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ABSTRACT

Purpose – This paper aims to examine the micro effects of performance measures introduced in England to control hospitals, following the changing context in the policy directing the delivery of healthcare introduced by the Labour Government. The legislative framework established in 1999 reflected a discontinuity in the way that hospitals are controlled in this country.

Design/methodology/approach – This exploratory case study is a result of a deep empirical investigation. It draws on some aspects of Laughlin's (1991) and Broadbent and Laughlin's (2005) analysis of organisational change.

Findings - This study indicates that, in seeking to change to meet the demands of a particular control device, this organisation pursued both proactive and reactive strategies. However, it was deflected from its intended pathway of change and, as a result; it failed to meet the intended outcomes. The pressure exerted by such a demand impacted on the hospital's activities in a conflicting way.

Originality/value – There is insufficient understanding of how the government's policies to control have affected hospitals' daily activities. Equally, there is scarce understanding of how managers and medical personnel deal with the pressure to change to meet government's expectation. This paper demonstrates empirically the complexities involved in using key targets to control hospitals activities. It contributes to the wide literature in performance management and organisational change.

Research limitations/implications – The paper examines the issues from the organisational members' perspective, and, therefore, from the perception of those affected by control devices introduced by the Government.

Key words: performance measurement in healthcare; organisational change; public sector reforms.

INTRODUCTION

An increasing concern with organisational performance measurement is reflected in public sector reforms around the world in the last three decades (e.g. Cavaluzzo and Ittner, 2004; Johnson and Kaplan, 1987; Pollitt, 1986). The literature has indicated that the reliance on the use of performance measurements to measure efficiency and effectiveness has become more visibly embedded in the strategies adopted by the Government to improve public services (Modell, 2001; Kaplan, 2001; Hood 1995). In the healthcare sector, critics of reforms argue that large increases in funding have not delivered a comparable increase in performance (Model, 2004; Mayle et al., 2002) and that the government's response to this criticism has overemphasised the adoption of crude throughput measures (Jones, 2002; Eddy, 1998). In the case of the English National Health Service (NHS), the main changes introduced since 1999 reinforced policies concerned with the overall ethos and alteration in structures (1999 Health Act). The legislation and policies directing the delivery of healthcare services introduced in England in 1999 gave greater significance to the use of performance indicators as control device than preceding Governments. For instance, for the first time in this country, under-performing hospitals lost their autonomy, because they did not fully meet the expectations of the Government (The NHS Performance Ratings-Acute Trusts 2001).

The aim of this paper is to build an understanding of how steering processes introduced by the UK Government have been redefined in healthcare systems. The implications of the operationalisation of such policies are very broad. There have been recent empirical studies examining the functioning of performance assessment framework (PAF) introduced in UK NHS. For instance, Chang (2007) explores the limitations and implications of it within local health authorities. Given (2005)

investigates the HR managers' response to the implementation of performance ratings. However, there is insufficient understanding of how approaches to control introduced by the Labour Government have affected the daily activity of general hospitals in England. The purpose of this paper is to fill this gap. It is pertinent to pursue additional understanding of the development of control processes in healthcare in order to build some understanding of the future role that they expect to play in society.

This case study draws on Laughlin's (1991) and Broadbent and Laughlin's (2005) analysis of organisational change. This approach provides the opportunity of examining how organisations attempt to adjust to meet the demands inherent in the multifaceted nature of organisational change. The paper presents the issues that emerged during the organisation's attempts to meet the demands of a particular set of key targets. It instigates further reflection and insights on how hospitals respond to the pressure to meet the demands of standards established by Governments. It addresses the issues from the viewpoint of the organisational members' perspective. Therefore, the paper adds to the wide literature on performance measurement and organisational change.

The remainder of the paper is organised in five main sections. The following section introduces the research approach. Section three provides a broad overview of how control has been established in England since 1997 (a macro perspective). Section four portrays the micro effects. Section five 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 performance ratings system introduced to control hospitals in England in the period between 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 micro level, in an attempt to achieve equity. The notion of equity introduced by the Department of Health (DoH) in 1999 was operationalised at the organisational level through the monitoring of a particular set of key targets introduced to lead to intra-organisational comparison (1999 Health Act). This study investigates the impact of such a policy on a particular English general acute hospital by adopting a broad approach that allows the recognition of the importance of the environment and the context within which this organisation operates. It adds to the wide literature on performance management and accounting change in organizations (Burns and Scapens, 2000; Morgan & Sturdy, 2000; Pettigrew, 1990; 1995).

