

The quest for effective regulation and performance management in UK public services

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Abstract

Regulatory bodies and performance management systems have proliferated in recent years in UK public services. Furthermore, as the shortcomings of one body or system are revealed, the preferred solution is frequently to replace them with new versions. This approach is costly and often does not seem to solve the problems it seeks to address. Indeed the result can be confusion and diminished performance at least in the short term as new people try to get to grips with the problems that their predecessors failed to solve. The new approaches have tried to replace trust in professionalism of individuals with monitoring of formalised performance measures, in an effort to improve economy, efficiency and effectiveness. As is well-documented in the literature, the focus tends to be on the first two of these, as the third is notoriously difficult to measure. Examples abound of the dysfunctional consequences in health and education, to name but two areas of public services, as organisations strive to ‘meet the target’, but unfortunately ‘miss the point’.

This paper will review relevant literature and publicly available documents on regulatory and performance management practices in UK public services in recent years, with a particular focus on the English National Health Service (NHS). It will investigate the changes that have occurred as new regulatory bodies and performance management systems have come to replace old ones, including the cost implications and outcomes of these changes. Drawing on the evidence of the recently-concluded public inquiry into events at Mid-Staffordshire NHS Trust (www.midstaffspublicinquiry.com), where it is believed hundreds of patients may have died needlessly as the organisation struggled to achieve a particular performance target (maximum four hour waiting time for patients arriving at hospital Accident and Emergency departments), the study will discuss not only performance management issues, but also the broader concerns raised regarding regulatory bodies and their fitness for purpose. It will also consider the future for healthcare in England, with a discussion of the latest developments in appointing Monitor as an economic regulator tasked with extending competition in the sector.

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1. Introduction

Regulatory bodies and performance management systems (PMS) have proliferated in recent years in UK public services. Furthermore, as the shortcomings of one body or system are revealed, the preferred solution is frequently to replace them with new versions. This approach is costly and often does not seem to solve the problems it seeks to address. Indeed the result can be confusion and diminished performance at least in the short term as new people try to get to grips with the problems that their predecessors failed to solve. The new approaches have tried to replace trust in professionalism of individuals with monitoring of formalised performance measures, in an effort to improve economy, efficiency and effectiveness. As is well-documented in the literature, the focus tends to be on the first two of these, as the third is notoriously difficult to measure. Examples abound of the dysfunctional consequences in health and education, to name but two areas of public services, as organisations strive to ‘meet the target’, but unfortunately ‘miss the point’. Regulation and performance management systems are devised and implemented in a top-down manner, and this paper argues that one consequence of this approach is an over-emphasis on the expected efficacy of surveillance and a neglect of the crucial role of agency. In the current era of financial crisis and consequent shrinking of resources available for public services, opportunities should be sought to channel more to front-line services and less to (often ineffective and counter-productive) ever-changing regulatory mechanisms.

2. Prior research

There is a body of research which investigates performance management in the NHS. In the UK, performance management in the public sector is based on an ongoing monitoring of quantitative performance indicators that have proliferated rapidly (Hood, 1991, 1995). Targets in the UK are supposed to achieve better value for money and accountability through public scrutiny. Regulation by targets assumes that priorities can be targeted, that the areas measured are representative of the whole, and that what is excluded does not matter. Centrally determined top-down implementation of organisational performance targets can trigger distortions in behaviour, as employees or organisations modify their actions to improve performance indicators chosen (often based on their ease of measurement rather than importance). Hood (2006) identifies the dangers of ‘gaming’ behaviour associated with such metrics in public services. Problems arising from gaming mean that even when reported performance meets targets, there is no assurance that desired performance has been achieved. Undesirable and hidden consequences include: areas not subject to performance measurement may have been neglected in order to focus on those subject to targets; unintended actions may have been taken to meet the targets (‘hitting the target and missing the point’); data may have been falsified (Bevan and Hood, 2006). A set of strategic performance measures is usually suggested as the solution, but would require that some of the less traditional, more qualitative

aspects of performance be accounted for, and the difficulties of doing so are often the reason for more instrumental targets being devised in the first place.

A number of recent studies on performance measurement and management in health services illustrate the problems associated with an instrumental approach to design of new performance management systems. Studies which have focussed on financial aspects of performance measurement in the NHS include those by Northcott and Llewellyn (2003), who criticise the calculation of average costs in health services in England, and direct attention to causes of inconsistencies which adversely affected effective benchmarking comparisons. Subsequently they examine the influence of these practices on cost comparisons, concluding that processes of hospital life “become average” as they are transformed to comply with the cost accounting average (Llewellyn and Northcott, 2004).

Failure to provide evidence of an integrated and balanced approach to measuring cost and quality in health services, as reported in previous studies (Jones, 2002; Guven Uslu, 2005; Guven Uslu and Conrad, 2008) further illustrate the adverse impact on the overall concept of performance management and its understanding and implementation in the NHS. Other studies explain the impact of power relations between professionals, as new costing systems provided more visibility to organisational activities (Conrad and Guven Uslu, 2011; Llewellyn and Northcott, 2005; Chua, 1995).

