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Deryl Northcott and Li-cheng

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Deryl Northcott and Li-cheng Chang

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Deryl Northcott *
Professor of Management Accounting
Postgraduate Group
Faculty of Business
Auckland University of Technology
Private Bag 92006
Auckland 1020
New Zealand
Tel: +64-(0)9-917-9999 x5850
Fax: +64-(0)9-917-9990
e-mail: deryl.northcott@aut.ac.nz
*Author for Correspondence

Li-cheng Chang
Canterbury Business School
Accounting and Finance
The University of Kent
Canterbury
Kent CT2 7NZ
UK
Tel: +44-(0)1227-764000 x3381
e-mail: L.Chang@kent.ac.uk

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AUT AUTHORS

PROFESSOR DERYL NORTHCOTT

Deryl joined the Postgraduate Group as Professor of Management Accounting in 2002 and also works in the Accounting and Finance Academic Group. Deryl has a PhD in management accounting and is a qualified Chartered Accountant with the ICANZ. She has spent six years at the University of Manchester in the U.K and prior to that she was a lecturer at the University of Waikato in New Zealand.

THE USE OF PERFORMANCE MEASUREMENT AS AN ACCOUNTABILITY MECHANISM: A CASE STUDY IN THE UK NATIONAL HEALTH SERVICE

ABSTRACT

The UK Labour government has recently developed the NHS Plan, which specifies long-term objectives and strategies for the development of the National Health Service. Along with the NHS Plan has come the development of Service and Financial Frameworks (SaFFs). The aim of SaFFs is to overcome the potential agency problem that exists between government and NHS organizations (Heymann, 1988) by enhancing the accountability of local NHS organizations for delivering the outcomes required by the NHS Plan.

This study uses a case study to explore how the SaFF has been applied as a new NHS performance measurement tool and identifies issues affecting the usefulness of the SaFF as an accountability mechanism. The findings illustrate how the introduction of SaFFs has allowed the government to introduce additional non-financial/process performance indicators and tougher performance monitoring processes.

This study also identifies issues related to the choice, relevance and informational quality of performance indicators. The findings suggest that, given the shortcomings in the SaFF's performance measurement contributions, a key early aim of this new accountability mechanism may be to serve central government's need to deliver a political message to the public. If the SaFF is to develop into an effective accountability mechanism and support the key aims of the NHS Plan, careful selection of performance indicators and adequate information systems will be crucial.

INTRODUCTION

Trends in new public management have seen the application of private sector performance measurement and accountability concepts within UK public sector organisations (Lapsley, 1999 & 2001; Hodges et al., 2002; Smith, 2002). Against that background, and in order further to reform the UK National Health Service, the Labour government has adopted the concept of multi-dimensional performance measurement to benchmark local NHS organisations' health care delivery and enhance their accountability and performance. There remains, however, a lack of empirical evidence to examine how NHS performance measurement has been used to enhance accountability.

This paper presents a case study of the recent introduction of a performance measurement and accountability mechanism – the Service and Financial Framework (SaFF). The aim of the study is to examine the role of the SaFF as both a performance measurement tool and an accountability mechanism. The study focuses on the following two issues:

- How is SaFF-related performance measurement used to hold local NHS organizations accountable for delivering health service requirements?
- How do local NHS organizations respond to the accountability mechanisms imposed via the SaFF?

The remainder of this paper is structured as follows. Section two offers an overview of recent developments in NHS performance measurement. Section three outlines the Service and Financial Framework requirement in particular. Section four describes the research method employed for this study. Section five presents empirical evidence of how the North West Regional Office applies the new SaFF accountability mechanism to performance manage one of its local NHS organizations. Section six examines how a north west health authority has engaged with the SaFF exercise. Section seven presents a discussion and conclusions.

BACKGROUND: DEVELOPMENTS IN NHS PERFORMANCE MEASUREMENT

The structure of the NHS has been transformed several times since it was established in 1948 (Levitt et al., 1999). The Thatcher government's 1991 separation

of health service purchasers and providers, and introduction of the internal health sector 'market', was perhaps the most dramatic restructuring (Lapsley, 1996). However, this internal market structure had little measurable impact on performance, whether defined in terms of volume, quality, or unit costs (Le Grand et al., 1998; Smith, 2002) and was abolished in 1997 by the Labour Government.

