internal and external set of unwanted (uncontrollable and unexpected) forces was generated along this process of change. A succession of complex circumstances emerged as a result of the operationalisation of some intended strategies initially implemented by the management. For example, the excessive focus on day case (although led to the achievement of some targets, such as targets 1 and 4 also led to a series of non-controllable disturbances. Some of them (as did its effects), added to the pressure exerted by external (non-intended) disturbances (e.g. A&E increased demand, lack of qualified staff) placed Green hospital in a difficult position. This adverse set of uncontrollable disturbances (as did its effects) led to further issues, which, ultimately, led to the non-achievement of some other key targets (non-intended outcomes), as it is explained below.

Non-controllable disturbances: the actual pathway

The effects of day case

The excessive and constant implementation of day case practice led to a series of conflicting change in clinical work. For instance, it meant that patients with severe conditions, which required longer stay in hospital (e.g. hip replacement, hernia), were left waiting longer. Some of them eventually became emergency patients, whose admission aggravated the A&E existing workload intensity, staff and cost pressure (32nd Board Meeting Report). The pressure of adopting day-case in an attempt to make beds available also led to early discharge, which itself led to a series of other uncontrollable (and

unwanted) disturbances and outcome (e.g. early discharge, low quality of care, bed blocking, delay discharge and cancellation of operation on the day, and etc), as it is described below.

Early discharge

Contradicting primary management assumption, the excessive focus on day case affected Green Hospital's general ability to present a satisfactory financial position (target 9), because early discharge led to readmission of patients, who did not receive an appropriate treatment when first admitted in the wards. Readmission became expensive within Green trust (Activity Management and Emergency Report, July/2001). Early discharge generated other conflicts such as low quality of care (34th Board Meeting Report).

Low quality of care

The pressure to discharge patient within Green Hospital proved detrimental to patients' general recovery, particularly in the case of elderly patients, who were not necessarily healthy enough to be discharged (Quality Report, Feb/2001).

“We are in such pressure to get people back home very quickly, very promptly in order to get patients coming in...Yesterday, for example, there was a patient next door, who was unfit to leave the hospital, because we thought she might be infected. However, she was discharged in the afternoon. In fact, she should have stayed overnight!” (Nurse 4) [Emphasis added]

The initial excessive concentration on day case led to a significant underachievement of two (out of three) targets regarding clinical focus. Green Hospital was unable to present a satisfactory emergency readmission rates within 28 days of discharge (target 12). It also failed to show a satisfactory number of deaths within 30 days of surgery (target 13).

Bed blocking and delayed discharge

Although the management strategy of closing wards initially indicated a potential benefit for the hospital, its effect engendered further disturbances that affected the achievement of other key targets.

For instance, it led to the permanent loss of beds, which itself contributed to both bed blocking^[7] and delay-discharge issues.

During the course of this empirical investigation, both the bed occupancy and delayed discharge rates presented by Green Hospital was motive for concern. The bed occupancy level reached 95% on average, which is considered a very high level (Activity Management and Emergency Report, July/2001). The Hospital's elevated percentage of bed usage (which totalled 68) was intensified by delayed discharge (Activity Management and Emergency Report, July/2001). Whilst the delayed transfers' national position was approximately 6%, this particular region presented approximately 15% of acute adult hospital beds (HA Activity Report, July/2001). The delay-discharge crisis within Green Hospital was aggravated by bed-blocking issue and vice versa. This aspect was a result of the Hospital's inability to offer convalescence care (which in England is provided by tertiary care^[8]).

Green Hospital's bed blocking problem was worsened by the lack of nursing homes within this region (Board meeting report, January 2001). On a particular day, for instance, the researcher counted 21 elderly patients that were impeded from being discharged due to a lack of a place to reside. This number was considered high and, thus, a reason for concern (HA Activity Report, July/2001). Bed-blocking also affected the quality of care delivered by Green Hospital, since long stay in hospital is seen as damaging to the elderly's general clinical condition, because they are prone to infection (Quality Report, Feb/2001). Added to A&E increased demand, bed blocking led to a further uncontrollable disturbance, which is the cancellation on the day of the operation.

Cancellation

Both bed blocking and delay discharge, added to the Hospital's general shortage of beds and an increased demand in the A&E department, led to an increase in the number of cancellation of operations on the day. This procedure became common within this Hospital, which was unable to show an achievement of less than 1% of operation cancelled on the day (target 6).