One recent study contributed to the performance management debate by providing longitudinal empirical evidence on the ‘process of change’ in health services, where new financial and non-financial performance metrics had the potential to facilitate communication and collaboration between clinicians, managers and accountants (Guyen Uslu and Conrad, 2011). The increasing importance of accurate coding of medical activity for purposes of income management was considered to have a direct influence on the need for, and provide a catalyst for, improved communication between professional groups.

Broadbent and Laughlin (2009) discuss the importance of understanding the distinctive conditions that apply where a PMS is being designed for use by one organisation to regulate ‘at a distance’ the activities of another organisation in the public sector. Their analysis leads to the conceptualisation of a ‘middle range’ (Laughlin, 1995, 2004) model of the alternative nature of PMSs, lying on a continuum from a ‘transactional’ ideal type at one end to a ‘relational’ ideal type at the other, built on respectively underlying instrumental and communicative rationalities, and guided by a range of contextual factors. In the former approach performance indicators are likely to be primarily calculation-oriented, while in the latter are more likely to be values-oriented. They suggest that the likelihood of participants taking ownership of the ends and means of the PMS are likely to be low for a ‘transactional’ approach and high for a ‘relational’ approach.

There is a little academic literature on the developments in regulatory bodies and their accountabilities in the NHS. This paper will review relevant literature and publicly available documents on regulatory and performance management practices in UK public services in recent years, with a particular focus on the English National Health Service (NHS). It will

investigate the changes that have occurred as new regulatory bodies and performance management systems have come to replace old ones, including the cost implications and outcomes of these changes. Drawing on the evidence of the recently-concluded public inquiry into events at Mid-Staffordshire NHS Trust (www.midstaffpublicinquiry.com), where it is believed hundreds of patients may have died needlessly as the organisation struggled to achieve a particular performance target (maximum four hour waiting time for patients arriving at hospital Accident and Emergency departments), the study will discuss not only performance management issues, but also the broader concerns raised regarding regulatory bodies and their fitness for purpose.

3. Theoretical framework

The analysis in this paper is informed by the theoretical framework developed by Dillard et al (2004). This framework recognises the political nature of institutional change, and alerts us to the value of considering three levels in the analysis: the institutional level, the organisational field level and the organisational level. It draws on the work of Weber (Weber, 1968). Weber's axes of tension (representation, rationalisation, power) provide a three dimensional representation that is applied within each of the three tiers of the institutional framework. Rationality encompasses legitimating grounds, while representational schema are the symbolic constructs underpinning actors' 'stocks of knowledge' and understandings. Power relations are important in interactions within and between the various levels. Weber's conceptions of formal versus substantive rationality and subjective versus objective representations offer 'axes of tension' to contrast the implications of alternative approaches to performance measurement and regulation. Broadbent and Laughlin (2009) suggest that a PMS based on formal, rather than substantive rationality and objective rather than subjective representations is less likely to be meaningful to the actors subject to it, and so the potential for dysfunctional consequences is greater.

This study of the NHS examines the role of the Department of Health and regulatory bodies at institutional level, the Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) at the organisational field level and the NHS Trusts and Foundation Trusts (FTs) at the organisational level. It also considers the changes made in the recent past and those to take place in the near future at the various levels in order to investigate whether axes of tension exist, which may provide the potential for contradictions to arise as understandings of the meaning of assuring 'quality of healthcare' are reconstructed.

Power (2007) discusses the centrality of 'infrastructures of referentiality' as the prevailing trends of audit and inspection in public services require that service attributes are rendered auditable. Well-governed organisations become synonymous with auditable organisations. He raises the concern that these infrastructures become increasingly self-referential, as the need to be auditable constructs the conception of what are the important attributes of services. Espeland and Sauder (2007) discuss 'commensuration' as one mechanism that induces reactivity, a change of behaviour in response to being evaluated, observed or measured. They emphasise the importance of agency and of making more explicit how actors make discourse meaningful in ways that shape their behaviour. Commensuration is characterised

by the transformation of qualities into quantities that share a metric, a process fundamental to measurement. This process shapes what we pay attention to, the connections between things, both creating and obscuring relations among entities. It decontextualises knowledge, so that meaning can be recreated and reinterpreted, and new understandings of accountability can emerge.

These insights are important in understanding and analysing the developments in New Public Management generally and in UK healthcare particularly in recent years. The commensuration of healthcare to render it amenable to inspection and measurement has been characterised by a proliferation of regulatory and performance measurement bodies, and a plethora of mainly quantitative measures, which seek to report on and compare performance of hospitals.

The paper outlines the regulatory bodies and their approaches to performance measurement in recent years. It discusses some of the dysfunctional consequences of the approach with reference to events at one particular English hospital where the quest to meet targets and achieve desirable 'Foundation Trust' status resulted in appalling standards of care for patients, some of whom died unnecessarily. The paper then considers plans for the future and possible implications as yet a new set of regulatory bodies and approaches to control seek to provide new visibilities and understandings as a competitive market for healthcare is more fully developed.

