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‘The Audit Society’ in action: a study of  
audit and performance management in the  
National Health Service in Scotland

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## Abstract

This thesis seeks to understand the role of audit in managing the performance of the NHS in Scotland and the impact which the relationship between performance and audit has upon key actors, including NHS organisations and national audit bodies. It is informed by Michael Power's *Audit Society* (1999) and associated works, which present audit as a collection of ideas which shape how society defines control, accountability and transparency. The premise of this doctoral research is that the age of performance assessment in the NHS is evidence of Power's *Audit Society* in action.

A longitudinal analysis of annual Overview Reports produced by Audit Scotland, which symbolise the national audit body's identity relative to the NHS, explores the impact which the performance assessment regime had upon the evolution of the national audit body and demonstrates the capacity of a national audit body to forge its own role in performance assessment and in doing so shift its identity from traditional external auditor to authoritative commentator on performance.

A recent performance crisis in a Scottish NHS board is the subject of a case study which explores the role of audit when significant gaming is uncovered in a previously high-trust system. This case demonstrates how the ritual appeal of audit can be mobilised by the government to restore public confidence in reported improvements in performance across the whole NHS.

The organisational impact of audit on performance management is explored through an observation-based case study set in a Scottish NHS board, which traces interactions between the main actors in audit and performance networks.

These analyses show how audit can permeate the performance assessment of NHS bodies, at both the national and organisational level, even where it is not given a formal role in the assessment framework.



## **Declaration**

I hereby declare that:

- (a) I have composed this thesis;
- (b) the work contained herein is my own; and
- (c) this work has not been submitted for any other degree or professional qualification.

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Alison Cumming

28 February 2014



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## Glossary of terms

<b>Annual health check</b>	National performance management system for the NHS in England from 2005 to 2009. Replaced by the periodic review.
<b>Audit Commission</b>	Statutory corporation responsible for appointing auditors to a range of public bodies in England, including NHS organisations and local authorities. The Department for Communities and Local Government announced in August 2010 that new arrangements will be put in place to secure the audit of local bodies in England and the Commission will ultimately be disbanded.
<b>Audit Scotland</b>	Independent public body responsible for assisting the Auditor General for Scotland in discharging her statutory functions to audit the financial statements and economy, efficiency and effectiveness of devolved public services.
<b>Auditor General for Scotland</b>	Crown appointment responsible for the audit of most devolved public bodies in Scotland, with the exception of local authorities. The Auditor General is independent of government and reports directly to the public and to the Scottish Parliament.
<b>Care Quality Commission (CQC)</b>	Non-departmental body in the UK Government with responsibility for the regulation and inspection of health care and adult social care services in England. Formed in 2009, replacing the Healthcare Commission.
<b>Commission for Health Improvement (CHI)</b>	Non-departmental body in the UK Government with responsibility for assessing NHS performance. Created in 2001 and replaced by the Healthcare Commission in 2004.
<b>Department of Health</b>	Department of the UK Government with responsibility for the NHS and formulation of health policy in England.
<b>HEAT</b>	National performance management system for NHSScotland from 2006 to present. Recognises four dimensions of performance – <u>H</u> Health improvement, <u>E</u> fficiency and governance; <u>A</u> ccess to services; and <u>T</u> reatment appropriate to individuals. Replaced the Performance Assessment Framework (PAF).

<b>Healthcare Commission</b>	Non-departmental body in the UK Government with responsibility for driving improvement in health care services in England. Formally known as the Commission for Healthcare Audit and Inspection. Replaced the Commission for Health Improvement in 2004 and was succeeded by the Care Quality Commission in 2009.
<b>Performance Assessment Framework (PAF) – Scotland</b>	National performance management system for NHSScotland from 2001 to 2006. Replaced by the HEAT system.
<b>Performance Assessment Framework (PAF) – England</b>	National performance management system for NHS organisations in England from 1999 to 2000. Replaced by the star ratings system.
<b>Periodic review</b>	National performance management system for the NHS in England introduced in 2009.
<b>Scottish Executive Health Department (SEHD)</b>	Department of the devolved Scottish Executive with responsibility for NHSScotland and formulation of health policy from 1999. Became Scottish Government Health Directorates (SGHD) following internal restructuring in 2007.
<b>Scottish Government Health Directorates (SGHD)</b>	Directorates of the devolved Scottish Government responsible for NHSScotland and the formulation of health policy. Succeeded the Scottish Executive Health Department following internal restructuring in 2007. Renamed Scottish Government Health and Social Care Directorates (SGHSCD) in late 2010.
<b>Scottish Office</b>	Department of the UK Government from 1885 to 1999 with responsibility for a wide range of functions pertaining to Scotland, including health. Following creation of the Scottish Parliament, the functions formerly carried out by the Scottish Office were transferred to the Scottish Executive (now Government) and the Scotland Office.
<b>Star ratings</b>	National performance management system for the NHS in England from 2000 to 2006. Replaced by the annual health check.

# **Chapter 1**

## **Introduction**



## 1.1 Overview

This doctoral research studies the role of audit in managing the performance of the National Health Service (NHS) in Scotland during the three terms of the New Labour Government, which ran from May 1997 to May 2010.

During this period, NHS organisations in England were held to account by Ministers and officials through a multiplicity of centrally imposed performance targets and measurement regimes, including the notorious ‘star ratings’ system. Such regimes were designed to make visible the activities and functions carried out by NHS organisations and to align organisational actions to political priorities, such as reducing waiting times.

Meanwhile, the creation of the Scottish Parliament brought about the devolution of policy control and management of the NHS to Scotland. Scotland subsequently pursued a distinct approach to health policy which prioritises collaboration and collectivism over managerialism (Kerr and Feeley, 2007). This has a profound impact on the way in which NHSScotland<sup>1</sup> has implemented performance assessment and on the role which audit has played in supporting performance assessment, although these divergences from the English approach have received relatively little attention in the academic literature.

These audit and performance management reforms are explored in the present study through the lens of Michael Power’s works *The Audit Explosion* (1994a) and *The Audit Society* (1999)<sup>2</sup> and the associated literature.

Once a process reserved to providing assurance over the content of financial statements, audit has ‘exploded’ into new domains, including clinical practice, education, the environment and intellectual property (Power, 1994a:1). People are increasingly subject to the demands of audit in their everyday lives; they are required to ‘tick boxes’ to demonstrate compliance with systems and controls. Power (1999) argues that audit is not just a technical practice, but a normative idea which shapes

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<sup>1</sup> The NHS in Scotland has been collectively known as “NHSScotland” since devolution, emphasising the rhetoric of reunifying a national service which had been fragmented by market reforms.

<sup>2</sup> *The Audit Society* was first published in 1997, with a paperback edition published in 1999. All page references in this paper are to the 1999 edition.

society's views of what constitutes control, accountability and transparency. This can give rise to dysfunctional effects, including the displacement of core organisational activities.

The premise of this research is that the age of performance assessment in the NHS is evidence of Power's *Audit Society* in action. This research will explore the impact of the softer approach to performance assessment adopted by the NHS in Scotland, compared to the strongly managerial approach adopted by the NHS in England, and the associated implications for the *Audit Society*.

## **1.2 Research outline**

### 1.2.1 Aims and objectives

This research project aims to understand how different approaches to performance assessment and associated audit mechanisms impact upon key actors at all levels of the NHS in Scotland, including policy formation, strategic and operational management and the official response to a performance crisis.

### 1.2.2 Contribution

The unique contribution of this study lies in providing a deeper understanding of the less-managerial Scottish approach to NHS performance assessment and the implications this has for the *Audit Society*.

Differences are expected in the extent to which the effects of Power's *Audit Society* are visible in the performance assessment frameworks in the NHS in Scotland and England. This provides an opportunity to not only understand the effects of these different approaches but to attempt to refine current theoretical understanding of the conditions which give rise to *The Audit Society*. This responds to criticism that Power's work is firmly located in the Anglo-Saxon tradition, saturated in New Public Management<sup>3</sup>, limiting its universal relevance (Pentland, 2000; Power, 2005).

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<sup>3</sup> New Public Management is used here to refer to the shift towards governments using managerial techniques to deliver public services, a phenomenon particularly evident in the UK, New Zealand, Australia, Canada and Sweden – see Hood, 1991; 1995.

This project also responds to calls for research on the effects of the *Audit Society* upon auditees, particularly evidence of game-playing and dysfunctional behaviour, to determine the effects of making agents accountable in terms of auditable performance measurement systems (Power, 2000a:115; 2003a:199).

Existing comparative studies of performance management in the post-devolution NHS favour quantitative analysis of aggregate performance data (Propper et al., 2008; Bevan and Hamblin, 2009; Connolly, Bevan and Mays, 2010). There is a lack of studies which consider behavioural and organisational consequences of different approaches to managing the performance of NHS organisations and which consider the impact of audit mechanisms. The present study aims to address this gap in the literature.