The Labour Government proposed a 'third way' working relationship for the NHS – "a system based on partnership and driven by performance" (Department of Health [DoH], 1997; p.10). Although health services commissioners and providers remained separated, the government sought to replace the prior climate of health provider competition with a culture of co-operation and "successful partnerships" (DoH, 1998a; p.3).

The "NHS Plan" (DoH, 2000a), a blueprint document for future NHS development, outlined the government's strategies for meeting its health care priorities. Long-term objectives were identified, which focused not only on the perspective of efficiency, but also on health service outputs and long-term health outcomes. For 2001/2002, fourteen broad health care priorities were identified[1], each with associated targets and planning milestones.

The NHS Plan claimed to introduce the so-called 'subsidiarity' principle to health sector management. This suggests that central government gets involved only in: setting standards, monitoring performance, putting in place a proper system of inspection, providing back up to assist modernisation of the service and, where necessary, correcting failure (DoH, 2000a; p.57). Local NHS organizations, on the other hand, were delegated greater authority and autonomy. Local Health Authorities (HAs), for example, were given the new leadership role of delivering central government's long-term objectives and ensuring that more specific local health care needs are met.

Within such a decentralised NHS structure, the potential exists for local interests to differ from those of central government's policy development (Heymann, 1988). In order to ensure that local NHS organisations aimed for short-term targets that would support the long-term objectives of the NHS Plan, performance measurement and accountability mechanisms were needed. Accountability

relationships between Department of Health Regional Offices (ROs) and their local Health Authorities (HAs) were therefore operationalised via a set of formal performance agreements.

The overarching health strategy document is the Health Improvement Programme (HImP), which is locally agreed between health communities (including HAs) and their ROs. The HImP sets out "the targets and milestones agreed locally to deliver the priorities and targets defined in the NHS Plan" (DoH 2000c; p.5). This agreement is underpinned by the Service and Financial Framework (SaFF) - the document that forms the focus of this case study.

OVERVIEW OF THE SERVICE AND FINANCIAL FRAMEWORK

The Service and Financial Framework (SaFF) operates as a planning document, a performance measurement tool and an accountability mechanism between central government (via NHS ROs) and local NHS organisations. A 2000 DoH document outlines the role of the SaFF as follows:

> "The SaFF will capture the agreed action, investment and activity to be delivered by the local health community and at what cost. This information will then be incorporated into Local Action Plans that provide more detail on how the SaFF will be delivered…. Once signed off, the Action Plans, incorporating the SaFF, will form the basis of the performance agreement between Regional Offices and their NHS Trusts and Health Authorities. The performance agreements will be used to judge performance throughout the year." (DoH, 2000b; pp. 34-35)

A further document notes that:

> "The SaFF will enable the Department [of Health] to gain assurance that NHS plans and in year progress are on track to deliver the requirements in terms of targets and milestones of the NHS Plan Implementation document…. The Department of Health HQ will provide Regional Offices

with targets…. Targets are to be met in 2001-02 and these will be explicitly agreed as part of the SaFF process." (DoH, 2000c; pp.12-13)

The SaFF therefore serves to formalise targets that form the basis for HA performance measurement, as monitored by ROs. The government notes that HAs (along with other NHS organizations) will be "required to provide information to monitor progress of their SaFF at different stages throughout the planning year and at the end of the year" (DoH, 2000c; p.14)

The targets and milestones identified in the SaFF are extensive and varied - more than 250 performance indicators are included for 2001/02. One illustrative example used here concerns targets related to reducing death rates from coronary heart disease.

The NHS Plan target is to reduce by 40% the mortality rate from coronary heart disease in people under age 75 by the year 2010. Related short-term targets / milestones are identified in the 2001/2002 SaFF. For example, one specified milestone concerns increasing the number of revascularisation[2] procedures carried out (DoH, 200b, p.15). Performance indicators are then identified to reflect whether local NHS organizations are able to achieve this target, as shown in Table 1.