4. Regulatory bodies

Institutional level

The story of regulation and performance measurement in healthcare over the last decade or so has been one of multiple bodies, sometimes conflicting and unclear responsibilities and accountabilities, reformed frequently and with changing remits.

Under the NHS 2006 Act the Department of Health (DoH) has ultimate responsibility and accountability to Parliament for the promotion of a comprehensive healthcare service in the UK. Its duties are delegated to an intermediate tier of management, including Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), and it has also put in place a range of regulatory bodies. Its approach has been one of conflicting policy actions which in some cases have sought to devolve power and to decentralise and remove itself from direct decision-making, while on the other hand to centralise power through increasingly tight management of performance through targets and other measures. According to Walshe (2011):

I think most commentators would say that between 1997 and 2002/2003, the NHS was increasingly centralised and power was exercised much more from the Department of Health, than it had been in the past, before 1997. From 2003 onwards, government adopted a series of changes, the creation of foundation trusts, policy on patient choice, policy on payment by results and the way in which organisations were reimbursed or funded for the care they provided, which – the introduction of an increasing role for non-NHS healthcare providers in the independent sector, all of those things spoke to a desire to create a much more diverse, plural and decentralised healthcare system in which the Department of Health would not performance manage every healthcare provider. So there are two

slightly contradictory, if you like, lines in policy development.

Furthermore the distinctions between regulatory and performance management activities are often unclear and / or overlap in the same organisations. There is not always a clear third party relationship, as opposed to a hierarchical relationship, for regulation as opposed to performance management, accountabilities can be confused and confusing and sometimes lead to a ‘form of hybrid regulation alongside performance management in place’ (Walshe, 2011).

The main national regulatory bodies which have existed over the last ten years are explained now, and the regional bodies are discussed in the next section.

The Commission for Healthcare Inspection (CHI) was set up in 1999 following a public inquiry into a scandal relating to paediatric cardiac care in one English hospital. Its remit was mainly the review of clinical governance, defined as:

‘..a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’ (Department of Health, 1998).

Under the NHS Plan (DoH 2000) it was also given responsibility for leading the collation and publication of performance assessment data, in collaboration with the DoH and the Audit Commission.

In 2002, the government announced plans to reform health and social care regulation with the creation of two new ‘super regulators’, firstly the Commission for Health Audit and Inspection (CHAI) to regulate all healthcare provision, and secondly the Commission for Social Care Inspection (CSCI) to regulate all social care. The CHAI, established in 2003 and subsequently known as the Healthcare Commission (HC), took over all responsibilities of CHI, private healthcare regulation functions which were previously the remit of NCSC and also the VFM audit function of the Audit Commission. It regulated around 582 NHS Trusts.

In April 2005, just over a year after the setting up of HC, the Chancellor of the Exchequer announced extensive reform of public service regulation and inspection, and a significant reduction in the number of regulatory bodies. The decision was taken to set up the Care Quality Commission (CQC) to take over the roles of HC, CSCI and Mental Health Act Commission. CQC was established in 2009, with a budget of £164 million (significantly less than the combined budgets of its three predecessors), and tasked with wide-ranging and diverse responsibilities. In 2010 the coalition government launched the new programme of reform in the White Paper ‘Equity and Excellence: Liberating the NHS’, with further changes announced for the role of the CQC and healthcare regulation. It is also responsible for a new system of registration of healthcare providers, a massive job in itself, which has consumed a large proportion of its resources to date.

Another regulatory body, Monitor, was set up in 2004, whose remit was to oversee newly-established Foundation Trust (FT) hospitals (FTs are discussed further below). Monitor

evaluates applications for FT status and also regulates these hospitals. Its authorisation process assesses their governance and leadership, as well as their financial viability and robustness. Once established FTs are regulated by Monitor, which requires regular performance reports from them, and has extensive powers to intervene if problems arise.

In spite of, or perhaps because of, the many bodies involved and frequently changing oversight and performance evaluation arrangements, relatively little power to effect change was transferred into the hands of the regulators along with their many responsibilities. Newdick and Smith (2010), in concluding their report on the organisation and structure of the NHS, state:

'As expert witnesses with extensive experience of working within and alongside the NHS, the discipline of revisiting numerous policy documents promising significant change as a result of new management arrangements has left us chastened as we sought to document, explain and understand the apparently relentless 'redisorganisation' to which the NHS is subject.' (p.49)

Organisational field level

The Secretary of State for Health's duty under s.1 of the 2006 Act is delegated to SHAs, who are effectively the regional HQs of the DoH. They assist the development of local strategies to achieve central targets and objectives and monitor compliance with guidance from bodies such as CQC. The 'operational' duties under s.3 of the Act are delegated to PCTs, who are required to commission healthcare services from a range of providers, including GPs, hospitals, dentists, etc..