“It is quite normal for us (the Hospital) to not know at this time of the morning (by 9.30 am), whether an elective patient would be admitted to be operated on in the afternoon. At the moment, for example, we have 3 (three) patients waiting in the A&E trolleys and also 3 (three) planned patients to get in routinely. However, we have just 1 (one) bed and a possible other bed next door (day-case discharge). So, there are 2 (two) beds for 6 (six) patients today...” (Sister Nurse 2)

A&E Increased demand

Increasing demand in the A&E^[9], added to both delay discharge and bed blocking issues, exacerbated the hospital’s ability to cope with the waiting-list achievement. As the Emergency Capacity Service is the Health Authority’s responsibility, NHS Hospitals do not have control over A&E demands. Within Green Hospital, the A&E demand increased by 10% in 2000/2001^[10], compared with the same period in 1999/2000 (Activity and Finance Report, Dec/2000). As non-elective patients have priority over the elective ones, increasing demand in A&E implied a reduction in the number of beds in the hospital’s wards, which generated a sequence of further events that affected this Hospital’s general waiting-list achievement.

“We have the power to decide who needs an operation immediately. However, the more the hospital does A&E, the longer the waiting list will be...Some times, I just prefer not to include a patient on the waiting-list to avoid hearing him/her complain about the long waiting. It is frustrating not being able to meet patients’ expectations!” (Consultant 1) [Emphasis added]

Waiting-list/time targets - the dysfunctional nature

The application of waiting-list/time scheme in practice proved complex and contradictory within Green Hospital. Despite the management team’s initial attempts, the Hospital failed to meet 3 (three) out of 8 (eight) targets related to waiting list/time (table II). It significantly underachieved target 3, since it was unable to present achievement of plans to reduce the number of outpatients waiting over 13 weeks. It also failed to show a satisfactory percentage of patients waiting less than 6 months for an inpatient appointment (target 17). The shortage of beds in the hospital led to longer waiting time in the A&E’s trolleys (Board Meeting Reports, Jan/2001), which led to trolley waits greater than 4 hours as a percentage of all non-elective patients (target 19). Longer trolley waits ^[11] also aggravated Green

Hospital's existing financial problem due to both the A&E general costs and, in particular, the cost associated with bank and agency staff (Activity and Finance Report July/2001). Green Hospital presented significant underachievement of a planned Income and Expenditure position (target 9). The workload intensity and the consequent pressure on staff (particularly on nurses and carers) led to recruitment and retention problems.

Recruitment and retention problems

Several non-controllable (internal and external) environmental disturbances emerged as influencing nurses' recruitment and retention issue within Green Hospital (added to the national lack of nurses). Some of them related to active private medicine in the region (which offers better remuneration than the NHS); high housing-cost; poor transportation links and the lack of social activities within the region (Workforce Information Report for August/2001). The average number of nurses and carers per month was 39 (thirty-nine) during 1999-2001, which is regarded as high level compared with the two other Hospitals located within the same region (HA Activity Report, July 2001). Green Hospital was the first NHS Hospital in the England to hire nurses from the Philippines (The Workforce Information Report for April/2001).

One of the dirty dozen

All these controllable and non-controllable events and its effects interrelated in a contradictory and complex fashion impacted on the Green Hospital's ability to meet the demands of the star-ratings scheme. It failed to achieve 9 (nine) out of the 20 (twenty) targets, as table II indicates^[12].

Table II – Green Hospital's result on the star-rating system

Whilst the other two NHS hospitals located within the same

It significantly underachieved in the following targets:	
Target 3	Reduction of outpatient waiting
Target 6	Less than 1% of operations cancelled on the day (as a percentage of elective admissions)
Target 8	Hospital cleanliness
Target 9	A satisfactory financial position
Target 12	Emergency re-admission rates
Target 13	Deaths in hospital within thirty days of surgery for non-elective patients
Target 17	The percentage of inpatients waiting less than six months for treatment.
Target 19	The percentage of patients in A&E who wait for more than four hours on a trolley
Target 20	The percentage of complaints resolved within four weeks.

Source: NHS Performance Ratings System - Acute Trusts, 2000/01

region were awarded three and two stars, Green Hospital was awarded zero. Its result in the 2000-2001 ratings system led to the replacement of the Hospital’s management team.

DISCUSSION

Macro steering

This case study indicates that the macro steering, which is expressed through a star-ratings system acted to enforce and regulate desired behaviour. The analysis of the legislation directing the delivery of healthcare services in England indicates that the Government’s expectation, in following a long tradition of central control towards the NHS organisations, is to control organisational behaviour through the establishment of national standards and key targets. This assumes that there is some alignment between the macro-steering process (Habermas, 1987) and the systems (as anticipate by Broadbent and Laughlin, 2005).

This study indicates that the operationalisation of an integrated system established by the Labour Government to force changes at the organisational level proved challenging. Whilst the introduction of a particular set of targets meant to drive hospitals to efficiency, evidence within Green suggest that the pressure to change to meet the macro demands predominated over concerns relating to quality of care.