Target/milestone	**Indicator**
Revascularisation The national target is to achieve ahead of time the original target of 3000 additional procedures over 1999/2000 baseline and make progress towards bringing on stream at least an extra 3000 on top of this by 2003	• Number of CABGS • Number of PTCAs • Total 26+ week outpatient waiters for cardiology • Total 13+ week outpatient waiters for cardiology • Number of patients waiting >12 months for cardiac surgery • Number of patients waiting 15<18 months for cardiac surgery • Number of patients waiting > 18 months for cardiac surgery

Table 1: Selected performance indicators for coronary heart disease within the 2000/2001 Service and Financial Framework (Source: DoH, 2000c; p.28)

Since there are more than 90 health districts in England, each reporting on a wide range of performance indicators, the process of monitoring SaFF performance measures process has been delegated to ROs, which act for central government in each region. This paper will examine how the SaFF is used by ROs to hold HAs accountable for their performance, and how HAs are impacted by, and respond to, the imposition of SaFF requirements. Before turning to the findings from this study, a brief outline of the research method follows next.

RESEARCH METHOD

A case study approach was adopted to examine the accountability relationship between the Department of Health North West Regional Office (NWRO) and one of its local Health Authorities (referred to as NWHA). Empirical evidence is based on:

- Semi-structured interviews with the NWRO performance manager
- Semi-structured interviews with relevant managers within NWHA
- NHS, NWRO and NWHA published and internal documents

In order to further understand the functions and purposes of the SaFF, two additional interviews were conducted with the Head of Performance Management and a Financial Officer within the NHS Executive South East Regional Office (SERO).

Interviews took place between March and July 2001. Consequently, the SaFF report referred to in this study is for 2001/2002. Interviews were tape recorded and later transcribed.

The next section presents empirical evidence of how the NWRO uses the SaFF to performance manage one of its local health communities.

Performance Management: The NHS North West Regional Office

The Role of the Health Authority

The Service and Financial Framework exercise begins with each NHS RO being given a so-called 'regional envelope' of annual targets for its region. The RO then has to agree, with all its local health communities (NHS trusts and HAs), specific targets for their annual SaFF. In other words, the RO has to ensure that each organization is planning to make the necessary progress towards the short-term (and, ultimately, long-term) targets set out in the NHS Plan. As well as requiring a planning function (via SaFF setting), this requires HOs to monitor the performance of health organizations such as HAs in delivering these targets.

According to the Head of Performance Management in the North West RO:

> "Performance management, as we are trying to implement it here, really fixes into three separately strands: monitoring, intervention, and improvement." [3]

Monitoring

First, the monitoring aspect of performance management entails developing information systems to record measurable performance against predetermined performance targets. The RO then uses the SaFF report to agree the year-end targets with the HA. Once targets have been agreed:

> "we go through an exercise, called profiling, which says, for example, we start here (current situation) and got the end up there (agreed target), what shape will that being that year." [3]

A profiling exercise is used to forecast possible service levels throughout the whole year. For example, waiting lists may increase in the summer because trusts cannot provide services on Bank Holidays, and there are also winter pressures because more elderly people contract flu during that period. A trust cannot simply rely on past trends and experiences to predict future demand and service levels. It

also has to consider what may happen in the following year, such the recruitment of a new consultant, and how this will influence activity levels.

After the forecasted trend of the activity level for the following year is decided, the RO then embarks on a monthly monitoring process:

> "There is monthly monitoring of a range of standards. We measure actual activity levels in terms of in-patient and day case episodes. We measure outpatients attendance, referral level through the GP referrals, the number of DNAs (which is people who do not attend). So we are measuring on a monthly basis, against those profile targets, the absolute activity levels and waiting lists themselves. The whole process involves getting that information back from trusts and health authorities and co-ordinating it to create a regional picture to be able to say 'are we where we committed to be? And, if not, why not?' And that moves us into the interventions." [3]

Interventions

At the conclusion of each month's monitoring exercise, if there is any underachievement, the regional office then has to decide how to intervene in a trust's operations. There are different degrees of intervention, depending on how serious a problem is perceived to be:

> "Intervention ranges from [i] discussion with the officers within that trust to say what is going wrong, getting them understanding the cause of that, discussing whether they are going back on their targets, how they are going back on targets, as a sort of informal discussion to [ii] a formal implementation of an immediate plan saying 'right, you have gone wrong by 10%, produce a formal plan signed up by the trust board to bring that 10% back down to target in a specified time." [3]