The theoretical model

The analysis of the empirical data in this paper is examined in the light of the notion of 'disturbance' (Laughlin, 1991, p.209). This term is adopted by Laughlin to express the effects that surface during organizations' attempts to change to meet the demands of a control device externally imposed (see also Morgan, 1986, p.249 and Bartunek, 1984, p.356). As explicated by Laughlin, the analysis supported by this notion permits the identification of possible 'pathways'(1991:210), which are routes built along the changing process and through which organisational disturbances travel, resulting in different levels of organisational change. These levels of change can be classified as

'first' or 'second-order' (Laughlin, 1991:214; Broadbent and Laughlin, 2005:16), depending on the degree of intensity with which the demands of the macro steering affect the organisational (micro) context. As elucidated by Laughlin (1991), these levels of change can be expressed in a tangible mode by changes that occur in the organisational design archetypes and in a less tangible manner by the changes in the interpretative schemes and subsystems. Laughlin's interpretation provides a language, which allows a more practical link between theory and practice.

Design archetypes are management processes built within organizations and they are informed by organisational values and beliefs (Greenwood and Hinings, 1988). In this case, design archetypes are the formal control processes developed by the hospital's attempts to change to meet the demands of a particular set of key targets introduced in 1999 by the Labour Government to assess general hospitals in England. Interpretative schemes correspond to the set of values of the organisational members and they are reflected in the design archetypes and subsystems (Giddens, 1979; Bartunek, 1984). Subsystems are tangible ways and resources adopted by organisations in trying to accomplish the design archetypes' demands. Subsystems are represented here by the informal ways and resources adopted by the Hospital in its daily activities to organize itself with the intention of accomplishing the demands of the formal processes developed to achieve the key targets. 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 investigates organisational and accounting change by examining the organisation's interpretative schemes, design archetypes and sub-systems and the way that they interact with each other. It aims to examine whether pathways of change assume the state of 'colonization' (deep change) or 'reorientation' (superficial change), which make it possible to identify cases of first or second-order change, respectively (Laughlin, 1991:215). This approach provides a language to explore the individual interpretations and responses of institutions in a way that it develops a structural linkage between these aspects and the organisational system. This paper provides insights on how the organisational actors deal with such functions.

Data collection

This empirical investigation took place during twenty-one months period^[1]; several methods were employed in the data collection process. Formal and informal interviews were conducted to provide relevant information that was not available from other sources, such as documentation and meetings. Formal interviews lasted 60 minutes on average and they were taped-recorded, with the consent of the interviewees. A sample of respondents was initially selected based on their position in the organisation. The Chief Executive formalised the access to the research site and arranged further contacts within the organisation. The interviewees were chosen in such a manner that allowed the researcher's interaction with different organisational members at different levels and positions. The aim was not to ensure an exhaustive sample of all levels of types of staff, but to provide a diversity of opinions. 36 (thirty-six) people were formally interviewed (table I).

[table I here]

Open-ended questions were adopted in the formal interviews, in order to allow more freedom to respondents in answering the questions, which evolved around their perception of the consequences of the introduction of national standards to control hospitals. The schedule of interviews was extended to follow up suggestions that other interviewees were relevant to the case. The objective was to seek information about the intangible elements, such as the organisation's interpretative schemes, as well as the more tangible elements, such as the design archetypes and the sub-systems set up to monitor and collect accounting information for control.

The researcher attended all the hospital's public board meetings² run during the period of empirical investigation and this allowed the evaluation of the debates about how the issues were portrayed by the organisational actors. Notes were also taken, as a result of informal conversations that took place shortly before the board meetings. These notes clarified some information gathered from the board meetings' reports that were provided to the researcher prior to each board meeting.

A large number of documents were collected and analyzed. These included documentation of the DoH, in particular the inspection of the legislative records regarding the legislation and policy directing the delivery of healthcare in England. This analysis set the context for understanding the organisational perspective. Documentation regarding this particular hospital were also analyzed (e.g. Financial and Activity Reports, Quality Reports, Board Meeting Reports). The organization's setting allowed an understanding of the organization's profile and the actual value given to documents that presented the hospital.

Data analysis

The data were analysed in the light of Laughlin's (1987) discursive process, which is developed from Habermas' (1987) methodological approach for understanding accounting change in organizations. This approach consists of 3 (three) different and consecutive stages that require the researcher's involvement, albeit in different ways. Stage 1 encompassed the formulation of critical theorems that Laughlin refers to (1987:628). At this phase, a network of issues was developed and the common themes were selected from the transcription of the interviews. The purpose was to search for understanding of the impact of the macro steering (set of key targets) upon the organisation. Stage 1 included the inspection of the legislative documentation in order to identify the themes that were represented in them; this was followed by the analysis of the organization's documentation that was publicly available. The details that surfaced from the analysis of the preliminary data collection allowed some understanding of the organization's overall profile (e.g. its location, financial situation, staff and ethos of the management), and this allowed some understanding of the management's main concerns.