### 1.2.3 Research questions

This study will answer the following research questions:

1. How are audit mechanisms manifest in the performance measurement regimes in the National Health Service in England and Scotland?
2. What is the effect on the national audit body when there is no formal role for audit within the NHS performance assessment framework?
3. How do key actors in the governance and management of the National Health Service respond to performance measurement and audit mechanisms, and which actors exert greatest influence over the response?

### 1.3 Structure of this thesis

**Chapter 2: Research context** introduces the setting for the current research, including the policy environment, the impact of devolution on Scottish public services and the public audit framework, and the governance framework and operational structure of NHSScotland.

**Chapter 3: Theoretical framework: Power's Audit Society** sets out the body of theoretical work underpinning this thesis. It explores Power's key arguments and the response they generated in the literature.

**Chapter 4: Research design and methods** summarises the research design and methods employed in this study, and the underlying research strategy.

The following four chapters present the results of empirical studies of the role of audit in managing the performance of the NHS in Scotland.

**Chapter 5: Performance management in the NHS in England and Scotland (1997 to 2010)** presents a comparative study of performance management reforms in the NHS in Scotland and England from 1997 to 2010 based on detailed analysis of official policy and guidance documents produced over the period. This chapter highlights key differences in the performance management approaches taken in Scotland and England and provides a detailed narrative on the policy environment.

**Chapter 6: The evolution of Audit Scotland's role in performance managing NHSScotland** traces the transformation of the identities of the Auditor General and the national audit body in the first 10 years following creation of the Scottish Parliament. It presents the findings of a longitudinal analysis of Audit Scotland NHS overview reports, which symbolise the national audit body's identity in relation to the NHS performance assessment regime in Scotland.

**Chapter 7: Audit in times of performance crisis – NHS Lothian waiting time management** presents a case study of the official response to a performance crisis in waiting time management. It explores the impact which the discovery of significant gaming has on the role of audit in performance management.

***Chapter 8: Observing performance, audit and organisational life in NHSScotland***

presents a case study based on observation of key governance committees in a Scottish NHS board. It traces interactions between the main actors in organisational audit and performance management networks to build an understanding of the impact of the performance assessment framework.

***Chapter 9: Discussion*** draws out key themes and findings from the four preceding empirical studies and explores these in the context of the existing literature on the *Audit Society* presented in Chapter 3.

***Chapter 10: Conclusion*** summarises key findings of this thesis and the contribution which it makes to the existing literature.



# **Chapter 2**

## **Research context**



## **2.1 Introduction**

This chapter introduces the setting for the current research, including the policy environment, the impact of devolution on Scottish public services and the public audit framework, and the governance framework and operational structure of NHSScotland.

## **2.2 The National Health Service**

### 2.2.1 Background

The National Health Service (NHS) was established in the United Kingdom in 1948 and endures as a model of universal healthcare provision. The organisational form and political priorities of the NHS have shifted during its 65-year history, but these reforms have been guided by three enduring principles (Greener, 2009:16).

Healthcare is provided free at the point of delivery on the basis of need, not ability to pay. Healthcare is universally provided, with no regard to gender, ethnicity, age or disability. Healthcare is comprehensive – all conditions are treated.

The NHS is a highly complex organisation, encompassing diverse stakeholders including strong professional groups with their own distinctive objectives (Greener, 2009). It delivers a wide variety of services, ranging from public health and preventative programmes to the delivery of primary and acute care.

The NHS is funded through general taxation raised by central government and government ministers are accountable to Parliament and the public for the performance of the NHS. The balance of power between central government and the various agencies responsible for delivering frontline patient care has shifted over time, but remains a source of tension (Klein, 1982). Governments of the day have introduced various policy mechanisms in an attempt to resolve this tension, famously including the “internal market” (Department of Health, 1989).

### 2.2.2 New Labour health policy (1997 to 2010)

The New Labour Government elected in 1997 rejected the market rhetoric which had dominated both health policy and the management of relationships between central government and frontline NHS organisations.

Performance measures and targets replaced price as the prevailing currency of the NHS. This target-driven ethos was applied across all public services, not just the NHS; over 300 headline targets were introduced across all Whitehall departments in 1998 (Hood, 2006:515). Ten of these targets were applied to the Department of Health, and these in turn became 300 lower level targets applied to organisations charged with delivering health care (ibid.).

Performance assessment regimes were designed to make visible the activities and functions carried out by these organisations and to align organisational actions to political priorities, such as reducing waiting times.

The NHS was already familiar with performance measurement technologies, which had been used extensively to support the functioning of the internal market (Humphrey, Miller and Smith, 1998). The use of standards and measures of performance is a doctrinal component of new public management (NPM), and so the adoption of these technologies by the NHS was symptomatic of a wider trend towards the quantification of goals, targets and indicators of success (Hood, 1991). However, the extent and significance of performance assessment shifted under New Labour.

The star ratings system in operation from 2001 to 2006 was the most notorious and extreme scheme introduced by the New Labour Government to manage the post-internal market NHS. This system 'named and shamed' poorly performing trusts and relied upon a framework of rewards and sanctions to align the outcomes of NHS organisations to central policy objectives (Bevan, 2006:68). The impact of the star ratings system has been the subject of extensive research activity. Various studies uncovered significant gaming of achievement of measures which undermined the veracity of reported improvements in performance (for example, Bevan and Hood,

2006), while others highlighted the burden which the system placed on NHS staff to deliver good results (for example, Mannion et al., 2005).

Performance management was the dominant mode of governance throughout the three terms of the New Labour Government, although the form and content of performance management schemes evolved over the 13 year period. This evolution is analysed in detail in Chapter 5.

Much of the existing literature on performance management of the NHS in the early 21<sup>st</sup> century has considered the New Labour reforms in isolation, without recognising that the NHS in other parts of the United Kingdom pursued an alternative path. The creation of the Scottish Parliament in 1999 enabled the development of a distinctly Scottish approach to the management of the NHS, which is considered further in the next section.

## **2.3 Devolution and the Scottish NHS**

### 2.3.1 Devolution

The New Labour manifesto for the 1997 general election campaign included a commitment to hold referenda soon after the election to enable the people of Scotland and Wales to vote on proposals to devolve powers from Westminster to new democratic institutions (Labour Party, 1997).

The Scottish electorate voted in favour of the creation of a Scottish Parliament in September 1997<sup>4</sup>. The proposed devolution settlement included full legislative and administrative responsibility for the National Health Service in Scotland (The Scottish Office, 1997a).

The UK Parliament subsequently passed the Scotland Act 1998, which created the institutions of the devolved Scottish administration, including the Scottish Parliament

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<sup>4</sup> The referendum asked the Scottish electorate two questions: whether there should be a Scottish Parliament and whether that Parliament should have tax-raising powers. 74.3% of voters were in favour of the creation of a Scottish Parliament (60.4% turnout) while 63.5% of voters agreed that the Parliament should have tax-raising powers (source: <http://www.scottish.parliament.uk/help/17029.aspx> accessed on 30 April 2012).

and the Scottish Executive. The first elections to the Scottish Parliament were held in May 1999, with the first meeting of the new Scottish Parliament taking place later that month. The Parliament assumed legislative powers in July 1999, following the opening of the Parliament by Her Majesty The Queen.

The Scottish NHS was historically administratively autonomous from that of the rest of the United Kingdom; the Scottish Office, not the Department of Health, was the UK Government department with responsibility for operation of the NHS in Scotland. The former department was nevertheless bound by the overarching policy framework set by the latter. The Secretary of State for Scotland was a member of the Cabinet of the United Kingdom Government so shared collective responsibility for policy and decisions taken by the Cabinet. These elements constrained the ability of the Scottish Office to adopt a significantly different approach to healthcare policy in Scotland than that adopted by the Department of Health (Woods, 2004).

The new Scottish Parliament provided an opportunity for Scottish public services, including the NHS, to take a divergent approach to the emerging UK tradition of managerialism exemplified by the Thatcher administration but perpetuated, albeit with the sharp edges blunted, by the New Labour government (Greer, 2004; Blackman et al., 2006).

### 2.3.2 Scottish health policy

The different political and managerial philosophies underlying the operation of the NHS in Scotland found a voice post-devolution as the Scottish Parliament adopted its own health policy, including a distinctive interpretation of the performance management regimes favoured in England.

The party political environment in Scotland creates an expectation that devolved Scottish policies may diverge from the rest of the UK: there is a bias towards left-of-centre parties in the party system and a strong nationalist voter base, which combine to create political pressure to create distinctively Scottish policies (Greer, 2005:504-5).