In addition, intervention may sometimes be imposed directly from central government. Examples can be found in recent media reports of 'naming and shaming' exercises where hospital trusts have failed to meet standards for waiting lists and hygiene:

"Government "action teams" are to be sent into seven hospital trusts after figures revealed severe waiting list problems. Staff from the government's "National Patient Access Team" will visit all seven this week and draw up a recovery plan, expecting "dramatic improvements" within six months." (BBC News Online, 2000)

"Forty-two hospitals will today be named and shamed by the government for having poor standards of hygiene as part of its campaign to clean up the NHS…. Ten of the worst culprits have already been put on "special measures" and hit squads of experts from the best trusts are to be sent in to tackle the problem and raise standards of cleanliness before an autumn deadline." (Society Guardian, 2001a)

One of the Trusts targeted in the 2000 waiting list action was under the jurisdiction of the NWHA and NWRO. In response to the 'naming and shaming' exercise, the Head of Performance Management within the North West RO argued that "the [National Patient Access Team] involvement was very much a political role" [3]. He further noted that this illustrated 'one extreme' of intervention that might result from performance measurement:

"Interventions range from one extreme - the minister or secretary of state highlighting a problem and sending in a team - to the other, which is us looking at things that are starting to go wrong and developing a dialogue with the hospitals about what needs to be done to bring things back on target." [3]

Therefore, performance interventions range from gentle, informal discussions, to public 'naming and shaming' – the latter perceived as having a much greater political element.

Intervention also takes the form of rewards. A recently introduced system of 'traffic light' gradings of NHS organizations forms the basis for identifying those trusts and HAs that need intervention, but also those which have earned greater autonomy. The NHS Plan explains:

> "All NHS organizations … will for the first time annually and publicly be classified as 'green', 'yellow', or 'red'. Criteria will be set nationally but assessment will be by Regional Offices with independent verification by the Commission for Health Improvement…. Red status will result from poor absolute standards of performance, triggering action … to ensure a 'floor' level of acceptable performance is achieved throughout the NHS. Green status reflects both outstanding absolute performance against core national targets and relative performance against the wider Performance Assessment Framework measures….The green-light NHS organizations will be rewarded with greater autonomy and national recognition." (DoH, 2000a; pp. 63-64)

These strong forms of intervention (both sanctions and rewards) transform the SaFF from a planning and performance measurement tool to a powerful accountability mechanism. NHS organizations that were assured they "need no longer fear the consequences of sharing information" (Alan Milburn, Minister of State for Health in DoH, 1998b; p.3) now face the prospect of being picked out as 'failing' organizations or 'outstanding performers'. And, there are real consequences. Some 'failing' trusts, for example, will have "new management teams drafted in" and be franchised out to external, private management (see BBC News Online, 2002). At the other extreme, new 'foundation trusts' are to enjoy unprecedented autonomy and financial freedom (DoH, 2002).

Improvement

The declared purpose of such intervention is to "serve as an incentive for continuous improvement on the part of all [NHS] organizations" (DoH 2000a; p.63) and to bring under-performing organizations back on track towards the initial targets. It might be argued that there are many reasons that things could go wrong. However, from the point of view of accountability, once local NHS organizations agree the SaFF with their ROs:

> "There is an obligation on that chief executive (of a local NHS organisation) to make it happen. If it is totally out of his control, then that chief executive should really been identifying it very early and bringing it the attention of the whole system." [3]

It is also likely that an HA or trust chief executive who repeatedly fails to deliver national targets will be removed from his/her position:

> "Alan Milburn, the health secretary, yesterday identified the 12 worst performing hospital trusts in England and said he would fire their chief executives if they could not deliver rapid improvement." (Society Guardian, 2001b)

Improvements in performance, therefore, seem predicated on improvements in the management of NHS organizations. Some chief executives have indeed been fired for poor performance. The Head of Performance Management within the SERO argues that:

> "A lot of the NHS chief executives are very poor in management. We have got rid of a number of them because they do not believe in effective performance."[4]

The issues of effectiveness and efficiency appear difficult to separate here, however. In at least one case where a trust appeared to have met clinical and patient-orientated targets, a chief executive was fired because of an increasing financial deficit problem (see Lawrence, 2003). The signal here is that financial performance has higher priority than is explicit within the SaFF framework. Such particular issues, if focused on in SaFF-based performance reviews, seem likely to direct any consequent improvements, therefore.