In 2001, Shifting the Balance of Power was published, creating 303 PCTs and 28 Strategic Health Authorities and four regional directors of health and social care. This reduced to 150 PCTs and 10 SHAs from 2006. In 2011 SHAs were reduced to 4 and PCTs to 50 'clusters'. They are to be abolished completely from 2013 and replaced by Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board.

Organisational level

There are currently two types of NHS hospitals, NHS Trusts and Foundation Trusts, with the latter having much greater independence than the former.

NHS Trusts are hospitals which were established as self-governing bodies with limited freedoms to provide services to Health Authority purchasers, as part of the purchaser/provider split. They are subject to direction by the DoH, must not exceed their financial allocations and are required to submit regular comparative performance data which enables them to be assessed against other hospitals.

Legislation to allow for the setting up of Foundation Trust hospitals was passed in 2003. These bodies are set up as ‘public benefit corporations’, a sort of halfway house between public and private sectors, and have greater autonomy and flexibility than NHS Trusts, being run by a Board of Governors and not subject to statutory powers of direction of the Secretary of State for Health. They have greater independence and powers to define their own constitutional and governance arrangements, to borrow money and to hold assets, including retaining surpluses from operations.

In order to attain FT status, a NHS Trust must meet specified standards of performance as judged by prevailing performance measurement metrics, discussed further in the next section. By 2014 the government intends that all remaining NHS Trusts should have acquired FT status.

5. Performance management frameworks

The regulatory bodies discussed above used several different frameworks to assess performance over time. Given the amount of change in just over a decade, documented above, it is perhaps unsurprising to learn that these numerous, short-lived bodies did not always have clear remits, responsibilities or accountabilities. Furthermore, their authority to act where problems arose was often severely limited.

Star ratings, Annual Health Check, National Outcomes Framework

The annual performance ratings for NHS Trusts, known as ‘star ratings’, were introduced in 2001 (DoH, 2001). Responsibility for them was taken over by the HC from 2003. The system ostensibly included measures to assess both cost and quality, and incorporated rewards and sanctions, including the threat of ‘naming and shaming’, by awarding Trusts a rating of between 0 and 3 stars, depending on their achievement of certain targets. In order to be considered for award of coveted FT status, the initial requirement was that a Trust had to achieve a 3 star rating. Where a rating of 0 stars occurred, Trusts were in danger of having management removed and replaced, if major improvements were not demonstrated within a short time period. The star ratings system was apparently intended to balance measures of efficiency and quality, and to reward those hospitals that achieved excellent results across the range of measures. The system incorporated two elements, a number of key national targets and a range of balanced scorecard (BSC) indicators. The former included maintenance of financial stability and a range of other measures, many of which related to patient waiting times for different types of treatment. Reduction of waiting times was a key pledge of the Labour government in its election manifesto, as these had been a political ‘hot potato’ for many years. The BSC indicators related more to quality, and included clinical, capacity & capability and staff measures. On closer examination, though, even these incorporate very little focus on clinical standards, and waiting times again feature strongly. According to Chang (2009) the key targets were classified as ‘must dos’ and a hospital could receive 2 stars provided it achieved the key targets, even if it missed most of the BSC indicators. Conversely a Trust could receive a zero star rating if it failed 2 to 3 key targets significantly, regardless of how well it performed on BSC indicators.

The 'Annual Health Check' (a system based mainly on self-assessment by Trusts) replaced star ratings in 2005, after criticisms that the latter were too onerous and targets driven. Key performance indicators remained a crucial aspect of the new system, however. This was superseded by the National Outcomes Framework from 2009, which attempted to address the criticism that previous PMSs were too focussed on quantitative targets rather than health outcomes for patients.

6. The case of Mid Staffordshire NHS Trust

The consequences of the limitations of the regulatory system are clearly apparent in the case of Mid Staffordshire NHS Trust, where an HC investigation uncovered 'appalling standards of care', and high numbers of unnecessary deaths. The investigation was triggered by unexpectedly high mortality statistics reported by an independent body, Dr Fosters, which monitors these statistics nationally. The findings of the HCC inquiry paint a picture of a Trust Board more focussed on attaining FT status, and achieving the necessary targets and cost savings to make that possible, than on patient care. It also reveals regulatory bodies whose activities were not sufficiently rigorous or synchronised to identify warning signs or to follow up reports of negligent care, of which there were many over several years. It also revealed the shortcomings in specifying adequately the responsibilities of the various regulators, and their lack of communication on key issues.

The trust was granted foundation trust status from February 2008 by Monitor, after a process that had begun some three years previously, and the history of the application detailed in the public inquiry (www.midstaffpublicinquiry.com) is an interesting one. In 2002/2003 the Commission for Health Improvement had granted the trust three stars in its rating system. In 2003 to 2004 the trust received zero stars in the HCC's annual star rating. In 2004/2005 the HCC gave it one star. In February of 2004, the trust produced a document entitled "NHS foundation trust consultation document". In the foreword, the then chief executive, David O'Neill, said this:

"Mid Staffordshire General Hospitals NHS Trust has performed extremely well over the past few years and continues to deliver high quality patient services, reassured against high clinical standards and national performance targets. We believe that NHS foundation trust status is the right way forward ... It will give us the opportunity to become more closely aligned to the needs of the local community and the freedom to make our own decisions more quickly."