At stage 2, the researcher searched for a deeper interaction with the organisational actors, in order to confirm the critical theorems; this took place mainly during formal and informal interviews. The objective was to seek for details to enrich and extend the theorems, to facilitate further reflection on them. At the final stage of this analysis process, the researcher returned to the organisation to ensure that the understanding of the theorems that surfaced during stage 1 was in line with the interpretation of the organisational actors. With the purpose of ensuring that this was the case, the researcher formally re-interviewed 5 (five) people, who held key positions within this organisation (i.e. Chief Executive, Finance Director, two Consultant Directors and a Finance Manager). These interviewees assisted the researcher in the interpretation or

development of particular situations or events. The aim was to corroborate and/or clarify insights that surfaced during the hospital's internal and board meetings and as a result of the inspection of the organization's documentation.

The analysis of the empirical investigation is a result of the triangulation of all data collected (Yin, 1999, 2003; Ryan *et al.*, 2002). Views about the nature of the organisational interpretative schemes emerged from the analysis of the design archetypes and from the values claimed by organisational members (Morgan and Sturdy, 2000; Bartunek, 1984). The theoretical approach adopted permitted both to discuss the issues that surfaced from the empirical investigation (considering the language offered by the prior theoretical framework adopted) and to embrace the richness and diversity inherent in the empirical situation.

The organisation's profile

The subject of this study is named Green Hospital^[3], which is the largest non-specialist (general) acute hospital in the South of England. The hospital's size was significant in justifying its selection. Green Hospital covered a population of approximately 450,000 and employed 2,692 people (as at the end of March 2001). It presented particular problems, not perceived in the two other hospitals located in the same region. For example, it showed the worst financial situation and faced a budget deficit of £ 4.747m in 2002/03 (which was anticipated in the Activity and Finance Report as at 31/03/01). Its main overspending directorate was the A&E department, which was the most directly affected by increased activity, recruitment and retention problems. The control processes introduced by the Government to guide English hospitals represent a macro steering mechanism.

THE MACRO CONTEXT

Background

There has been considerable literature discussing issues related to performance measurement approaches. Most authors have taken a practical view (e.g. Boyne et al., 2002; Smith, 1995b; Cavalluzzo and Ittner, 2004) while others have adopted a broader perspective (e.g. Covalleski and Dirsmith, 1986a; Covalleski, et al., 1996; Broadbent and Laughlin, 1997). A rhetoric that emphasises accounting change as a way of promoting the notions of efficiency, effectiveness, and performance accountability in the public sector is reflected in the literature in a worldwide perspective. Notwithstanding diverse approaches, researchers seem to be in agreement about the fact that public services have experienced increasing pressure to improve the quality of service delivery and, simultaneously, increasing pressure to diminish the financial demands on taxpayers (Brignall and Modell, 2000). Many researchers around the world have called attention to a move from the traditional/bureaucratic administrative to a market-based approach to control public services and reforms that have placed considerable emphasis on customer focus, stakeholders' interests, and other means of appraisal (e.g. Guthrie et al., 1999; Humphrey and Scapens, 1990; Kouzmin et al., 1999).

In the UK, for instance, the Government have introduced a set of objectives, targets and performance indicators throughout the public sector, from central government to local level organizations (Chang, 2007; Givan, 2005). The intention is to improve accountability and influence behavior. In England, performance measurement policies were contained in the approach introduced by the Conservative Government (Smith, 1993, 1995; Baggott, 1998) and then subtly imposed on the NHS by means of a

compulsory set of measures introduced by the Labour Government in 1999 (1999 Health Act). That is to say, whilst preceding initiatives comparing hospitals' performance intended only to disclose such information to the public (e.g. League Tables); a set of key targets was legally enforced during the period of 1999 to 2004 as a control device (NHS Performance Ratings – Acute Trusts, 2000/1). The emphasis on performance measurement introduced in 1999 was partially operationalised through the introduction of a series of bodies setting standards of healthcare to be delivered nationally (Department of Health, 2000, 2001b). This proposal intended to facilitate the modernization and reform policy of the English NHS for the following 10 years (The NHS Plan, July 2000).

This paper adopts Laughlin (1991) and Broadbent and Laughlin's (2005) analysis of organisational change to examine empirically how a particular English hospital reacted in the light of the pressure to change to meet the demand of the first star-ratings system introduced in England to assess general hospitals. This theoretical language offers the opportunity of building a broader perspective on how organizations attempt to adjust to meet macro desired behaviour. There is limited understanding of how such policies to control have affected micro contexts. The national performance framework introduced by the English Government in 1999 put forward a new emphasis on performance measurement to reflect aspects that they believed were of significance to public sector organizations. It is within this framework that a particular set of key targets was introduced to assess the performance of hospitals in England.