Whatever the relative emphasis placed on different performance measures, it is clear that new NHS performance measurement initiatives, such as the SaFF, help to operationalise direct accountability relationships. The commitments formalized within SaFF agreements provide a basis for triggering such interventions and for holding

HAs accountable for failing to achieve agreed targets. The interventions and consequences that may follow are substantial, and herald a new era of NHS accountability.

Financial Accountability

The SaFF exercise is not only about agreeing performance targets. It also demonstrates how each health community uses its allocated financial resources. In terms of financial accountability, each health authority is required to deliver all the national targets within a set financial budget. In other words:

> "They [health authorities] must balance the books at the end of the financial year. They must break even. So that will be their financial target." [5]

To ensure that health authorities are on track to achieve break even each financial year, there is a quarterly monitoring process. This process requires that each HA submit its financial accounts to inform its RO whether the financial imperative of breakeven is to be delivered.

The approach taken to assure financial accountability seems, therefore, to assume that if all national targets are achieved within budget, efficiency is achieved. Yet, as suggested by a financial officer for the SERO:

> "It is almost like setting a target for activity and saying that you must deliver that within a breakeven framework. By delivering that, by definition you will spend your money efficiently. If you can hit all the targets that we want you to hit, you must be giving value for money".[5]

This appears to run counter to government rhetoric, which has signaled a move away from simple measures of "financial efficiency" and "counting the number of patients treated", towards measures of "real efficiency" that incorporate both "cost and quality of care" dimensions (DoH, 1998a, p.3). Also, the introduction of the National Reference Costing Exercise has placed the focus of financial efficiency clearly at the level of comparative benchmarking across the NHS (see Northcott &

Llewellyn, 2003a), rather than on any internal balancing of organizational books. The SaFF mechanism is not perceived as capturing the benchmarking philosophy behind these initiatives, however.

The evidence from this case study suggests that, although the SaFF has reinforced the importance of financial accountability, it has done little to reform notions of financial efficiency. Instead, it emphasizes a traditional accountability perspective where losses cannot be tolerated and efficiency is equated with break-even.

Issues Regarding the Use of the SaFF as an Accountability Mechanism

Clinician Commitment

The Service and Financial Framework is intended to be an accountability mechanism by which local NHS organizations demonstrate how they will deliver central government's requirements within allocated financial resources. Although the government believes that the SaFF can compel local NHS organizations to deliver those national targets, there may be practical barriers. First, some NHS actors perceive a lack of ownership of those targets by clinical professionals. The Head of Performance Management in the South East RO argued that:

> "Lots of doctors do not get down to thinking about the government policy… the problem is that they do not recognise themselves as employees of an organisation. They do not have the loyalty to go for the objectives of that organisation. They practise as freelance, individual professionals. They will try to continue to improve the standard of care they deliver to patients, despite whatever is in the NHS Plan." [4]

The SaFF exercise may impose accountability on managers within local NHS organizations, but the people delivering health services are the clinical professionals. If they are unwilling to commit to national requirements, it is unclear whether the SaFF can work well as an accountability mechanism. This is an issue of professionalism, which warrants further study.

Financial Resources

Second, the Head of Performance Management in the North West RO argued that some of the short-term targets incorporated within SaFFs are far too tough, with financial resources for achieving them limited:

> "The ministers do not appear to fully appreciate where we are now.… There is always a gap between the reality and ministers' perceptions of what is happening…. they [ministers] only want to hear the good news etc.… the gap between the reality and ministers' perception of where we are has grown increasingly in the last [Labour] government." [3]

Given this perceived gap between reality and ministers' perceptions, the government might under-estimate the amount of money needed to deliver national health targets. The North West RO Head of Performance Management further argued that:

> "They [Labour government] appear to imply that the funding required to deliver the changes to meet the NHS Plan is far less than we really need… we spent much less of our GNP on health than most of the western world. And even after the funding increase in the next three and four years, we still will spend much less than most of the western world. And the NHS plan describes the NHS as probably one of the best in the western world. If they think they can get an NHS which is one of the best in the western world by giving extra money, but still end up with one of the worst funded in the western world, then there is incompatibility." [3]