In 2005 the Shropshire and Staffordshire Strategic Health Authority, SASSHA, suggested that the trust was two years away from foundation trust status, particularly bearing in mind that it had received a one star rating from the HCC. In 2004/2005 the trust had a financial deficit of GBP 2.15 million. In October 2005 the trust predicted a deficit of 2 million. In fact, it achieved a surplus of GBP 500,000. In December 2005 the trust established a committee to ensure that it achieved foundation trust status.

In January 2006 a peer review of the trust standards for the care of the critically ill and injured children identified a number of concerns. A letter was sent to the trust identifying a number of immediate risks to clinical safety and outcomes. The letter specifically identified as a serious problem the lack of senior medical and nurse cover. In April 2006 it was announced at a board meeting that the trust faced a shortfall in funding from the SHA of GBP 10 million. The trust initiated action to save money by removing beds, reconfiguring the

wards and losing 150 posts. In June 2006 the board noted that the surplus at the end of the 2005/2006 financial year was an excellent outcome, particularly leading up to the application for foundation trust status. Also in June 2006 the SHA confirmed its support for the trust's application for FT status be made in November 2007, but the Strategic Health Authority feedback to the trust about its performance was based solely on Monitor's and the HCC's measurements. The support was given despite the adverse peer review in January of the same year, six months previously. In November 2006 the board was informed that the trust was in line to deliver GBP 10 million in savings in 2006 to 2007. The 2005 to 2006 the rating given by the HCC under the new system they had adopted was "Fair/Fair", representing quality of service and use of resources. In February 2007 the trust chief executive and chair made a presentation to the Stafford Oversight and Scrutiny Committee, after which the OSC supported the trust's application for FT status.

In May 2007 the HCC report of the patient survey placed the trust in the worst 20 per cent of trusts nationwide in a number of areas of care, particularly patient care, hygiene and dignity. Through 2007 there was constant focus on the finances of the trust, on saving money and increasing the surplus to try to meet Monitor's financial requirements for FT status. There was concern expressed at board level about the Dr Foster mortality rates and that the trust was performing very poorly in the national survey of patients. But there was no action plan to increase the number of nurses, nor to examine the causes underlying these problems. The 2006/2007 HCC rating was "Fair/Weak", against quality of services and use of resources. In October/November 2007 the HCC mortality outliers team generated 11 alerts for the trust. Also in October 2007 Monitor made three visits to the trust, in which key risks were recorded.

In November/December 2007 the trust submitted its application for foundation trust status. Despite the known mortality outliers and the keys risks identified in February 2008, Monitor approved the trust's application for FT status, although there was a side letter raising matters which had arisen in the assessment, including compliance with targets for A&E, MRSA and thrombolysis. In March 2008, the trust met with the HCC to explain the mortality data and the HCC began its investigation.

In explaining to the public inquiry how such a Trust had been awarded FT status, the former Chief Executive of HCC said:

'I believe that the AHC was some review of trusts' performance, I believe it had some quality of care in it, but it had its limitations....We had to carry out this annual rating. We sought to broaden that out. It did not cover all of the services or activities that each NHS Trust provided. That was absolutely impossible. It did include some quality of care measures.'

Dr Wood, who led the original HCC inquiry and gave evidence to the public inquiry on 10 May 2011, revealed her unease about AHC ratings being potentially misleading to the public in an email to two senior clinical advisors to the HCC in October 2008...It was 'a case of the Emperor's new clothes', she said, because 'we may describe one of the ratings as measuring 'quality of care' but it doesn't do what it says on the tin'.

In other evidence, Stephen Hay, Monitor's chief operating officer, admitted that it did not have a 'systematic, robust approach to assessing clinical governance' of the hospitals it was

responsible for. He said he believed there was confusion over whose job it was – Monitor’s or HCC’s to look at how the boards of FTs measured the quality of care they were providing.

He accepted that in 2007 Monitor placed insufficient emphasis on clinical, or quality, governance in its assessment process. Monitor was ‘heavily reliant’ on the HCC’s assessment of a trust in terms of quality of care provided. He added that:

‘Until we learned the lessons from the failings at the Trust, I do not think it was clear either to us or to the HCC which of us was looking at the way in which the boards of foundation trusts assured themselves of the quality of care they provided. This is an issue we have now addressed.’

7. Axes of tension

The foregoing highlights ‘axes of tension’ that have arisen as a result of developments in NHS regulatory bodies and performance measurement frameworks (see Table 1 below).