Micro effects

The debate in this paper indicates that Green Hospital was compelled to create diverse coping mechanisms during its attempts to change to meet the demands of the key targets. This hospital was embraced by a set of internal and external, controllable and non-controllable environmental forces, which themselves were composed by diverse elements linked in a complex manner, as they compelled and were compelled by each other, emulating the notion of a domino effect. Whilst different strategies were pursued in seeking to attain the demands of particular targets, a set of interrelated dysfunction emerged, some of which led to the non-achievement of others and this combination of facts affected the hospital's clinical work in perverse ways.

Evidence indicates that dysfunctions such as rationing, exclusion and disregard to clinical priority became common practice within Green Hospital. This situation reflects a practical case of the steering media that gets out of control and moves societal systems into new levels of activities and concern, regardless of what intentions the macro steering had for changing the behaviour of the systems. As a result, many dysfunctions emerged throughout the changing process, as Broadbent and Laughlin (2005) anticipate. The central argument of this study is that, unlike Broadbent (1992) and Bartunek (1984) foresee, this study suggests that the dysfunctions that travelled along the pathways emerged as effect of external environmental pressures that embraced this particular hospital, rather than from cultural differences perceived within the organisation (interpretative schemes).

Some of the issues that emerged from the effects of the external environmental circumstances and impacted on the Hospital's inability to meet the macro-steering demands cannot be resolved at the hospitals' (micro) level (Commission of Health Improvement Quality Report, Regional Office, 29th Nov 2001). Two aspects are perceived by the organisational members as having a major effect on the Green Hospital's general performance. The *first* relates to its inability of distributing emergency workload (as it is the case of all NHS Hospitals in England, since the provision of emergency workload is the Health Authority's responsibility). This factor was perceived as affecting Green Hospital's difficulties of coping with A&E increased demand. The *second* aspect relates to a series

of problems resulting from the location of the hospital, which can only be remedied through the expansion of intermediate care within the region (e.g. bed blocking, lack of nursing home). The Hospital's concerns with issues such as recruitment and retention of nurses and A&E's workload intensity are also a result of the Hospital's locality.

Organisation's interpretative schemes and design archetypes

While Laughlin (1991) uses aspects of two case studies to illustrate correspondingly 'reorientation' and 'colonisation' change pathways, this study presents a single case study that seems to illustrate both situations (Broadbent and Laughlin, 2005:16,17). Evidence indicates that the Hospital's policy of prioritising young patients in an attempt to balance resources is an example of 'colonisation' pathways of change, since this is a disturbance externally imposed onto the structure of Green Hospital's design archetypes. The notion of rationing is part of the lifeworld that informs the macro-steering mechanisms and this has permeated the micro level and has become part of the Hospital's design archetypes. Clinicians' discourses indicated that rationing (for whatever reason) is part of the organisation's interpretative schemes and this is reflected in a tangible way on the structure of this organisation's design archetypes. Whilst consultants' statements about prioritising young patient in detriment of the elderly (e.g. see quotation on page 15) might have been considered very inappropriate sometime ago, it is currently part of their discourses. This fact suggests that the colonisation of pathway is present, because such disturbance seems to affect the interpretative schemes. Therefore, regarding the level of change, a first-order change may be applicable to this case. The replacement of Green Hospital's management team, as a result of having been awarded zero stars, suggests that the macro-steering intention and attempts of colonisation have increased.

On the other hand, a case of 'reorientation' pathways is also present, because the implementation of the rating system is equally perceived by different organisational members (both managers and medical personnel) as a medium of money and power rather than a reflection of the societal lifeworld. This perception is manifested in the clinicians' discourse (e.g. 'this is what the health system

in this country imposes!', p. 5). Such statement suggests no intention of challenging the star-ratings' policy, but to 'absorb' (accommodate) them (Laughlin, 1991). The focus on day-case procedure (albeit not the only one) is an example of the Hospital's attempt to find a system (structure) to absorb the disturbance and, therefore, to avoid changes to the interpretative scheme. Nonetheless, in this case, attempts to 'absorb' did not function and, instead, led to other disturbances and the consequent under-achievement of other key targets (non-intended outcome). Therefore, it is difficult at this stage to affirm that the imposition of external performance indicators, on its own, led to second-order change. There is the suggestion that the actual pathway followed by this organisation has resulted in both reorientation and colonisation.