He then sums up the likely outcome of this – an unfavorable one in terms of motivating continuing performance improvements:

> "It's likely, therefore, that we're having a period of expectation, probably to be followed by a period of disappointment.[3]

Measuring Efficiency

Third, financial performance measurement might not be sufficiently comprehensive within the SaFF exercise. As discussed earlier, the government believes that financial accountability is achieved by local NHS organizations when targets are delivered within the limit of allocated financial resources. However, since it is argued that some of those targets might be too tough, financial resources might be inadequate for local NHS organizations to deliver all the required targets. This research was conducted early on in the SaFF's implementation, so it is not yet clear whether all targets can be met by every health community. But, for those that do achieve the targets, it may be reasonable to assume that they have spent public funding efficiently. However, for those that do not, perhaps the majority, there are no proper measures within the SaFF to indicate whether public funding has been spent efficiently, or to direct future efficiency improvements.

The issues discussed above could limit the effectiveness of the SaFF as an accountability mechanism. As the use of SaFFs develops, these issues warrant further examination. Since this study focuses on the perspective of managers, it is suggested that future study focus on the clinical and medical profession to discover their attitude towards the SaFF. Additionally, it would be useful to compare how allocated financial resources are spent in organizations that do or do not achieve all required SaFF targets, to suggest suitable performance indicators for measuring financial accountability.

THE SERVICE AND FINANCIAL FRAMEWORK AT HEALTH AUTHORITY LEVEL

The targets specified in a health authority's SaFF are intended to ensure that its use of public funding is consistent with government policy. Therefore, how the local HA conducts and reacts to the SaFF exercise will determine whether this accountability mechanism serves government aims. This section presents some preliminary empirical evidence of how one north west health authority (denoted NWHA) commits itself to central government accountability requirements via the SaFF exercise, and identifies some implications of the development of this accountability mechanism.

The SaFF and Target Setting at NWHA

For NWHA to fulfill its accountability requirements, it has to demonstrate in its SaFF how will use its allocated public funding to achieve national targets and milestones. In the case of heart disease, for example, it has committed itself to achieving the target that '75% of heart attack patients should receive thrombolysis treatment within 30 minutes by March 2002', despite a considerable gap between this target and the current situation (see Table 2).

Health authority plans for commissioning Coronary Heart Disease services		
Host HA basis	*Expected number at March 2001*	*Planned number at March 2002*
% patients where first response is within 8 minutes of a Category A call to the ambulance service	70	100
% patients who receive thrombolysis within 30 minutes of hospital arrival	23	100

Table 2: Excerpt from the NWHA SaFF report for coronary heart disease

The NWHA's preparedness to commit to this challenging target seems to suggest that the adoption of clinical standards drawn from the Coronary Heart Disease National Service Framework (DoH, 2001; p.30) would give more convincing direction for local managers. As suggested by the NWHA Director of Public Health:

> We've got all these specific measurable targets for the trusts, specific targets for primary care teams, specific measurable targets for the community and that makes a difference. We've got something to work towards.[6]

The formalized requirement to achieve this government-led SaFF milestone gives this HA a chance to direct resources towards reducing the gap between its current situation and the required target. The acknowledgement of this gap compels the HA to utilise its allocated funding to address current shortfalls in performance. As a consequence, the NWHA made a decision to commit funds to an additional thrombolysis nurse position in order to speed up the delivery of thrombolysis services. In this instance, therefore, the SaFF target setting process had a direct

influence on redirecting resource utilization and improving an aspect of health care delivery. The prospects for meeting this target are now much improved.

National versus Local Accountability

Although national health targets may be of concern to the general public, the focus of those national requirements might not take specific local issues into account. In the case of the NWHA, efforts have been made to narrow the gap between national targets and current performance. However, this may have drawn attention away from local variations within the health authority, thus reducing the HA's accountability to its local population. While the issue of accountability towards local populations is beyond the scope of this study, future research could investigate the influence of the SaFF on local accountability.