The first compulsory steering mechanism introduced a star-ratings scheme, which covered only the acute hospitals – the so-called general hospitals (NHS Performance Ratings - Acute Trusts, 2000/01). This scheme evaluated hospitals against new broad-based measures during the period of 12 months between 2000 and 2001. It was the

government's statement that this initiative aimed to improve healthcare outcomes and provide a more open and accountable NHS for 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 (CHI) was set up to complement the rating system and 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 (Sally and Donaldson, 1998).

The rating scheme consisted of two sets of key targets which integrated non-financial and financial indicators. These indicators were intended to provide a balance across areas such as clinical, capacity and capability, and patient focus (table II).

[table II here]

The aspiration of the English Government to reduce the number of patients on elective (planned) waiting list/times became a central focus of the local healthcare programs (the Waiting-List Action Team Handbook, August 1999, DoH) and this policy was explicitly reflected in the performance ratings system introduced in the period between 1999 to 2004 (see targets nos. 1,2,3,4,5, and 17,18,19, Table II).

The ten targets established in the first set were regarded as the most significant factors in determining the hospitals' overall performance. The second set refined the judgement between those hospitals which performed *very well* (performance rating of three stars) and *well overall* (performance rating of two stars). The performance therein its other scorecard areas (the clinical, patient and staff focus) was categorised into one of five bands, with five points awarded for the best performance and 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 -Acute Trusts, 2000/01, 2000). The 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 government's report presenting the result of the first star ratings system indicated that such a 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). Without providing further details, the 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 performance ratings system^[4], 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 CHI.

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 - was 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.

Zero stars –A zero stars hospital either failed against the key targets or was assessed as having very poor clinical governance by the CHI.

To meet the set of key targets established at the macro level required alteration of the hospital's design archetypes and sub-systems, which provoked a series of conflicts. There were significant incentives to pursue the targets as the so-called super hospitals (3-stars) gained financial freedom while the dirty dozen (zero-stars) lost their

autonomy. Thus, the number of stars awarded to hospitals determined the degree of intervention by the macro steering into the micro level. The question raised is how such an approach affected a particular empirical context.

THE MICRO EFFECTS

The operationalisation of the first performance ratings system within Green Hospital proved complex. Difficulties in managing the pressure to meet its demands accentuated by the lack of resources were issues raised constantly during the hospital's board meetings. However, the management team sought to implement a series of strategies with the intention of meeting some key targets simultaneously.

Controllable disturbances: the intended pathway

During the period between 1999 and 2001 Green Hospital embarked on a series of policies with the aim of leading the organisation to achieve some key PIs. These initiatives impacted on the hospital's daily activities in a conflicting way. A number of these initiatives and their interaction are now considered in more detail.

Controlling the number of admissions

Controlling the number of patients on the waiting lists and the duration of their wait was an approach primarily adopted by the hospital's management to try to balance the hospital's existing resources and tackle the waiting-list achievement at the same time:

“...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)

“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 4) [Emphasis added]

“We (Consultants) 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...Sometimes, I just prefer not to include a patient on the waiting-list to avoid hearing him/her complain about the long waiting. But, it is frustrating not being able to meet patients' expectations!" (Consultant 1) [Emphasis added]

Prioritising young patients to the detriment of the elderly was another strategy adopted by the management team in seeking to balance the hospital's resources. There was the belief that elderly patients have multiple health problems, which implies longer stays and the constant attention of staff. This perception was not only explicitly reflected in the discourses of clinical managers during board meetings (e.g. 30th board meeting), but also stated in the interviews with medical personnel:

"...Yesterday, I saw a 86-year 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 [one of the hospital's surgeon] could operate on her. We would not have had this conversation if she were a 30-year old patient! We do this selection naturally! This is what the healthcare system imposes in this country." (Consultant 3) [Emphasis Added].

The notion of rationing healthcare in the name of balancing resources was, thus, reflected in a tangible way in the hospital's design archetypes, which were informed by the values of the management team. That is, there was an indication that rationing has been part of individual's interpretative schemes for some time, regardless of the pressure experienced by the organisation to change to meet the demands of a particular control device (see also Harrison and Dowswell, 2001).

Concentration on day-case surgery

Controlling the number of waiting-list admission by selecting patients according to the nature of the operation was another example of attempts to balance the hospital's resources and tackle the achievement of some key targets simultaneously. Day-case procedures were frequently preferred to more complex cases (30th Board Meeting

Reports, January/2001). Day-case patients (e.g. cataract operations) were frequently favored, as part of the management team's expectation of tackle the demands of several key targets at once, for instance, the achievement of target 1 (shorter inpatient waiting lists). The discourses of medical personnel implied that this was a common practice within the Hospital.