Table 1: NHS Regulatory Framework: Axes of tension

Cost / Quality
Corporate / Clinical Governance
Policy Evaluation / Performance Measurement
Transparency / Opacity
Outcomes/ Systems and Processes
Devolving / Centralising Power

There is a fundamental tension between controlling / reducing costs, making service provision more cost effective, while at the same time maintaining/ improving quality of care. The PMS was focussed on quantitative measures, even to assess quality, so many so-called measures of quality were in fact proxies based on waiting times for access to services. As the literature suggests, and as the evidence from Mid Staffordshire NHS Trust reveals, such commensuration is likely to change the behaviour of those being measured, towards a focus on what is being measured rather than the underlying rationale of improving patient care so that it is both timely and effective.

In assessing Trusts’ suitability for coveted FT status, Monitor’s focus has been on corporate rather than clinical governance. The Mid Staffordshire case revealed the impact of this on one organisation where the Board were so intent on proving their capabilities in the former that they completely marginalised the latter. The minutes of Board meetings showed an inordinate amount of time devoted to matters such as outsourcing the laundry service, while clinical governance issues merited only a few lines.

There has been a huge amount of change in the NHS, but very little attempt to evaluate policies before making changes. The focus has been rather on *organisational* performance measurement. Talbot (2010) suggests that evaluation has always been an under-developed part of the British policy system. Again, a policy evaluation process would have a more qualitative focus, while performance measurement retains a more quantitative focus.

While ostensibly PMS and regulation are making organisations more transparent and accountable, paradoxically they often have the result of making the inner workings of organisations more opaque and less visible, given the way in which they redefine and re-inscribe what really counts.

Regulation has tended to focus increasingly on systems and processes, rather than outcomes. Rather than more surveillance and direct inspection, the focus turns to ‘control of control’, assuring the quality of the control system, rather than first order operations.

While government has increasingly delegated responsibility for regulation and performance measurement, at the same time it has retained the authority to take action. The distinction between performance measurement and regulation has become blurred due to two opposing tendencies in government – the competing pressures to devolve on one hand the responsibility for providing public services, while at the same time equally powerful pressures exist to retain control over functions that have been made autonomous, so e.g. nationalised industries were privatised, but then subject to increasingly intensive regulation. In healthcare, internal markets were introduced to split the purchaser and provider roles in health services, then government required a range of regulatory bodies to devise PMS and oversee and monitor performance.

8. The future for healthcare

The discussion above is of particular concern given the government’s plans for the future of healthcare, recently enshrined in legislation (NHS Health and Social Care Act, 2012) after much debate and amendment. In July 2011 the coalition government published its proposals for the futures of the NHS in a White Paper entitled ‘Equity and Excellence, Liberating the NHS’. The proposals were wide-ranging and dramatic for the structure of the National Health Service. As the name of the White Paper suggests, the proposals are founded upon the belief that "liberating the NHS" from bureaucratic top-down control and putting power in the hands of patients and healthcare professionals are the central means of producing excellent service and best practice. The White Paper stated:

"Current statutory arrangements allow the Secretary of State a large amount of discretion to micromanage parts of the NHS. We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved. We will legislate to establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities... In the future performance will be driven by patient choice and commissioning."

The new legislation, therefore, seeks to push through to their conclusion the market-based reforms of the NHS that had been only partially completed by the previous Labour government. Patients should have greater freedom to choose where and from whom they are provided care. Meanwhile, the top-heavy bureaucracy of the strategic health authorities and primary care trusts would be radically cut. Services will be commissioned at a local level by GP practice-based commissioners responding to local patient needs. All acute hospital trusts will become foundation trusts, as it is claimed that with greater autonomy they can respond to consumer demand, to innovate and excel and be rewarded for it.

The role of Monitor is to be extended to being the sector (economic) regulator for the whole of the healthcare market in England under a model with its origins in UK utility regulation.

David Bennett, the new chairman of Monitor, who had been a senior partner at McKinsey and head of the Downing Street policy directorate and strategy unit under Tony Blair, caused a storm when he gave an interview to The Times in which he described the regulator's new role in promoting competition:

"We did it in gas, we did it in power, we did it in telecoms. We've done it in rail, we've done it in water. So there is actually 20 years' experience of taking monopolistic, monolithic markets and providers and exposing them to economic regulation. How can you compare buying electricity with buying healthcare services? Of course they are different.... I would say there are important similarities and that's what convinces me that choice and competition will work in the NHS as they did in those other sectors".

Following the uproar which greeted the new proposals, Monitor's remit was subsequently amended, as the government back-pedalled on the duty to promote competition, and announced that competition would be based on quality, not price. Its responsibilities include price setting, tackling anti-competitive behaviour and ensuring continuity of essential services in the event of provider financial failure. It will continue to be responsible for the authorisation of FTs until 2014 – the deadline by which all NHS Trusts must become FTs, and it will also retain oversight of FTs until 2016. It will acquire from DoH the responsibility for setting national tariffs to reimburse NHS and other providers for their services, although responsibility for the overall design and structure of the tariffs will rest with the NHS Commissioning Board. It will have to act to prevent anti-competitive behaviour not in the interests of patients and will also be required to support the delivery of integrated services where this would improve quality of care or reduce inequalities in access or outcomes. This represents a considerable dilution of the initial proposals to allow 'all willing providers' to enter the market in order to 'promote competition', and seems likely to make regulation even more complex given the tension between the need for transparent pricing to enhance competition and the need to retain some integrated services. These amendments recognise that for some complex illnesses concentration of treatment into e.g. regional centres of excellence makes more sense than having the service provided in every local hospital. There may be potential for competition *for* the market, rather than *within* the market, in such situations.