However, the health policy environment in Scotland is also significantly different from the rest of the United Kingdom. Clinical professionals have traditionally had

greater influence over the development of health policy in Scotland which creates an environment which gives precedence to values of professionalism, integration, partnership and collectivism (Hazell and Jervis, 1998; Nottingham, 2000; Spry, 2002; Greer, 2004; Greer, 2005; Kerr and Feeley, 2007). This is facilitated to a large degree by the smaller scale of the NHS in Scotland, which serves a population around one-tenth of the size of England.

This sets an expectation that Scottish health policy, including the approach taken to performance management, will be less managerial than its English counterpart. This proposition is explored in Chapter 5, which presents a comparative study of performance management reforms in the NHS in Scotland and England from 1997 to 2010 based on detailed analysis of official policy and guidance documents produced over the period.

Early performance measurement frameworks adopted by NHSScotland were underpinned by collaboration and relied upon professional values to incentivise performance improvements (Farrar et al., 2004; Bevan and Hamblin, 2009), although the approach would become more managerial over time. This evolution is analysed in Chapter 5.

The Scottish Executive was also under pressure to demonstrate that a Scottish approach to health policy was delivering improvements at least equal to those evident in other parts of the UK (Nottingham, 2000). A number of quantitative-based studies have attempted to compare the relative performance of the NHS across the UK (Alvarez-Rosete et al., 2005; Propper et al., 2008; Bevan and Hamblin, 2009; Connolly, Bevan and Mays, 2010). Such studies generally present evidence that the English NHS has delivered greater improvements, although fail to address the inherent methodological bias of defining performance in narrow measurable terms.

### 2.3.3 Structure of NHSScotland

Scotland visibly rejected the use of market mechanisms to deliver healthcare in abolishing the purchaser / provider split of the internal market and replacing it with an integrated framework based around a geographic structure (Greer, 2005).

The Scottish Office started the process in *Designed to Care* (1997c), merging provider Trusts, before the Scottish Executive (2000) announced that a single 'unified' NHS Board would be created in each of Scotland's 15 Health Board areas. These unified Boards would replace the separate board structures of Trusts and regional Health Boards, although Trusts remained as operating entities. The policy emphasised collaboration rather than competition as the new unified Boards were responsible for the efficient, effective and accountable governance of the NHS in the local area (Scottish Executive Health Department, 2001). The main functions of the new Boards included strategy development, resource allocation and performance management (ibid.).

The remaining Trusts were eventually dissolved to create a single operating and accountability structure within each NHS Board area (Scottish Executive, 2003). The previous Trust structure ensured a separation of strategic and operational functions and the government sought to retain this through the creation of operating divisions with their own management teams responsible for delivering frontline healthcare services. These divisions are accountable to the unified board, which has overall responsibility for the local healthcare system.

The structural reforms were accompanied by a broadening of the membership of governing boards. The number of board members was increased and more stakeholder groups were represented on the board, including staff-side, local authorities and clinical representatives. Clinical management roles were also formalised, with nursing and medical directors added to the executive membership of the board.

Unified NHS Boards remain responsible for both the delivery and strategic management of local healthcare services, including protection and improvement of the health of the local population.

## **2.4 Audit**

The growth of NHS performance assessment also created opportunities for audit bodies to expand and develop their roles, either through an explicit role in the control process or through reviewing and reporting on the conduct of these measures. Like performance measurement, the growth of audit is closely associated with NPM which demands that central bureaucracies devolve power and autonomy to operating units while retaining control and accountability for these units (Hood, 1991; 1995). Audit can play a key role in supporting this accountability relationship (Power, 1994a).

The New Labour Government expanded the remit of the Audit Commission through policies such as Best Value and verification of performance targets. The Audit Commission successfully lobbied for new responsibilities, cultivating relationships with power brokers, which arguably compromises the political neutrality constitutionally required of public audit bodies (Bowerman et al., 2003; Campbell-Smith, 2008).

### 2.4.1 Audit and NHSScotland

Prior to devolution, responsibility for public audit in Scotland was shared by the National Audit Office in Scotland and the Accounts Commission (Midwinter and McGarvey, 2001:843). The former body was responsible for the audit of the Scotland Office, while the latter body had responsibility for local government and NHS bodies.

The role of the Auditor General for Scotland was established by the Scotland Act 1998 and the functions held by the Auditor General were defined in the Public Finance and Accountability (Scotland) Act 2000. The 2000 Act also established Audit Scotland as the national audit body which would carry out work on behalf of the Auditor General. These statutory provisions prescribe high level, predominantly technical, roles in relation to the audit of financial statements, examinations of the economy, efficiency and effectiveness with which public bodies use their resources, and reporting findings of these examinations to the Scottish Parliament.

The Auditor General nominally reports to the Scottish Parliament and all reports, including NHS overview reports, are considered by the Public Audit Committee<sup>5</sup>. The Auditor General is routinely invited to attend public meetings in order to brief Committee members on his or her findings. The Committee may choose to note the findings of the report or may request further action, including requiring further evidence from the audited body or convening an inquiry.<sup>6</sup>

The Audit Scotland Code of Audit Practice, first published 2001 and revised in 2006 and 2011, sets out the operational framework for the conduct of public audit in Scotland. The Code summarises the key principles which auditors of devolved public bodies must adhere to in the performance of their duties, as well as the responsibilities falling to those auditors.

The Auditor General for Scotland has a statutory duty to appoint external auditors to devolved Scottish central government, NHS and further education bodies.<sup>7</sup> While Audit Scotland is appointed to conduct the majority of these audits, around one-third of these are effectively outsourced to private audit firms, including three Big 4 firms.<sup>8</sup> Audit appointments are made on a five-year cycle.

Robert Black, a former local authority chief executive with no formal qualifications in public finance or accountancy, held the role of Auditor General for Scotland from creation of the post in 2000 until his retirement in July 2012. He was succeeded by Caroline Gardner, his former deputy, a career auditor and professional accountant.

The role of Audit Scotland in relation to the performance of NHSScotland is explored in Chapter 6.

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<sup>5</sup> Known as the Audit Committee until 11 December 2008.

<sup>6</sup> Information taken from the Public Audit Committee web pages on the Scottish Parliament internet site at <http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/29860.aspx> (accessed on 14 November 2011).

<sup>7</sup> Under section 21(4) of the Public Finance and Accountability (Scotland) Act 2000, asp 1

<sup>8</sup> Audit Scotland publishes current audit appointments on its website at <http://www.audit-scotland.gov.uk/about/as/audits.php> (accessed on 25 August 2013).

## **2.5 Summary**

This chapter has provided a brief overview of the policy and operational setting for this study. Chapter 5 presents a more detailed narrative of key policy developments in relation to the performance management of the NHS in England and Scotland between 1997 and 2010, while Chapter 6 explores the shifting identity of Audit Scotland in relation to NHSScotland performance networks over the same period.

The theoretical framework which supports this study will be developed in the following chapter.



## **Chapter 3**

**Theoretical framework:**

***Power's Audit Society***



### **3.1 Overview**

This chapter sets out the body of theoretical work underpinning this thesis, centred on Power's *Audit Society* (1999). This seminal work was instrumental in transforming audit as a research subject from a narrow technical domain to a sociological phenomenon which has influenced the construction of accountability in public discourse.

It begins by exploring the key arguments of Power's *Audit Explosion* (1994a) and *Audit Society* (1999) before considering the wider academic literature, with a particular focus upon the role of the national audit body in the Audit Society.

### **3.2 Introduction**

#### 3.2.1 Michael Power and the *Audit Society*

Michael Power has made a significant contribution to the development of a sociological perspective within the auditing literature through his works on *The Audit Explosion* (1994a) and *The Audit Society* (1999). Academic works in the field of auditing have traditionally focused on the technical demands of audit practice. Power looks beyond this "silo" of financial auditing to the proliferation of a powerful idea with its origins in the world of accounting; he looks beyond the technical practice to the "aspirational" elements of audit as a broader assurance-giving function (Power, 2000a:112). These essentially critical ideas provoke much debate about the social nature, merits and impacts of auditing (Humphrey and Owen, 2000:48; Pentland, 2000:307).

Audit, traditionally a practice applied only to financial statements, has 'exploded' into new domains in recent years, including medicine, education, the environment and intellectual property (Power, 1994a:1). In public services, this has largely coincided with the advance of New Public Management ("NPM") (Hood: 1991; 1995). Indeed, an "audit mentality" has been presented as central to the practice of NPM (Lapsley, 2008:89).

Power (2000a:112-3) identifies the advent of NPM as one of three key drivers of the audit society; the other two being public demand for greater transparency and accountability, with expectations set by private sector corporate governance reforms, and a shift in regulatory style, including a new focus on quality assurance.

While the precise shape of audit is specific to each context in which it operates, there are “systematic similarities and overlapping issues” (Power, 1998:23) which demand further study and critical appraisal.

The broader appeal of Power’s work, and in particular its adoption by academic fields far beyond traditional accounting research, can perhaps be attributed to its resonance with readers working in professional domains and in receipt of public services.