“... A senior nurse has been appointed for pre-assessment, in order to attempt to convert in-patient surgery to day-case surgery, wherever this is possible. The Trust has already focused on day cases to enable it to reduce the length of waiting lists more rapidly and cheaply.” (Senior Nurse 2)

“In doing day-case, I can actually achieve a certain sense of self-satisfaction which, in the current circumstances (pressure to meet targets); I would not be able to... Therefore, I can help more patients by doing 50% or 60% or possibly more of all my surgeries as day-case. However, I still have the remaining patients who require hospital beds and, therefore, I still have to compete with other surgeons for beds.” (Surgeon 1)

Day-case procedures were also adopted to alleviate the pressure on trolley waiting in the A&E; as day-case patients can be accommodated on trolleys this leaves more beds for patients transferred to wards from A&E. Green Hospital managed to report fewer patients waiting in A&E on trolleys for more than 12 hours (target 4). It was the management expectation that the focus on day cases would result in additional beds being available in the wards. Therefore, the hospital's capability to reduce cancellations of operation of elective (planned) patient should have increased (24th Board Meeting).

The focus on day cases was also intended to improve the hospital's ability to report a satisfactory financial position (target 9) and the use of day cases was regarded as a rapid and economical method to tackle the waiting-list targets (28th Board Meeting Report, 2001), because it does not (usually) entail inpatient costs (e.g. costs associated with accommodation, meals and attention from staff, especially carers and nurses).

During the course of the investigation, the day case rate of Green Hospital was 74%, which was considered excessive compared with the national standard peer group rate of 65% (Financial and Activity Report, March, 2001). Concerns with the high level of day-case procedure undertaken within Green hospital were raised in the board meeting (e.g. 29th Board Meeting, 2000).

Closing wards

Closing wards was another strategy initially adopted by Green Hospital in seeking to cope with the demand of some key targets. 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 during the period between October 2000 and January 2001. This act resulted in a permanent loss of nine beds (31st and 32nd Board Meeting Reports).

“I hope we can reopen these wards in the future. The closure of these wards improved morale of staff, since it diminished the pressure on them (especially nurses and carers) as well as it allowed the recruitment on other surgical wards that admit patients from A&E. However, closing wards in a busy hospital like this, it is a warning for politicians, given the continuous rise in demand.” (Chief Executive)

Regardless of the statement above, a closure of an additional medical ward was announced in the following board meeting, in seeking to accomplish a saving of £350,000, as part of the Performance Improvement Plan for 2001-02 set for that region (27th Board Meeting Report).

Non-controllable disturbances: the actual pathway

Despite the management effort to implement initiatives to accomplish the demands of some key targets, ensuing internal and external sets of unwanted and unexpected

environmental forces emerged which led to non-intended (actual) outcomes. For example, the focus on day cases contributed to the achievement of some targets, such as targets 1 and 4. However, the excessive concentration engendered an adverse set of unmanageable disturbances that, added to external environmental pressure (e.g. A&E increased demand, lack of qualified staff), contributed to the Hospital's negative result in the ratings system (table III).

[table III here]

The effects of day case use

The excessive concentration on day-case practice resulted in a series of conflicting changes in clinical work. For instance, patients diagnosed with severe conditions, which required longer stay in hospital (e.g. hip replacement, hernia), were left waiting longer (32nd Board Meeting Report). Some of them eventually became emergency patients:

“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. (Consultant 1) [Emphasis added].

However, such an approach aggravated the existing A&E intense workload, as was claimed by managers during board meetings (e.g. 33rd Board Meeting Report). Similarly, constant pressure to release beds in wards to accommodate A&E patients led to a succession of other uncontrollable and unwanted disturbances, such as early discharge, low quality of care, bed blocking, delayed discharge and cancellation of

operation on the day. These issues were not only raised in several board meetings and interviews, but also mentioned in the hospital's internal reports (i.e. Activity Management and Emergency Report, July 2001).

Early discharge

Although the initiative of focusing on day cases was intended to alleviate the hospital's financial position, it adversely affected the hospital's general ability to present a satisfactory financial situation (target 9), because it led to pressure to discharge patients prematurely. Readmission is costly:

“We are in such pressure to get people back home very quickly due to cost pressure; getting patients coming in and out very promptly! ...sometime something can go wrong! When we do blood test for instance! (A&E clinician in a board meeting)

On some occasions, early discharge led to readmission, which implied additional cost (Activity Management and Emergency Report, June/2001). The pressure to discharge patients rapidly generated further conflict, such as leading to a low quality of care (32nd Board Meeting Report).

Low quality of care

The pressure to discharge patients within Green Hospital eventually proved detrimental to patients' general recovery, particularly in the case of the elderly, who are more vulnerable to infection (Quality Report, Feb/2001):

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 excessive concentration on day cases impacted on the hospital's ability of presenting a satisfactory emergency readmission rates within 28 days of discharge (target 12) and to show a satisfactory number of deaths within 30 days of surgery (target 13). Green Hospital significant underachieved two (out of three) targets regarding clinical focus (table III).

Bed blocking, delayed discharge and cancellation

Although the management strategy of closing wards was initially believed to indicate a potential benefit for the hospital in terms of financial pressure, its effects influenced 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 (34th Board Meeting Report).