There are considerable challenges relating to designing appropriate tariffs, not least obtaining reliable cost data from providers. As there is the possibility of Trusts being monopoly providers of some services but in competition to provide other services, there is an important issue of transparency of costs to avoid potential cross-subsidy of services, by manipulating allocations of fixed costs of shared services to offer lower prices on competitive services. Monitor has commissioned PwC to carry out a major investigation of NHS costing and so far they have found many poorly developed costing systems in Trusts. The Audit Commission has also said that the quality of costing information in many Trusts is poor, in spite of around fifteen years' experience of developing reference costs which are used in the Payments by Results system of allocating funds to hospitals on the basis of standard payments for actual activity carried out. Reference costs are based on Healthcare Resource Groups (HRGs)

which group together similar procedures for costing purposes. The development of patient-level costing systems (PLICS) is in its infancy.

Dixon et al (2011) discuss some of the challenges likely to be faced in the future, arising out of far greater complexities in health as compared to utility markets. The NHS is characterised by many providers offering a vast range of different services. Healthcare is paid for from general taxation and the majority of provision is in the public sector. The complex role of GPs as advisers, providers and commissioners is unique. Quality is of course much harder to assess, making it harder for regulators to monitor and for users to make informed choices. The tension between competitive and integrated services is more acute in the health sector. They suggest that increasing the role of regulation in healthcare offers additional mechanisms to shape the behaviour of providers, such as commissioning and performance management. In some cases the creation of markets in the utilities has led to an increase in regulation – the initial expectation of short-term regulation to oversee the introduction of competition proved to be very wrong. It is likely that the duties of the regulator will be extended as new and unforeseen problems arise.

The quality/cost trade-off will be of central importance, and this currently sits at the intersection of NICE's standard setting, CQC's quality assessment and Monitor's price setting. It is not yet clear how these cross-regulator issues will be dealt with. A further issue in relation to quality is how to ensure patients can make an informed choice as to which provider offers the best quality of service for their needs. One development which has attempted to address this issue has been the requirement since 2010 for preparation of 'quality accounts', annual reports to the public made by providers of NHS healthcare about the quality of their services. In the White Paper *Equity and Excellence: Liberating the NHS* (DoH, 2010) the government stated its intention to use quality accounts *'to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes'* (p.14). The requirement to publish quality accounts applies to all providers of NHS healthcare services (excluding primary care and community services). Their primary purpose is to encourage Boards to report on the quality of their services and their plans for improvement. Foot et al (2011) point out that their usefulness is limited by the need to achieve these two distinct goals of local quality improvement and public accountability. Providers were asked to present qualitative and quantitative information relevant to specific services and specialities, covering three areas of quality: clinical effectiveness, patient experience and safety. They were free to select the measures they wished to include in their accounts. In their review of a large sample of the first year's published quality accounts, Foot et al (2011, p.15) concluded that *'the quality indicators sections are extremely varied in the number and choice of measures, statistical rigour, and format and quality of presentation. This diversity of quantitative content, coupled with lack of benchmarking information, means it is not practically possible to differentiate quality of care between providers on the basis of their quality accounts'*. They suggest that a more meaningful and cost-effective way of providing quality accounts would be for core quantitative measures of service quality to be gathered and reported from a central source to better ensure comparability and public accountability, while allowing

organisations to reproduce this information in their individual quality accounts, together with other measures relating to local issues and priorities which are a focus for quality improvement. The Audit Commission (2012, p.11) confirms in its report that its review of the 2010 quality accounts prepared by FTs identified four main shortcomings including a widespread lack of comprehensive systems and controls for compiling quality reports and for ensuring data quality, and variation in the interpretation of performance indicators. They go on to say that they had found improvements in the 2011 quality accounts for FTs, but that many of the criticisms identified above were applicable to the 2011 quality accounts prepared by NHS Trusts which do not have FT status. (This was related to the fact that the Audit Commission were required to give an opinion on FTs' 2011 quality accounts but not on those of NHS Trusts for that year. From 2012, however, the external assurance regimes for both types of Trust are to be aligned.)

In terms of accountability Monitor will remain accountable to Parliament, as the utility regulators are, through the relevant select committee – a system which has been criticised as unsatisfactory by the House of Lords Select Committee on Regulators (2007), which stated that 'there is a crucial need for greater parliamentary oversight of regulatory bodies' (p.7). Other than in extreme situations, the Secretary of State will not have powers to intervene even if Monitor is deemed to be performing badly. Given the politically sensitive arena, though, it may be difficult for the government to stand back, e.g. if a poorly performing hospital was about to be closed.