“[Power] has captured a widespread, but rather latent, sense of unease with the rise of monitoring and regulation and a resulting decline in trust”

(Humphrey and Owen, 2000:31).

This resonance transforms an academic text on auditing to a meaningful and provocative study of trends in accountability.

### 3.2.2 From “Audit Explosion” to “Audit Society”

In *The Audit Explosion*, Power seeks to understand why ‘audit’ has become so prominent in public policy (1994a:1). His key concern is the qualitative shift which accompanies the quantitative explosion of financial auditing philosophies and techniques into new domains (1994a:2-3). Power seeks to understand how and why audit has established itself as the dominant model of control and accountability, with an almost unshakeable position in public policy (1994a:7-8).

Power advances eight arguments to show how audit as an idea has spread through society, with implications for trust, governance, control systems and transparency.

*The Audit Society* (1999) refines the arguments made in *The Audit Explosion* and explores how audit as an idea has embedded itself in public policy discourse.

By applying Rose and Miller's (1992:181-4) distinction between 'programmes' and 'technologies' of government, Power (1999:6-8) separates the concept of auditing as an intellectual design for governance from the individual techniques, tools and practices which are deployed to operationalise this design. These latter technologies are the traditional focus of auditing research, but, by isolating the "programmatic" qualities of audit, Power elevates and expands auditing research into a new normative sphere. These normative features underlie the meaning of auditing practice and allow the abstract idea of auditing to attach itself to different goals such as accountability, control and transparency.

### **3.3 The ritual appeal of audit**

The fundamental purpose of an external audit is to provide an opinion on the truth and fairness of a set of financial statements following an independent examination of the books and records of the company.

However, despite the programmatic rise of audit in society, Power (1999) argues that the original practice of financial statements audit benefits from a certain mystique; neither the audit process nor the assurance it generates is transparent to purported beneficiaries.

Detailed audit findings are communicated to management and those charged with the governance of an organisation (such as non-executive directors or elected members) but withheld from a wider audience, often even in public services (Bowerman et al., 2000:86). Auditors become the arbiters of what stakeholders and the wider public need to know about the financial systems and practices of an organisation. This reveals an inherent tension over the primary function of audit: is it a management control technique or a mechanism to discharge public accountability?

The intrinsic value of the financial statements audit to shareholders, lenders and other company stakeholders is the credibility bestowed on the company by a clean audit opinion.

“The purpose of an audit is to enhance the degree of confidence of intended users in the financial statements. This is achieved by the expression of an opinion by the auditor on whether the financial statements are prepared, in all material respects, in accordance with an applicable financial reporting framework.”

(Financial Reporting Council, 2009)

The audit opinion holds a symbolic value which is not directly related to the actual audit procedures which underlie the opinion itself.

Financial markets are complicit in this myth, relying on audit in a ritual sense to provide investors and others with reliable information virtually without challenge or question (Malsch and Gendron, 2009).

It is not possible to quantify the assurance provided by audit, or indeed to precisely define the nature of that assurance; it is essentially a judgement-based practice (Power, 1999:28) with a socially constructed knowledge base (Power, 1996). Thus, the “abiding paradox of the audit society...: the expansion of auditing and its assumption of new roles is conditioned by its failure and by an essential obscurity in what it can deliver” (Power, 1999:31).

The audit process is characterised by rituals and institutionalised actions with a rhetorical value which may actually exceed their technical value (Pentland, 1993; Van Maanen and Pentland, 1994).

The audit process is underpinned by the exercise of professional judgement in conditions of considerable uncertainty; a process which is far more qualitative than the rationalised account of audit as an objective scientific practice but which “requires ritual procedures to transform indeterminacy into institutionalized order” (Power, 2003b:385).

Even outwardly technical processes, such as tax auditing, are products of judgement, negotiation with the auditee and practical considerations, such as the need to complete an audit within defined resource boundaries (Pentland and Carlile, 1996).

The apparent obscurity underlying the nature and value of audit is compounded by the lack of independent evaluation of audit practices themselves. There is no

systematic evidence to support the efficacy of audit as an accountability mechanism yet it has enduring appeal to regulators and government (Power, 2000a:114). This lack of reflexivity inhibited recognition or exploration of the potential negative effects of expanding audit processes (Power, 2003a:194), but is also a symptom of the dominance of audit as an institutional mechanism of accountability, possibly to the extent that the two terms start to be used interchangeably. It then becomes virtually impossible to propose alternative mechanisms to audit (Power, 1993).

In spite of this inherent obscurity, new programmes for enhanced governance and control have continued to develop accountability mechanisms based on the principles of financial statements audit. Audit practice has a ritualistic appeal, driven in part by its promise of credibility and legitimation, which appears to dominate the desire for substantive and transparent assurance mechanisms.

Auditors have also been portrayed as sacrificial victims when the functioning of capital markets is threatened by scandal or crisis (Guénin-Paracini and Gendron, 2010). Auditors can survive the blame levied at them for corporate crises, as the process of self-sacrifice is part of a more elaborate ritual which sees the legitimacy offered by the audit process as instrumental in the return to order (ibid.) The legitimacy offered by audit can thus protect it from serious external challenge.

### 3.3.1 Audit and the production of comfort

Pentland (1993) undertook an interpretative ethnographic study of auditors at work to illustrate that a number of ‘comfort-producing’ rituals are carried out at the micro level of an audit engagement in order to produce assurance over the financial statements at the macro level. Carrington and Catasús (2007) import concepts of comfort theory from academic nursing studies in order to understand how auditors perceive the production of comfort through a series of interviews with audit seniors.

Financial statement audit reports have become “quality labels” (Power, 1999:125) with a symbolic value which exceeds their intrinsic value. Audit reports create an impression of transparency without revealing anything of substance about the audited organisation.

Standardised audit opinions communicate more about the respective responsibilities of auditor and auditee than they do about internal control weaknesses or financial reporting errors identified in the course of an audit. Audit opinions are devised to produce comfort, with qualified opinions given only in exceptional or extreme circumstances, but the reader has no way to determine where on a notional scale of auditor assurance any particular unqualified opinion lies.

Management letters, containing more specific findings on financial management and the control environment within the auditee organisation, are produced by external auditors. These letters are internal documents produced for the eyes of the auditee organisation only, making them tools of managerial accountability rather than democratic accountability, as might be expected, for example, in a public sector context (Hollingsworth et al., 1998:98-9), or shareholder accountability to the owners of a company.

However, Power argues that “where audit arrangements emphasize the production of comfort, this reflects an institutional need for auditing not to be too ‘successful’ in finding problems and in producing discomfort by reporting these problems” (Power, 1999:126).

The more embedded the role of audit as a producer of comfort becomes, the less valid the claim that audit is a tool which discharges accountability: “audit expresses the promise of accountability and visibility to... stakeholders. But this promise is at best ambiguous: the fact of being audited deters public curiosity and inquiry and the users of audits are often just a mythical reference point within expert discourses” (Power, 1999:127).

Performance auditing of public services challenges this view. More recent manifestations of audit processes, such as value for money audits, produce longer narrative reports which tend to be more adversarial in tone and content (Power, 1999:126). These discursive reports on performance can be the subject of parliamentary scrutiny, typically through a parliamentary audit committee where both auditor and auditee may be called to give evidence on the reported findings (Jones, 1993:199).

Justesen and Skaerbaek (2005) further highlight the heterogeneity of reports produced by practices bearing the label of audit and the effects these have on auditees and the wider users of audit reports.

In contrast to Pentland's (1993) study of financial statements audit (1993), Justesen and Skaerbaek (2005, 2010) find that the critical nature of value for money audit reports can generate *discomfort* among auditees who feel under pressure to visibly react to critical findings. Criticism is considered a virtually inevitable outcome of the performance audit process which differs in objective from financial statements audit (Justesen and Skaerbaek, 2005:323). The former is designed to identify opportunities for improvement, rather than to verify financial statements produced by the auditee. The authors show that the auditor is not the only influential actor making a case for change; other actors including politicians and the media interpret audit findings and so intensify demands for change (Justesen and Skaerbaek, 2010:341).

### 3.3.2 Legitimacy

The programmatic appeal of audit has become so great that it is seen to confer legitimacy on audited processes or bodies: Power (2000a:117) argues that "being audited *per se* is a badge of legitimacy". This is illustrated by the birth of 'clinical audit', whereby a set of ad hoc assessments of clinical results was transformed into a legitimate practice within the new sphere of healthcare management when it was labelled as an 'audit' (Power, 2000b:130).