During the investigation, both bed occupancy and delayed discharge rates presented in the reports were highlighted as sources of concern (TeamWork^[8] Group Report, Dec 2000). Bed occupancy averaged 95%, which was considered high (Activity Management and Emergency Report, July/2001). The issue of bed blocking aggravated the delay-discharge crisis within Green Hospital, and vice versa. This was an effect of the hospital's inability to offer convalescence care, which in England is provided by tertiary care^[9] (Teamwork Management Services Report for December 2000).

The bed-blocking problem experienced by Green Hospital was worsened by the lack of nursing homes in its vicinity (Board meeting report, January 2001). On one day 21 elderly patients were retained in the wards, although they were ready to depart. This number was considered high and a reason for concern (HA Activity Report, Dec/2000).

Bed blocking also affected the quality of care delivered by Green Hospital, since a long stay in hospital was seen as damaging to the general clinical condition of the elderly (Quality Report, Feb/2001).

Both bed blocking and delayed discharge added to the hospital's general shortage of beds and increasing demand in A&E led to an increase in the number of cancelled operations on the day (28th Board Meeting Report). The hospital failed to achieve less than 1% of operations cancelled on the day (target 6). Cancellation of operations for elective (planned) patients usually occurred due to the shortage of beds, which were competed for both elective and non-elective (A&E) patients:

"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 in the afternoon. At the moment, for example, we have 3 (three) patients waiting in the A&E trolleys and another 3 (three) planned patients to get in routinely. However, we have only 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^[10], added to both delayed discharge and bed blocking issues, exacerbated the hospital's ability to cope with the waiting-list achievement. 3.6% of the increased demand in A&E during 2000 related to over-contracted emergency activity (Teamwork Management Services Final Report for December 2000). NHS Hospitals do not have control over A&E's demands, since the Emergency Capacity Service (ECS) is responsibility of local health authorities (Health Authority Activity Report, July/2001). Within Green Hospital, the demand in A&E increased 10% during the period of 2000 and 2001 compared with the same period in 1999/2000 (Activity and Finance Report, Dec/2000). As non-elective patients have priority over the elective, increasing demand in A&E caused a reduction in the number of available

beds in the wards, which impacted on the waiting-list achievement. Green Hospital's workload intensity and the consequent pressure on staff (particularly on nurses and carers) led to recruitment and retention problems (Workforce Information Report, March 2000).

Recruitment and retention problems

Several non-controllable (internal and external) environmental disturbances emerged as influencing the recruitment and retention of nurses by Green Hospital (Workforce Information Report for April/2001). Factors such as active private medicine within the region (which offers better remuneration than the NHS); high housing-cost; poor transportation links and a lack of social activities were pointed to as issues by the HR manager during board meetings (Workforce Information Report for June/2001). During the period between 1999 and 2001, the average number of nurses and carers leaving Green Hospital was 39 (thirty-nine) per month, which was considered high, compared with the level at the two other hospitals located within the same region (HA Activity Report, July 2002). Green Hospital was the first NHS Hospital in England to hire nurses from the Philippines (Workforce Information Report for June/2001).

Controllable and uncontrollable consequences

As initially intended by the management team, Green Hospital was able to accomplish some waiting-list/time targets. For example, it was able to present achievement of plans to reduce the total inpatient-waiting list (target 1); no patients waiting more than 18 months for inpatient appointment (target 2) and no patients with suspected breast cancer waiting more than two weeks to be seen in hospital (target 5). It also achieved target 18, because it was able to control the number of outpatients seen within 13

weeks of General Practitioner (GP) referral for first outpatient's appointment, as a percentage of all outpatients seen following GPs' written referral for first appointment.

Albeit in different ways, controllable and non-controllable events and resulting effects that surfaced during the hospital's attempts to change to meet the demands of the key targets interrelated in a contradictory and complex fashion, which influenced the hospital's general capacity to accomplish relevant key targets (table III). Green Hospital failed to achieve 9 (nine) out of the 20 (twenty) key targets. It was unable to meet 3(three) out of 8(eight) waiting-list/time targets [¹¹]. It significantly underachieved target 3, because it did not manage to present achievement of plans to reduce the number of outpatients waiting over 13 weeks. Following an increase in the demand of A&E incoming patients, Green Hospital was unable to achieve less than 1% of operation cancelled on the day (target 6).

The shortage of beds in wards led to longer waiting time in A&E on trolleys (Board Meeting Reports, Jan/2001), which affected the hospital's ability to report a satisfactory percentage of patients waiting on trolleys for more than four hours before being admitted in the hospital's wards (underachievement of target 19). However, the hospital had fewer patients waiting on trolleys for more than 12 hours (target 4). Contradicting initial expectations, longer trolley waits aggravated the hospital's existing financial problem due to an increase in A&E general costs and, in particular, in the costs associated with bank and agency staff (Activity and Finance Report July/2001). As shown in table III, Green Hospital reported significant underachievement of a planned Income and Expenditure position (target 9).