Waiting Times and Waiting Lists Management

Reducing waiting lists and waiting times has been one of the Labour government's top health priorities. The Head of Performance Measurement of the NWHA noted that:

> "The issue of reducing waiting times has become an important political agenda and the political consequences are potentially very high, because automatically it could mean that chief executives loose their jobs."[7]

Within the SaFF exercise, each HA is given waiting list reduction targets by its regional office. To ensure these targets are delivered, the monitoring of waiting lists has become one of the most important performance management issues for every RO. For local HAs, the submission of information regarding waiting lists and times is a statutory requirement. However, this RO level report is considered unhelpful for local performance management, since it is argued that:

> "It is a feeding machine to the central government…. Things happen at local level. They don't happen from the regional level or from the centre … it is like a big stick to beat you up.[8]

At another level, waiting list information is seen as a useful indicator of other problems, however. At the NWHA, waiting list information has been drawn on in performance management:

> "It is an early indicator of whether or not we have a problem. Reducing waiting times in itself doesn't solve anything. It is just an indicator of whether we have a problem either at this end, referrals coming in, or that end, activity going through the door." [8]

For example, there was a sudden rise of referrals in May 2000, and as a result, the number of people referred was greater than the number treated. By monitoring people on waiting lists, the NWHA found that most of the additional referrals came from A&E, since people could not get hold of their GPs during bank holidays. Therefore, by looking at waiting times and lists, the NWHA was able to gain an early indication of a related problem.

Although waiting list information can reflect whether the provision of secondary care is efficiently and effectively managed, it does not consider clinical priorities. In order to avoid breaching agreed targets, NHS organizations might manipulate their waiting lists and patients who need more complicated operations might not be afforded priority:

> "The way we did it was that we did a lot of easy operations. So you reduce the number of people on the waiting list, but it was not necessary in the right priority order health wise. So you got a lot of people with tiny problems who were treated. But people with big operations, such as hip replacements or other joint replacements, may have to wait longer than they should have done. Now we hit the target and that is what we have to."[8]

This sort of waiting list manipulation has been commonplace (see: Society Guardian, 2001c; BBC News Online, 2001), and the government has begun to take severe action against this practice (see: The Guardian, 2002).

Aside from issues of deliberate manipulation, the quality of data gathered to monitor SaFF performance is an important issue in achieving effective accountability. As mentioned earlier, the Service and Financial Framework for 2001/2002 has included new indicators because of the introduction of the NHS Plan and National Service Frameworks. For those existing indicators, such as waiting lists, information systems are relatively well developed. However, for new indicators, data collection systems may not be in place. For example, the indicator – "number of smokers who set a 'quit date' with the smoking cessation services", is a completely new data item. Within the NWHA, there is no information system in place to collect relevant data for this indicator. Hence, it is likely that data provided by different providers could be inconsistent. As it is argued:

> "The story told by the local NHS to the Department of Health is very volatile…. there is sometimes a culture whereby as long as you can generate a figure then people don't worry too much… the figure of smoking that goes to the regional office, it is just a guess." [9]

For benchmarking purpose, if information systems are not adequate, or if health communities interpret indicators or collect information differently because of different ways of providing services, the data used by central government may not capture true performance differences. At this early stage of the SaFF's development, it seems likely that such problems of information quality may limit the framework's usefulness as an accountability mechanism.

DISCUSSION AND CONCLUSIONS

In order to enhance the performance and accountability of local NHS organizations, the Labour government has imposed a more stringent monitoring process by integrating performance measurement into the mandatory SaFF exercise. Evidence from the North West region suggests that the studied RO has used identified

indicators to performance manage its local health communities, which involves performance monitoring, intervention and, (it is intended), improvement. The studied HA has also committed itself to achieving specified short-term targets via its SaFF submission. However, concerns remain about issues related to financial accountability, clinicians' support, local accountability, the achievability of some targets drawn from National Service Frameworks, and information quality. These points can be summarised as follows.

Financial Accountability in the SaFF

First, although the Labour government committed itself to invest much more public funding to the NHS to support its long-term objectives, the aspect of financial accountability is not comprehensively captured within the SaFF framework. The assumed HA goal is to achieve required targets within the limit of allocated financial resources. Achieving financial break-even may not be a comprehensive indicator of how efficiently (and effectively) financial resources have been spent, however. In other words, there is a lack of performance indicators to ensure financial accountability by local NHS organizations. This in turn limits the effectiveness of the SaFF in operationalizing a comprehensive accountability relationship.