The capacity of audit to bestow legitimacy on a process is demonstrated in an empirical study of the introduction of audit into the Financial Times business school ranking system (Free, Salterio and Shearer, 2009). The audit process generated legitimacy at two levels, which the authors label "affirmatory" and "derived" legitimacy. In this case, the business schools (the auditees) valued the "affirmatory" legitimacy which resulted from holding all participants in the ranking system to the same audit requirements. The ranking system itself benefited from a secondary form of "derived" legitimacy as it could now demonstrate that the underlying data was subject to audit procedures and thus differentiate itself from competing ranking

systems which did not invoke any form of independent verification (ibid: pp. 131 & 137).

Legitimacy is conferred on the ranking system even though only a selection of the constituent measures are within the scope of the audit, and only a sample of business schools submissions are audited each year. Similarly the application of the ranking algorithm is not subject to audit.

“...it is the social belief in the potency of audit that effectively converts it into a competitive or discursive resource to be deployed by information providers.”

(Free, Salterio and Shearer, 2009:137)

Free, Salterio and Shearer show that the nature of assurance provided by the audit process is not transparent. They find that the outcome of the audit process is as much a product of negotiation and dialogue between auditor and auditee as a product of objective technical practices. And so we return to the premise that the ritual appeal of audit exceeds its technical value.

McGivern and Ferlie (2007) applied Power's ideas to interview data gathered for a study of the implementation of formal appraisal of medical consultants within the NHS. At the time of the study, NHS Trusts were subject to a range of performance targets, one of which was to ensure that a percentage of its consultants received a formal performance appraisal each year. The target measured the occurrence of the appraisal; it did not consider the substance or the effectiveness of the appraisal. As a result, the appraisal was not valued by the medical profession as a means of career development or professional education, but was regarded as an event which had to take place to meet a target. The appraisal became a 'tick-box' exercise which did not interact with clinical reality.

By meeting the minimum requirements of the target, the medical profession could mobilise this audit-inspired mechanism to secure legitimacy without embracing the substance of the appraisal: “legitimacy provided through the impression of audit was more important than professional development” (ibid, 2007:1380).

The conceptual ambiguity of audit, discussed in the following section, supports its emerging role in legitimating organisational activities. If audit is a legitimacy bestowing device, then surely it has the greatest impact as such a device when it is able to harness and exploit ambiguity.

### 3.3.3 Exploiting the ambiguity of audit

Audit is an ambiguous term in popular usage: the badge of 'audit' is applied to many different types of verificatory activity (Power, 1994a:4). 'Audit' can "symbolise a cluster of values: independent validation, efficiency, rationality, visibility... and the promise of control" (Power, 1994a:13-14). Power (1999:5) identifies only one essential ingredient which needs to be present for a verificatory practice to take the name 'audit': a relationship of accountability.

Audit can perhaps be more easily defined according to what it is not, rather than what it is. It can be distinguished from similar assurance-giving practices such as inspection. Audit "takes the management system as its primary object whereas [inspection] focuses more on the substantive conduct of the inspectee" (Power, 1999:130). Furthermore, inspectors can impose sanctions on organisations or escalate inspection findings to a higher level of the regulatory framework. This contrasts with the quietly coercive power of audit which wields the threat of publication of a negative opinion on organisational activities.

However, Power (1999:130) observes growing convergence between the two practices, in line with the shift towards managerial and external models of control, with inspection assuming more of the features traditionally associated with audit.

Instead of tying his arguments to a restrictive definition of 'audit', perhaps closer to one found in financial statement auditing textbooks, Power exploits this inherent ambiguity in support of his account of the programmatic dimensions of auditing. The fluidity of the definition of 'audit' is fundamental to its ritualistic appeal.

Other commentators have attempted to construct a definition of 'audit' which supports the audit society thesis.

Pentland (2000:309) proposes a two-dimensional definition encompassing the technological and programmatic elements of audit. These dimensions are loosely coupled so can diffuse at different rates; the development of the rhetoric (programmatic qualities) of the audit society could be more advanced than the technical practice of auditing. Pentland thus supports Power's thesis that the popular idea of, and support for, audit is based on an idea which exceeds its current technical capabilities.

Lindeberg (2007) analyses auditing textbooks in search of an identity for 'audit' as distinct from evaluation. He identifies a continuum which stretches between the extremes of financial statement audit and programme evaluation (2007:346-8). There are limitations to Lindeberg's analysis, including a US-bias in the textbooks which he sampled, which impact upon the relevance of his findings. Furthermore, textbooks themselves present idealised views of the audit world, so could form part of the audit society myth, and not provide an independent source of technical knowledge (2007:347). These limitations do not, however, detract from Lindeberg's message that further work is required to understand the relationship between the audit society and the proliferation of other evaluative practices.

Critics argue that this "confusion" over the definition of audit exposes a fundamental weakness in Power's arguments (Humphrey and Owen, 2000:40-42): how can it be accepted that audit is such a powerful influence in shaping control and accountability within society if there is no consensus on what audit even is?

Power references both practices labelled audit, which bear closer resemblance to data-gathering exercises than the traditional financial statement audit model, as well as practices which bear other names but which are conceptually or practically similar to the financial statement audit model (Humphrey and Owen, 2000). In the absence of a definition of 'audit', the audit society risks being reduced to an argument about the dispersion of a word, not a concept (Lindeberg, 2007:337).

These critics do not consider that the ambiguity of audit may in fact be the key to its power and influence.

The flexible definition of ‘audit’ makes the boundaries surrounding the audit profession permeable and enables auditors to claim professional jurisdiction in virtually all operational fields (Pentland, 2000:308). This permeability is itself enabled by the auditor’s expert knowledge of control systems and processes; this knowledge has the capacity to outweigh traditional knowledge or to overcome content-based boundaries which control entry to different professions (ibid.).

Auditors have defined themselves as experts on the design and operation of generic and transportable systems, which they can sell to new markets and settings: the vagueness of audit enables the ‘explosion’ of auditing into new domains (Power, 1994a:13-14; 1999:6).

The idea of ‘audit’ persists in policy discourse even if use of the word has declined: “while the word ‘audit’ may have decreased in importance, the demand for monitoring has not” (Power, 2000a:113). The vagueness of audit can be “observed and analysed” and the legitimacy bestowed by being audited, even in the absence of a precise definition of audit, provides further evidence of its dominance and programmatic appeal (Power, 2000a:116). By wearing the badge of audit, assessment practices gain credibility as tools of accountability even if the constituent activities are unstructured or ad hoc.

Furthermore, the labelling of an activity as ‘audit’ changes the identity of that activity, regardless of its underlying substance or constituent technologies. ‘Audit’ carries a set of expectations which influence how others view the activity (Power, 2008:399).

While the audit society thesis could be refined to reconcile the ambiguity of ‘audit’ to its dominance in policy discourse, the absence of a definition of audit does not disprove the existence of Power’s audit society. Indeed, this ambiguity is a primary source of the legitimacy bestowed upon organisations by audit practices, and lies at the heart of the social influence of audit.

### 3.4 Making management auditable

Perhaps the most important conceptual argument advanced by Power in *The Audit Explosion* and *The Audit Society* is that “audit actively constructs the contexts in which it operates” (1994a:7).

The dominance of audit over competing verificatory and assurance practices lies in its ability to make practices ‘auditable’ (Power, 1996; 1999) and to construct “concepts of performance in its own image” (Humphrey and Owen, 2000:36). Complex organisations are rendered auditable “by virtue of abstracting from their first-order performance objectives and focusing on the management system for defining and monitoring performance” (Power, 2003a:189), with that system imported from both financial auditing and quality assurance practices.

The interaction between the auditor, auditee and official knowledge is combined in an official process of ‘rendering auditable’ (Power, 1999:69-70). Ethnographic studies have found that auditors react to and influence the environment in which their work is situated, and this process is characterised by a reflexive understanding of the audit process (Radcliffe, 1999).

This challenges the traditional view of audit as an activity independent of financial reporting (Mautz and Sharaf, 1961). In the financial audit model, the audited organisation produces its own annual accounts (the public representation of that year’s financial performance) which are then subject to independent examination by a third party auditor. The auditor applies technical procedures in order to determine the truth and fairness of that representation with reference to mandated standards of financial reporting (Power, 1996:290).

On closer inspection, even financial statements audit is not a purely objective practice, as recognised at Section 3.3 above.

Power offers an alternative social constructivist account of the audit process, drawing on two principle themes – “the negotiation of audit knowledge and the creation of auditable environments” (1996:295). This alternative view posits that audit creates

processes and conditions within organisations which make them conducive to the application of audit technologies, and thus facilitate audit.

Audit gives precedence to what can be “described in managerial language or analysed in terms of an organizational model” (Strathern, 1997:311, emphasis removed). It rejects as ineffective those systems which cannot be described or analysed as such, without considering what other outcomes that alternative system delivers or purpose it serves. Auditors define the social order which they expect auditees to conform to by subjecting organisations and systems to prescriptive analysis. In effect, there is a “conflation of management with performance” (Strathern, 1997:318).