Adjustments made in an attempt to accomplish the demands of the first performance ratings scheme proved contradictory, despite the management team's effort towards its achievement. The dysfunctional nature of the waiting-list/time targets was a theme that surfaced in every board meeting and interview attended during the course of this investigation, which preceded the publication of the result of the performance ratings scheme by the Government in September 2001.

Discussions raised during the hospital's board meetings concerning delayed discharges and the lack of staff were raised and emphasized on the CHI report, which corroborated the findings of this study. The executive team recognised the significant pressures facing this particular Hospital. They acknowledged that this organisation was facing issues, with the responsibility for addressing them lying with the regional office (CHI Quality Report, Regional Office, 29th Nov 2001). Nonetheless, whilst the other two NHS hospitals located within the same region were awarded three and two stars, Green Hospital was awarded zero stars and become one of the dirty dozen, which led to the replacement of its management team.

DISCUSSION

Linkages between macro –micro steering

This study builds an understanding of the structures of the relationships that emerged during attempts to change to meet the macro-steering demands. It discusses the interaction between the macro and micro levels, based on prior theories of those relationships. Laughlin's (1991) model and Broadbent and Laughlin's (2005) analysis provided a language to allow reflection on the control processes concerning the macro steering and the micro effects within the context of performance measurement in the UK public services.

The analysis of this case suggests that the macro steering (expressed through a particular set of key targets), acted to enforce and regulate desired behaviour. The analysis of the empirical situation suggests that this organisation was compelled into diverse coping mechanisms during its attempts to change to meet the demands of the key targets. It was embraced by a set of internal and external 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.

The pathways of change

The analysis of this case suggests that an initial linear pathway of change was originally intended by this organisation. This pathway was built by the generated proactive strategies intentionally implemented by the management team at first, in seeking to achieve certain outcomes (some key targets). However, the intended pathway was distorted along the way by expected effects (e.g. the permanent loss of beds) resulting from expected internal disturbances (e.g. closure of wards). This initial pathway was also affected by the pressure exerted by a set of non-controllable environmental forces (e.g. the increased demand of patients in A&E) and ensuing effects (e.g. pressure on staff and consequent issues regarding recruitment and retention) externally imposed into the micro level settings. In the end, the intended linear pathway was transformed into a twisty (actual) pathway, which led to non-intended outcomes (the non-achievement of some crucial key targets).

Whilst different strategies were pursued in seeking to attain the demands of particular targets, their interaction led to the non-achievement of others. This combination

affected the hospital's clinical work in perverse ways. For instance, evidence indicates that dysfunctions such as rationing, exclusion, and disregard to clinical priority became common practice within Green Hospital. This case reflects in practice the theoretical situation described by Broadbent and Laughlin (2005), who anticipated that the steering media can get out of control and move societal systems into new levels of activity and concern (e.g. exclusion and rationing), regardless of the intentions of those responsible for the macro steering mechanism.

However, unlike Broadbent and Laughlin (2005), Broadbent (1992), Laughlin (1991) and Bartunek (1984) foresee, this case suggests that resulting dysfunctions emerged from external environmental pressures, rather than from cultural differences perceived within this organisation (interpretative schemes). Internal report produced by TeamWork confirmed that there were two main external environmental forces impacting on the hospital's difficulties in coping with the pressure exerted by the macro steering. The first aspect concerned the hospital's inability to control the increasing demand in A&E, given that local health authorities are responsible for the provision of emergency services. The second aspect concerned a series of problems resulting from such features as bed blocking, private medicine, workload intensity and the consequent issue of recruitment and retention. These two problems can only be remedied through the expansion of intermediate care within the region (e.g. increasing the number of nursing home) and this was an issue raised during a particular board meeting by TeamWork. At a later stage, it was also acknowledged by the CHI (Quality Report - Regional Office, 29th Nov 2001).

Organisation's interpretative schemes and design archetypes

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.

Laughlin's (1991) and Broadbent and Laughlin's (2005:16, 17) analysis suggest that the process of change can be understood in two separate ways - 'colonisation' or 'reorientation' pathways. The analysis of this situation suggests that the application of the model proved more complex than the model might suggest. This single case illustrates both situations simultaneously. For example, Green Hospital's history of prioritising young patients to the detriment of the elderly in an attempt to balance resources seems to reflect a case of 'colonisation'. Their discourse indicates that they have exercised this choice for some time, and this represents an effect of a disturbance externally imposed onto the structure of the hospital's design archetypes. This fact indicates that the notion of rationing has become part of the lifeworld that informs the macro-steering mechanisms, which has permeated the micro level and has become part of the individual interpretative schemes and design archetypes.