In terms of efficiency measures, the government acknowledges that the evaluation of efficiency lies beyond the SaFF itself. The SaFF merely formalises efficiency improvement targets. The *measurement* of efficiency is operationalised via NHS-wide benchmarking, rather than by a comprehensive assessment of the efficiency of each NHS organization in relation to its own SaFF objectives and outcomes. Efficiency is to be benchmarked against the Reference Cost Index results for the "best [performing] trusts around the country", judged according to criteria set out in the Performance Assessment Framework (PAF) (DoH, 2000c; p.13).

Two practical difficulties with this approach are (i) the problems of capturing comprehensive performance data to monitor the complex and varied health outcomes represented in the PAF (Northcott & Llewellyn 2003b) and (ii) issues related to the reliability of reference cost data as a measure of NHS trust efficiency (Northcott and Llewellyn, 2002 & 2003a). Besides these practical issues, Klein (1999) articulates a more fundamental challenge to the benchmarking approach. He notes,

in relation to the government's aim of comparing the relative performance of health care providers, that it "is likely to encourage the expectation that it will be possible, in Nye Bevan's words, 'to generalize the best' – by definition, an impossible policy aim" (Klein, 1999; p.2).

To explore this issue further, future research could compare how allocated financial resources are spent in organizations that do or do not achieve all required SaFF targets, to suggest suitable performance indicators for measuring financial accountability.

Second, it is argued that the aims and processes associated with the SaFF exercise might not enjoy full support and commitment from clinical and medical professionals. In particular, some measures (e.g. waiting lists targets) may be perceived as encouraging the manipulation of clinical priorities. Since this study focuses on the perspective of managers, the attitudes of health professionals towards the SaFF have not been examined. Future research could focus on the perspective of the clinical and medical professions, studying the impact of professionalism on the SaFF's utility as an accountability mechanism.

Third, it is suggested that the SaFF might ignore local NHS organisations' accountability to their populations. Short-term SaFF targets are linked to government's long-term objectives, which are believed to be of most concern of the general public (and therefore, or greatest political import). However, these targets may not reflect specific needs of local areas. It is therefore argued that the focus placed on national targets might ignore specific local variations, resulting in a lack of local accountability. In other words, the use of the SaFF may enhance local NHS organisations' accountability to central government, but ignore accountability to local populations. In this case, the SaFF is functioning mainly as a political tool, assisting the government to deliver a political message to the general voting public. It is perhaps less effective in promoting health improvement according to local needs.

To ensure that health equality is achieved via the provision of consistent national clinical standards, effectiveness-based standards drawn from the National Service Frameworks are integrated into the SaFF. Although some targets for

2001/2002 are hard to achieve, evidence from the NWHA suggests that the integration of clinically effective indicators is welcomed, since this offers more certain and convincing targets to work towards.

Finally, effective information systems are crucial to the use of the SaFF as an accountability mechanism. Evidence from this study suggests that no appropriate information systems are available for newly developed indicators, which might compromise the consistency, quality and comparability of data used. Therefore, the improvement of information quality will be central to developing the SaFF as an accountability mechanism for reporting and evaluating the performance of local NHS organizations.

The issues raised in this study have implications for effective use of the SaFF for its intended performance measurement and accountability purposes. But, since this study was carried out during the early development of the SaFF for 2001/2002, it is not yet clear how these issues will impact. Future research is warranted to consider these issues as they unfold.

NOTES

See the Appendix for a summary of the key health care priorities identified in DoH, 2000b.

[1] A procedure to re-establish blood supply to the heart.
[2] Interview with the Head of Performance Management of the NHS Executive North West Regional Office, 27th April 2001.
[3] Interview with the Head of Performance Management of the NHS Executive South East Regional Office, 15th March 2001.
[4] Interview with a financial officer of the Finance Department of the NHS Executive South East Regional Office, 15th March 2001.
[5] Interview with the NWHA Director of Public Health, 02 May 2001.
[6] Interview of the NWHA Head of Performance Management, 13th July 2001.
[7] Interview with a NWRA Information Department Officer, 18th July 2001.
[8] Interview with the NWHA Director of Public Health, 5th July 2001.

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