Strathern (2000:311-2) offers an anthropological explanation to reach the same conclusion. She expounds that auditors inevitably produce a ‘second order’ description of an organisation or process; they are not active participants in the delivery of an organisation’s core purpose and so always provide an outsider view from a distance. Strathern compares the role of the auditor to a social anthropologist in the field, making intangibles visible through the practice of observation. But these second-order observations can become institutionalised and accepted as part of the reality of the audited organisation (ibid, 313). In so doing, audit can obscure the less observable elements of organisational life and diminish their importance; key professional skills, such as experience and judgement, and organisational culture and values can become marginalised even though these qualities often hold organisations together.

In focusing on what it makes visible (in Power’s language, “auditable”), audit processes can obscure the true functioning of an organisation and create a situation where “the rhetoric of transparency appears to conceal that very process of concealment” (Strathern, 2000:315). Strathern thus argues that the organisation is less transparent once it has been made auditable.

#### 3.4.1 Measurement

Auditability is not an absolute concept: it is often “a product of consensus about the nature *and detail* of evidence required by those whom the audit is intended to serve”

(Power, 1996:298, emphasis in original). What is accepted as auditable will differ between situations, for auditability is itself a negotiated outcome rather than an objective science. Nevertheless, measurability is a necessary precondition for auditability (Power, 1996:299).

The practice of measurement is based on a range of variables and assumptions. The fact of measurability alone is insufficient for a practice or process to be auditable; the basis of that measurement must also be trusted, as must those experts or others who perform the measurement. Using the example of brand valuations, Power (1996:306-8) shows how auditability can be achieved when a form of measurement becomes widely regarded by stakeholders as reasonable. They may reach this conclusion through scientific analysis, or simply a desire to believe in the soundness of the measurement by “constructing networks of trust which can be proceduralized” (Power, 1996:309).

Strathern identifies links between educational practice and the birth of accountability, and audit as an instrument of that accountability. She suggests that audit practices have their roots in educational examinations and the desire to objectively assess human abilities by externally verifiable means. However, this act of measurement became part of a drive for improvement through the setting of targets (Strathern, 1997:307).

Self-assessment checklists and ‘good practice guidance’, often produced for the public sector by national audit bodies, provide further examples of ways by which public services are reduced to measurable criteria and thus rendered auditable (Bowerman et al., 2000:83).

#### 3.4.2 Impact on the auditee

The literature inspired by Power’s work provides empirical evidence that the auditee is subjected to “profound transformation” in order to produce an auditable self (Power, 2003a:191).

Vikkelso’s (2007) study of electronic patient records finds that practices and practitioners can be transformed by attempts to make organisations auditable. The

purpose of an electronic patient records system changed during the period of its implementation. While the system was originally intended to improve communication and cooperation in patient care, it evolved to become an “instrument of performance auditing” (ibid, 277). The delivery of healthcare was actively redefined through standardisation and codification as managerial logic was imposed upon clinical practice. Concerns for the patient experience were displaced by the quest for auditability through quantification of clinical practices and indeed the processes and interactions at play in developing the new system ultimately became more significant than the impact of implementing the final system.

Skaerbaek and Thorbjornsen (2007) analyse the relationships between a new performance measurement system in the Danish Defence Force (“DDF”), the officers of the DDF and the identities of those officers. The authors trace the development of a shared identity by following the interactions within a network of DDF officers, auditors, government officials and the new performance measurement system.

DDF officers believed that the new system was implemented as a direct result of recommendations made by the National Audit Office of Denmark (“NAOD”), which reported that existing systems were not fit for purpose. The NAOD then assumed a more active role in introducing change by announcing the creation of a group to monitor the development of the new system by the DDF.

The officers made the DDF auditable by creating a new identity for the organisation as “Denmark’s largest education provider”. The officers were unable to define measurable objectives or outcomes for their traditional military functions, so re-defined themselves as providers of a service with quantifiable outputs, namely fully-trained, battle-ready soldiers. The Danish National Audit Office was active in the network which created this new identity for the DDF. This study provides empirical evidence to support Power’s view that audits are not neutral processes: auditors promote new definitions of organisational performance and quality (1994a:25) in order to make organisations auditable.

### 3.4.3 Making professions auditable

Many judgement-based professions have been transformed by the imposition of audit ideology in recent years.

Jones (1993) considers the “profound impact” of increasing managerialism, and associated introduction of value for money audit, on the criminal justice system. The performance of criminal justice services is not easily quantified and the drivers of performance can be difficult to establish, for example the relationship between crime rates and policing. Jones observed a shift in decision-making power away from professionals towards accountants, increased parliamentary scrutiny, weakening local autonomy and distinctiveness, and re-definition of the priorities of the justice system to render the system measurable (Jones, 1993:199-200).

A professional jurisdiction was transformed by attempts to define performance in a manner conducive with the philosophy of value for money auditing – criminal justice was rendered ‘auditable’ before Power’s published work coined the term.

Social work, too, has been “made auditable”, with an auditable framework imposed upon a profession which has a weak knowledge base. A profession underpinned by judgement-based decisions is less well-equipped to compete with the rationality apparently promised by audit practices, than a profession with its roots in science or hard knowledge (Power, 2003a:193; Llewellyn, 1996). Displacement effects emerged; social workers started to prioritise the achievement of government targets without considering whether they delivered substantive improvements for service users (Munro, 2004:1086-7). Such behaviour was detrimental to social workers themselves; the defensive behaviour encouraged by the audit society permeates the mindset of the practitioners, generating in a blame culture and low staff morale. This culminated in the exit of many practitioners from the profession (Munro, 2004:1089-91).

Other commentators argue that these professional domains have not had audit technologies imposed on them under the influence of financial auditors. Instead, these professionals have chosen to adopt and develop these technologies in their own context (Humphrey and Owen, 2000:41), sometimes in pursuit of a commitment to

improve the quality of service provision. Indeed, many professions considered audit to offer new opportunities for continuing learning and development rather than a threat to their professional autonomy.

Power (1998:28-9) counters that the early organic manifestations of audit in professional domains were soon captured by external demands for managerial autonomy, particularly where the auditing practice was in its infancy. There is the potential for audit to instigate a shift in the balance of power away from professional judgement and in favour of routinized practices which, through the audit process, become synonymous with best practice and good performance. The capacity for audit to undermine professional autonomy in this way increases as audit moves from being a local to a national practice and often becomes embedded in professional accreditation processes (Power, 1998:32).

#### 3.4.4 Systems and controls

Another important element of making an organisation auditable is the imperative to make performance visible to external parties through distilling activities into systems and controls which can be externally verified (Power, 1996:303). This is considered in greater detail in the following section.

### **3.5 Control of control: systems over substance**

As audit technologies have developed over the last century, audit has increasingly become a second order control over the primary internal control systems installed and operated by audited organisations (Power, 1999:82). A characteristic of the audit society is the “focus on the quality of... *systems* rather than the quality of the product or service itself as specified in standards” (Power, 1999:84, emphasis in original).

Auditable systems and controls become ends in themselves, rather than means to further the achievement of service outcomes. That is, they exist to be audited rather than to support core organizational activities or objectives. Furthermore, this reversion to auditable systems can help to explain the portability of audit and its

spread through society beyond its origins in financial accounting. Such systems neutralise organisational complexities, creating a simplistic reality conducive to the application of audit technologies (Humphrey and Owen, 2000:35).

For example, environmental and quality audits tend to focus on the systems which organisations install to monitor environmental performance and quality rather than the actual environmental impact of their activities. The development of 'Best Value' in Scottish local government focused upon the systems and processes which local authorities put in place in order to demonstrate that they consider 'Best Value' in decision-making (Sheffield and Bowerman, 1999), rather than focusing upon whether authorities actually provide 'Best Value' services.

Corporate governance reforms introduced in response to corporate crises and scandal have focused on strengthening internal control processes and externalising these processes through public reporting on their existence and operation. This regulatory trend emerged in the 'Cadbury Code' of 1992 (Power, 1999:54-57) but continues to be prominent in subsequent corporate governance reforms, including the most recent iteration of The UK Corporate Governance Code (Financial Reporting Council, 2012) and the Sarbanes-Oxley Act, the US regulatory response to the Enron collapse.

Organisational performance comes to be defined in terms of control systems, rather than outcomes or quality (Power, 1994a:15-16). Auditors no longer audit the practices and operations of auditee organisations, but focus instead on the systems which underlie these operations. This creates a risk that auditees develop a compliance mentality and prioritise systems which can be audited ahead of working to achieve the substantive goals of the organisation (Power, 1994a:16).

The systems-focus serves a dual purpose: it facilitates audit, but also makes it more remote from operational realities (Power, 1999:60). Auditors certify non-financial information based upon reviews of the systems which collect the underlying data – they do not verify the actual data (Bowerman, 1995). Audit practices are simplified and standardised. Control systems permeate the language of audit and come to be equated with good performance.