Clinicians' discourses indicated that, although they feel frustrated when they are not able to meet patients' expectations, they are able to switch to the *rationing mode* naturally (for whatever reason). Therefore, rationing has become part of this organisation's interpretative schemes. Whilst consultants' statements about prioritising young patient at the expenses of the elderly might have been considered very inappropriate sometime ago, it is currently part of their conversation and practice. This fact suggests that the 'colonisation' pathway is present, because such disturbance has affected the organisation's interpretative schemes. Therefore, regarding the level of change, a state of second-order change might be applicable to

this case. The replacement of the management team, followed by the hospital's poor result in the performance ratings system, suggests that the macro steering intention and attempts of colonisation have increased.

On the other hand, a case of 'reorientation' pathways is also present here, because the implementation of the ratings system is 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 shared by the organisational members. It is, for instance, manifested in the clinicians' discourse (e.g. 'this is what the health system in this country imposes! p. 18). Such a statement suggests that there was no intention of challenging the performance ratings policy, but to accommodate it. Therefore, the hospital's management team (which includes consultants) made the choice of attempting to 'absorb' the disturbances (Broadbent and Laughlin, 2005, p. 17). The focus on day-case procedures (albeit not the only one) is an example of the hospital's attempt to find a system (structure) to accommodate the disturbances to evade changes to the interpretative scheme, rather than challenging them. Nonetheless, attempts to 'absorb' in this case did not function and, instead, led to further disturbances and the consequent under-achievement of other key targets (non-intended outcome). However, it is difficult to affirm that the imposition of external key performance indicators, on its own, led to second-order change in this case.

The analysis of this case indicated that even when organisations pursue proactive strategies, they can be deflected from their intended purpose and, therefore, fail to achieve the intended outcomes. It also suggests that, even reactive strategies can fail

to provide the deflection needed (e.g. accommodate the destructive disturbances) and, instead, they can lead to worse outcomes, rather than those intended.

CONCLUSION

This paper adds to the wider debate on performance management in healthcare and builds some understanding of how organisations respond to the pressure to change to meet the government's expectations. It discusses the interface between organisational and accounting change and indicates that the operationalisation of the first performance ratings introduced in England to force changes at hospitals' level proved challenging and led to radical changes. This represented a new experience for the English healthcare system.

The analysis of the legislation and policies directing the delivery of healthcare services in England suggests that reforms have introduced new steering mechanisms, without allowing sufficient time for preceding reforms to settle before new reforms are introduced. New alternative arrangements for checking on the performance of English hospitals and doctors were introduced in 2004 (DoH, 2004). Although they have not been fully implemented yet, they predicted the end to the unpopular star ratings system (White, 2004). A payment-by-result system has been introduced. The nature of the new scheme reflects the macro-steering desire of moving towards a more directly resource allocation policy. As changes of this nature have progressively and persistently been introduced at hospital level, it may well be that they will gradually impinge onto the interpretative schemes. Nonetheless, as interpretative schemes are of dynamic and amendable nature, it is crucial that further research is undertaken, in order to provide 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 during the period of 1999-2001. They aimed to inform the local community and Health Authority about the general aspects of the hospital's management. The meetings evolved around discussions previously set in a large report containing information related to the hospital's financial, activity, quality and personnel matters. Those reports were posted to the researcher a couple of days prior to the meetings. These meetings were organised into two main parts. Only the first part, which lasted approximately three hours, was open to the public and, thus, to the researcher.

[³] As anonymity was assured, the hospital under consideration is named Green Hospital, due to the green area that surrounds it.

[⁴] 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). It informed that thirty-five NHS general hospitals were awarded three stars while twelve were awarded zero stars. The English press quickly named the former group 'the super hospitals' and the latter 'the dirty dozen'.

[⁵] Disease omitted to protect the identity of the consultant, as requested by him.

[⁶]Bank staff is formed by the hospital's staff when they are not working in their normal shifts. Agency staff are hired from agency (e.g. BNA-British Nurses Association), which 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 hospital for whatever reason.

[⁸]Teamwork Management Services Report was prepared by Teamwork Group, which was a consultancy company hired by the local Health Authority, with the Hospital's collaboration, to review service pressures faced by this Hospital. They presented their conclusion in the Hospital's board meeting held on the 11th Oct 2000.

[⁹] There are three levels of care in the UK 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.

[¹⁰] Further research indicated that Performance Managers working for the local Health Authority expressed concerns with the increased demand of Green Hospital's A&E. According to them, this was difficult to explain, since increasing demand in A&E is usually associated with deprivation, which is totally non-existent in this particular region of the country.

[¹¹] Targets 8 (cleanliness) and 20 (complaints) were not examined and/or commented upon here, because they were not mentioned, at any stage, during this empirical investigation.

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