CONCLUSION

This paper aimed to contribute to both the wider debate on performance management in healthcare and to the understanding of organisational change, because it discusses the interface between organisational and accounting change based on a deep empirical investigation. The theoretical approach adopted provided the basis for structuring interaction with the rich contextual information gathered in the empirical investigation. The analysis concerning the nature of the organisational design archetypes provided the basis for discovering the impact of the institutional steering-mechanisms on the organisation. This study builds an understanding of the structures of the relationships that emerged during the process of change and the interaction between the macro and micro levels, based on prior theories of those relationships, and demonstrating how particular pathways of change were followed.

The pathways built along the process of change within Green Hospital can be reflected into two distinct chains representing the 'intended' and the 'actual' pathways. The intended pathway initially takes a linear form, as it relates to the internally generated proactive strategies intentionally implemented by the management team to achieve certain (chosen) outcomes. In contrast, the actual pathway takes a rather tortuous form, because it is generated from the original initial linear (intended) pathway, which is distorted along the way. The actual pathway, thus, is a result of the pressure

of the unwanted set of forces that emerged from the management controllable initiatives (intended pathway) and from the (uncontrollable) external disturbances (as its effects). Unlike what the intended pathway was initially believed to achieve (intended outcome), its ‘conversion’ into the actual pathway led, instead, to non-intended outcomes (the failure of some key targets).

The analysis of this case indicates that even when organisations pursue proactive strategies, they can be deflected from their intended course and, therefore, fail to achieve the intended outcomes. It also suggests that, even reactive strategies can fail to provide the deflection needed (e.g. absorb the destructive disturbances) and, instead, they can lead to even worse outcomes, rather than those intended. The analysis of the legislation and policies directing the delivery of healthcare services in English suggests that reforms have been a matter of replacing steering mechanisms, without allowing sufficient time to preceding reforms to settle before new reforms are introduced. For instance, the star-rating system has been replaced by the payment-by-result system (DoH, 2004). The nature of the ‘new’ scheme reflects the macro-steering desire of moving towards a more directly resource allocation policy.

Therefore, as changes of this nature have progressively and persistently been introduced at the operational level, it may well be that they will be gradually impinged onto the NHS’ interpretative schemes. Nonetheless, as interpretative schemes are of dynamic nature, it is crucial that further and incessant empirical-based research is performed, in order to pursue additional understanding of the development of control processes in healthcare and the future role that they expect to play in society.

Notes:

[¹]The 21 months investigation ended in July 2001. The study, therefore, examines a unique and defined period, which includes the organisation’s attempts at that time to cope with macro and micro disturbances.

[²] The hospital Board meetings took place every eight weeks and they aimed to inform the local community and Health Authority about the general aspects of the hospital’s management. It mainly evolved around discussions based on a large report containing information related to financial, activity, quality and personnel matters. Those reports were posted to the researcher a couple of days prior to the meetings, which were organised into two main parts. Only the first part, which last approximately three hours, was open to the public and, thus, to the researcher. Those meetings (as the informal interviews that took place shortly prior to them) became a very rich source of information.

[³] The Government’s report presenting the first rating result was published in the main English newspapers in September 2001 (e.g. The Guardian, Thursday, 26th September 2001). The Government report informed that thirty-five NHS general

hospital were awarded three stars while twelve were awarded zero star. The English press quickly named the former group 'the super hospitals' and the latter 'the dirty dozen'.

[⁴] As anonymity was assured, the hospital under consideration is named Green Trust, due to the green area that surrounds it.

[⁵] Disease and speciality omitted to protect the physician's identity.

[⁶] Bank staff are formed by the hospital's staff when they are not working in their normal shifts. Hiring extra nurse from agency (e.g. BNA-British Nurses Association) is the most expensive way of covering the lack of nurses. It costs 50% more than the nurses employed by the hospital.

[⁷] Bed-blocking is a term used to name beds that are occupied by patients who, although are clinically fit to be discharged, remain in the hospital for whatever reason.

[⁸] There are three levels of care in the UK National Health Service (NHS): primary care through family doctors, opticians and others; secondary care through hospitals and ambulances services; and tertiary care through specialists hospitals for particular types of illness.

[⁹] Further research indicated that the local Health Authority's Performance Managers expressed concerns with Green Hospital's A&E increased demand. According to them, this was difficult to explain, since, A&E increased demand is usually associated with deprivation, which is non-existent in this particular region of the country.

[¹¹] On a particular day, although the researcher counted 20 patients waiting for further treatment on the A&E's trolleys, no trolley waits was officially recorded. The current 'trolley waiting' definition (the Patient's Charter), sets the trolley-waiting times as calculated from the decision to admit the patient to the time this patient is admitted into the ward for further treatment, rather than from the time the patient arrives in the A&E to the time he/she receives appropriate treatment.

[¹²] Targets 8 (Hospital cleanliness) and 20 (complaints) were not commented upon at any stage during this empirical investigation and this is the reason through which they were not examined.

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