Auditors also gain power and influence from the growing reliance upon control systems; the ability to reduce any organisational or professional field to auditable control systems enables auditors to transfer their skills to any setting. This is supported by the ambiguity of audit and the fluidity which is pivotal to its influence.

As discussed above at Section 3.4.3, audit technologies have been exploited to open up professional decisions to scrutiny from outwith the profession, inviting interest from policy-makers among others (Jones, 1993).

The introduction of the Teaching Quality Assessment and Research Assessment Exercise exposed the UK higher education sector to audit. The means by which students were taught were awarded greater weightings in the assessment methodology “than the outcome in terms of students’ knowledge” (Strathern, 1997:309). Strathern posits that the extension of such an approach into student assessment would award marks to candidates for “bringing their pencils into the exam” (ibid.).

The presumption that auditors can apply their methods in new fields is not without challenge. A knowledge gap separates professional experts from those who observe them (Tsoukas, 1997:834). Professional judgement is the product of detailed knowledge which cannot be captured by simplistic representations, such as performance indicators. This information asymmetry makes it virtually impossible for an outside observer to fully understand an expert system, despite representations of that system which may be publicly visible and apparently auditable.

The idea that auditors can provide assurance over the operation of virtually any organisation by reviewing its internal control systems creates a situation of compound auditing. Controls are introduced above organisational control systems so the auditors themselves become subject to a further layer of audit. This “threatens an infinite regress to the n<sup>th</sup> auditor as further layers of regulatory influence are created” (Power, 2000a:117). There is a need for further research to document and explain these increasing layers of accountability (ibid) and the impact of expanding internal control systems on organisational behaviour and outcomes.

Much like the term ‘audit’, Power contends that the concept of ‘internal control’ is vague in practice and Maijor (2000) finds that this is also the case for internal control research. Maijor finds that although there has been an ‘internal control explosion’, there is a lack of research findings which investigate the benefits to organisations of installing internal control systems or reporting on the effectiveness of internal control systems. This mirrors concerns expressed in the literature as to the lack of evaluation of audit mechanisms themselves.

### **3.6 Auditing public services**

#### 3.6.1 *The Audit Society and New Public Management*

“New public management” (“NPM”) demands that power and autonomy are devolved away from central bureaucracies to operating units, but at the same time those at the centre cannot relinquish control, and ultimately accountability, for these units (Hood, 1991; 1995). Audit provides a potential solution to ease these tensions, helping central government to shift its emphasis to supervising the delivery of public services, as opposed to actual delivery of those services (Power, 1994a:12-13).

It is important to recognise the wider context in which the audit society has come into existence and its role in ‘hollowing out’ the state (Rhodes, 1994) as a key manifestation of the managerial accountability demanded by NPM.

Power (1994a; 2005) argues that three demand-side factors were the essential drivers of the explosion, all of which were intertwined with the rise of NPM: political demands for greater accountability, fiscal constraint and the problematizing of efficiency and quality of services as performance accountability.

#### 3.6.2 *Differentiating public services audit*

Public services audit differs considerably in scope and objectives from traditional financial statements audit, which is designed to deliver assurance to shareholders and has no wider public interest objective despite the wide range of users of audited financial statements. The theoretical and institutional arrangements underlying public services audit must differ significantly from those established around the audit

of private company financial statements if public sector audit is to succeed in its primary function of discharging public accountability (English, 2003).

Performance auditing, or value for money auditing, has emerged as a distinct activity of public services audit in the second half of the 20<sup>th</sup> century. This is arguably a more subjective endeavour than traditional financial statements auditing, requiring auditors to deliver an opinion on the economy, efficiency and effectiveness of public service delivery.

Performance audit has been described as “of considerable political and democratic significance. It is practised by powerful, independent institutions and is presented as a mode of investigation aimed at establishing whether, at what cost, and to what degree the policies, programmes, and projects of governance are working” (Pollitt and Summa, 1999:2). The relationship between performance auditing and the audit society is considered later in this section.

### 3.6.3 National audit bodies

“The audit explosion refers to the transformation of existing, and the emergence of new, formal institutions for monitoring” (Power, 2003a:188). National audit bodies are “the most conspicuous actors” (ibid) in the public service field and so there is a reasonable expectation that their role and activities will have been transformed by the audit explosion. New organisations concerned with inspecting and evaluating non-financial performance should also be visible if Power’s proposition is to be supported empirically.

According to Power (1999:46), reforms of national audit arrangements in the UK in the early 1980s, including the creation of the National Audit Office and the Audit Commission, were instrumental in raising the profile of managerial accountability over that of more traditional political forms of accountability. Central to this is the principle of the policy neutrality of these bodies, which concern themselves primarily with the management systems which support policy development and delivery. The audit process is designed to be structurally independent of the policy-making process. This distinction is increasingly challenged by value for money auditing (Power, 1999:49-52).

The status or legitimacy of national audit bodies is rarely challenged (Power, 1999). For example, “the [National Audit Office of Denmark] reports... are regularly being quoted by the press without critical debate about the reports themselves” Skaerbaek (2009:976).

Some exceptions are present in the literature, such as Funnell’s (1998) account of the introduction of efficiency audit in Australia, where the executive government demonstrated increasing hostility towards the Auditor General’s reaction to legislative changes. The current literature leaves open the question whether national audit bodies can truly fulfil their functions if they are not open to the same climate of scrutiny and challenge they create around audited organisations. Such a climate is however likely to build public trust in audit processes and bodies and this will be considered further at Section 3.8.

#### 3.6.4 Independence as a powerful tool for public service auditors

National audit bodies play a key constitutional role in holding government to account. This demands that they provide an objective assessment of financial statements and wider financial, and on occasion operational, performance (Hollingsworth et al., 1998:80-1). National audit bodies are expected to be structurally independent of both the legislature and executive, and independent of political influences including the policy making process (ibid.).

Auditors promote the myth that they do not make policy in order to secure their legitimacy as independent of government and management (Gendron et al., 2007:127). Bowerman et al (2000:91) lead examples of UK audit bodies becoming more willing to question government policy.

The increasing influence exerted by national audit bodies in rendering public bodies, and indeed policies, auditable could constitute a threat to their independence, particularly as their remit expands beyond core financial issues. This is evident in recommendations made by these bodies which effectively promote “a system of management as if it was the one-best way” (Gendron et al., 2001:304).

Recommendations of this type challenge the traditional role of state auditors to

uphold sound financial control systems and regularity of public expenditure. They begin to shape the policy agenda and managerial framework of public services.

Empirical research by Gendron et al. (2001) finds support for these claims in the evolution of public reporting by the Office of the Auditor General of Alberta between 1979 and 1997. During this period, the role of the Office evolved from traditional state auditor to proponent of a performance accountability framework rooted in the ideology of New Public Management. The Office's written reports bore some characteristics of management consultancy, leading the authors to question the effect this has had on the independence of the Office.

The greater the modernizing role of national audit bodies in developing accountability and management tools, the harder it is for them to sustain their independence, both in substantive and presentational terms, of the executive and agencies they are constitutionally required to hold to account (Christensen and Skaerbaek, 2007:127).

The legitimacy of national audit bodies is secured in part by their independence from executive government, underpinned by legislative or constitutional provisions and by maintaining a public image of impartiality. In Westminster systems of government, this constitutional independence is the very foundation of parliament's ability to hold the financial affairs of executive governments to account (Funnell, 1994:179). Any apparent criticism or threat to the independence of the Auditor General or equivalent could be construed as an attack on the system of democratic accountability which it supports. Public audit can derive credibility, or even invincibility, through its association with fundamental democratic principles. This association also leaves the executive government with little choice but to recognise the value of public audit, at least in a symbolic sense. This is reminiscent of the way in which financial analysts mobilise audited financial statements to bestow credibility on their own work (Malsch and Gendron, 2009).

### 3.6.5 Making public services auditable

Public sector audit institutions are particularly active in shaping the performance measurement systems which facilitate audit (Power, 2000a:115). In England, the

Audit Commission has become an “agent of change by promoting the systems which make auditing possible” (ibid, 116).

Day and Klein (1987) suggest that political processes do not themselves generate clear objectives against which effectiveness can be judged. The absence of pre-defined objectives forces the auditor first to define and operationalise measures of performance before it can begin to audit efficiency and effectiveness. Definitions of the efficiency and effectiveness of the auditee organisation are *constructed* around the audit process; they are not already defined so they cannot merely be verified by the auditor.

Lindeberg (2007:341) highlights the lack of predefined criteria for performance auditing, which necessitates the construction of appropriate criteria for each individual audit. As the auditor inevitably dominates this construction process, they define ‘performance’ in terms of audit, despite the appearance of political neutrality which is imbued in NPM technologies (Everett, 2003:99). The performance of public bodies is thus made “auditable”.