9. Discussion and conclusion

The frequent changes in regulation, inspection and performance measurement and management that have taken place over the last two decades in the NHS have resulted in some serious shortcomings in accountability and oversight, resulting in some cases in seriously substandard care for patients, and even in unnecessary deaths. The initial inquiry into the case of the Mid Staffordshire NHS Trust revealed some appalling standards of care, and painted a vivid picture of the dysfunctional consequences of 'meeting the target and missing the point'. The objective of achieving FT status was pursued by the Trust Board with almost complete disregard for the negative effects of cost-cutting on standards of care. Doctors and nurses felt marginalised and clinical governance matters were not a priority at Board meetings. Regulators were not sufficiently clear about their responsibilities, and thus Monitor concentrated on establishing the financial viability of the Trust and its corporate governance mechanisms, while assuming it would have heard from HCC if there were any problems with quality of care. HCC meanwhile had published satisfactory ratings shortly before an independent body revealed disquieting mortality statistics for the Trust (albeit with an asterisk to indicate that the Trust was under investigation). An initial requirement to achieve 3* star rating for financial and quality standards in order to obtain FT status was subsequently reduced to 2*, with particular emphasis on financial aspects, as government pushed for more FTs to be authorised, and SHAs tried to meet their targets of delivering Trusts capable of moving to the new status. The increasing move to quantification of

performance through metrics and targets led to a regime focussed more on remote review of box-ticking exercises by HCC and less on direct inspection of standards of clinical governance as had been the approach of CHI. Transparency and accountability appear to have been hindered rather than helped by a regime that became more focussed on quantifiable metrics and on cost rather than quality.

While CQC remain responsible for assessing quality of care under the regime, a new world of competition and economic regulation is being instituted. The complexities of the new approach can only be guessed at, and many questions remain to be answered, not least how quality will be safeguarded, given the shortcomings and inadequate communication between regulators to date discussed above.

Dixon et al (2011) discuss some of the issues the regulator will face and compare these to issues faced in utility regulation. The NHS tariff was originally introduced to support patient choice rather than to promote efficiency, but the way it has come to be used – to impose a downward pressure on provider costs by reducing the tariff in real terms – means that it has similar properties to the RPI- x tariffs in the utility industries as they were originally introduced. Despite these similarities, there are also important differences. It has never approached the complexity of the NHS tariff, in which there are several hundred prices for individual services (and even this number is achieved only by bundling together similar but not identical services). Furthermore, there remain a number of areas such as specialised services and community services where suitable tariffs have yet to be devised. The NHS tariff has been further complicated by the introduction of incentives in relation to specific objectives, e.g. reducing emergency admissions, promoting day surgery and rewarding better quality. Monitor is therefore faced with an extremely difficult and complex task, partly due to the heterogeneity of the product (health care), the number of product lines (procedures, care bundles, etc) and the potential for cross-subsidy between them, and the information available to support Monitor in defining the tariff is limited.

The language is hard to recognise as belonging to healthcare as we know it in the UK. In addition to a preoccupation with the quantification of metrics to enable regulation by inspection (which will continue under CQC's responsibility for ensuring quality), we also now see healthcare subject to further commensuration as a product subject to economic regulation like gas and electricity. Commensuration affects the three dimensions of representation, rationality and power. New representations of organisational purpose have the objective characteristics informed by infrastructures of referentiality, rather than the more subjective understandings of patient care that traditionally informed hospital life and the provision of healthcare. As commensuration reconstructs accountability, it gives rise to new conceptions of rationality. Legitimising grounds for organisational activity come to be based on formal rather than substantive rationality, as quantifiable, auditable measures of healthcare become the focus of attention and the measures which define success or failure. The power to make decisions and control resources shifts, too, as more qualitative clinical governance becomes subservient to more quantitative corporate governance. The influence of commensuration on PMS and regulation in healthcare are very apparent in developments over the last fifteen years or so, and look set to become even more pronounced as economic regulation and a competitive market in healthcare are pursued in the future. As Espeland and Sauder (2007) say:

'Once accountability is understood quantitatively and is equated with good governance, the meanings of many core values – efficiency, improvement, transparency, responsiveness, etc. – are redefined and reinscribed in our institutions as technical rather than political accomplishments.'

Meanwhile, as Lord Darzi, the former Labour health minister, was to put it:

"We now have health and wellbeing boards, clinical commissioning groups, clinical senates, local healthwatches, the NHS commissioning board, a quality regulator and an economic regulator ... At the end of the day, who is responsible for making sure that the NHS saves more lives this year than last? Who is accountable for how its budget is spent? Who will inspire NHS staff to lead the difficult changes?"

Power (1994) suggests an alternative model of control and accountability based more on qualitative measures, local methods, high trust and public dialogue, rather than the current predisposition for quantitative measures, external agencies, low trust and private experts. Given the evidence discussed above of the results to date of the latter approach, might the former offer us possibilities for a better way of ensuring we provide better quality healthcare for the population, rather than one based on the model of utility regulation?

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