Similarly, Lapsley and Pong (2000) found that value for money auditors are not neutral agents but positively shape the definition of ‘best practice’ in public service provision: “public service auditors are not passive agents, but active pursuers of efficiency gains in service provision” (ibid., 562).

Gendron et al. (2007) find support for this claim as they examine how government auditors gain recognition as ‘experts’ in guiding and implementing NPM reforms. Through case study research of state audit in a Canadian province, the authors find that auditors make space for themselves by undermining the legitimacy of competing, usually professional, pools of expertise (Power, 2005:329). State auditors achieve this, for example, through repeatedly making recommendations that public service organisations should implement performance indicators despite the consistent rejection by the government of previous, identical, recommendations on the basis that existing mechanisms already served to discharge public accountability for the effectiveness of public services

Although public servants were initially sceptical about managerial reforms and the ability of auditors to fulfil the new functions in relation to performance, the auditors eventually succeeded in constructing expertise by basing their new local performance standards on established practices imported from other jurisdictions. The ability to tap into an international peer network set the Albertan auditors apart from other professional groups competing in the same space to establish expertise in performance measurement, giving auditors the ‘holy grail’ of legitimacy to support their propositions.

State auditors sustained their claims to legitimacy by undermining competing sources of expertise and by emphasising the credibility bestowed on the audit process by its independence from the programmes under review. This was cemented by establishing an ‘indirect’ assessment model, whereby performance was defined and measured by programme managers, with the resulting process then subject to audit review, exploiting the portability of audit technologies. Public servants recognised the auditors as a source of expertise and support when they sought to implement performance management systems.

Chisholm and Shaw (2004) undertake a Foucauldian analysis to demonstrate that the bodies which regulate the New Zealand outdoor activities industry gained power and legitimacy by introducing accreditation and audit procedures in response to public concerns over the safety of these activities. They suggest that regulatory organisations could benefit from the introduction of such procedures in real terms, through organisational growth, and in a more abstract sense by establishing themselves as experts on public safety issues within the outdoors industry (ibid, 320).

In the United Kingdom, the National Audit Office fashioned itself as an advisor on financial management to its audited bodies. It even fulfilled the role of consultant to central government in the introduction of resource accounting and made recommendations on the future of the public finance initiative (PFI) to a government-commissioned review (Bowerman et al., 2003:7).

Audits of specific public sector projects exhibit similar characteristics, such as the introduction of a new accounting system by the Danish Defence Forces (“DDF”).

The National Audit Office of Denmark played an active role in the development of the system. This left the auditor open to accusations that it had become a modernizing consultant, a long way from the traditional role of the independent auditor to report on the implementation of the system (Skaerbaek, 2009).

However, in this case study the national audit body successfully ‘manoeuvres’ between two roles; modernizer and independent auditor. The auditor achieved this position by recruiting powerful allies within a network, including statutory provisions and influential figures within the audited body, to confer legitimacy on pronouncements made by the auditor and to make the DDF auditable. Thus, “the auditor’s manoeuvrability appears to be conditioned by the situations and the unexpected events that they face” (Skaerbaek, 2009:985).

The international literature does not present a universal account of the national audit body as modernizer and key agent of change in embedding of managerial accountability in public services (Funnell, 1998; Gendron et al., 2001). Pallot (2003) recognises the role played by the New Zealand Audit Office in making non-financial performance auditable through defining criteria for audits of such performance. However, the New Zealand Audit Office proved to be a source of challenge to the managerial reforms advocated by the Treasury. Any role which the Audit Office played in facilitating and legitimating these reforms must be considered in conjunction with the willingness of successive Auditor-Generals to raise concerns about the erosion of public or democratic accountability.

Pallot’s work demonstrates that the audit society may not be a phenomenon which is universally internationally recognisable and that there remains scope to refine empirical understanding of Power’s arguments.

It is not always clear whether auditors create this modernizing or enhanced role for themselves; changes in the scope and content of public sector audit practices are often introduced as part of a wider programme of government reform (Lapsley and Lonsdale, 2010:87). That is not to downplay the shrewdness of national audit bodies in identifying and capitalising on opportunities to enhance their role (Wilkins and Lonsdale, 2007). But it is clear that the growth and influence of NPM technologies

has contributed to an environment in which the influence of national audit bodies can increase significantly.

### **3.7 Extremes of audit failure: decoupling, colonization and displacement of organisational objectives**

Power (1999) describes two opposite extremes of audit failure which may be present in the audit society: decoupling of audit from organisational processes and the colonization of organisational life by audit values. The worst extreme of audit failure occurs when organisational objectives and core activities are entirely displaced by audit structures; the functioning of the core organisation is undermined by the dominance of audit.

Decoupling and colonization represent ‘ideal types’ in that neither is likely to be present in a pure form in any organisation. Power asserts that these concepts must be explored primarily at the empirical, not theoretical, level. Subsequent empirical studies have found that these concepts must be studied together and not in isolation in order to capture the complexity of potential organisational responses to audit technologies (Arnaboldi and Lapsley, 2008:45).

#### 3.7.1 Decoupling

Decoupling refers to the situation where management systems become ‘institutionalised routines’ which operate independently of primary organisational activities. Auditable systems become compartmentalised into their own sub-organisations, divorced from substantive organisational processes, which may also be used to represent the organisation to the outside world (Power, 1994a:28-9).

The primary aim of these new systems or practices is often to facilitate audit or regulatory control, and not to improve the underlying practice or furtherance of substantive organisational purpose or objectives. By installing such systems, organisations attempt to maintain external legitimacy through institutionalised images of assurance (Power, 1996).

External audit and assessment can be mobilised ceremonially in order to “deflect questioning of organisational conduct” (Power, 1999:96) but the processes are remote from the very organisational practices over which they are intended to provide assurance.

Power draws on the classic neo-institutionalist works of Meyer and Rowan (1977) who describe how organisations build systems, with more symbolic than substantive properties, to act as a buffer against unwanted external influences, in this case external audit. Internal audit departments and audit committees are examples of ceremonial devices created by organisations to demonstrate that they are fulfilling audit obligations (Power, 1999:96).

In a study of the implementation of Best Value audit in Scottish local government, Arnaboldi and Lapsley (2008) identified organisational buffers to audit, including the creation of teams responsible for coordinating the organisational response to Best Value. They found limited evidence of a so-called “tick box mentality”, where managers did the minimum required to satisfy audit requirements, but did not actually embed the supporting changes into the operations of the local authority. Based on the lack of evidence of legitimation and decoupling practices within the case study sites, the authors tentatively suggest that the Meyer and Rowan analysis does not hold in the context of public services long-exposed to NPM technologies but that further research is necessary to explore this.

McGivern and Ferlie (2007:1380) found that medical consultants embraced the terminology and process of formal appraisal as a legitimating device, but did not embrace the substance of appraisal as their actual behaviour and clinical practices were unchanged by either the appraisal process itself or the resulting findings.

### 3.7.2 Colonization

Laughlin (1991: 218) describes colonization as “a second order change... [which] is seemingly *forced* upon the organisation” (emphasis in original). Laughlin draws on the work of Habermas to describe a situation where a deliberate change is made to one part of an organisation, often as a result of an external disturbance such as a government policy, which has a greater reach than originally intended. This can

bring about a more fundamental change in the overall workings and culture of the organisation. Organisational actors, who did not choose the new direction, are faced with a situation where they either accept the new environment or exit the organisation (Laughlin, 1991:218-220).

Power (1999) suggests that colonization can occur where organisations are made auditable. It represents an instance of audit failure and occurs when audit practices and values “spill over” from their intended purpose and come to permeate organisational practices and culture. This could in turn have a detrimental impact on organisational performance.

This is the opposite extreme from decoupling: every aspect of colonized organisations comes to be dominated by audit values, whereas the operations of decoupled organisations are barely influenced by independent audit processes.

Colonization is a characteristic which the Audit Society shares with NPM. NPM itself seeks to colonize public sector professionals and render their performance more publicly accountable by removing their discretion and minimising professional judgement.

Everett (2003) demonstrates how value for money audit techniques were colonized by economic and market ideals which cast serious doubt on the political and ideological neutrality of such techniques. Through the audit process, these ideals are likely to permeate the operations of the auditee.

Only in rare instances will an entire organisation be colonized. Organisations which are populated by strong professional identities are less likely to be susceptible to audit’s colonizing abilities. This complements the finding that professions with hard knowledge bases are less likely to be rendered auditable (Power, 2003a:193; Llewellyn, 1996). In such organisations, attempted colonization through audit techniques and values is likely to engender resistance and even conflict. The original purpose of both audit and the organisation is subverted, creating dysfunctional outcomes (Power, 1999:97-8).

Arnaboldi and Lapsley's (2008) study of Best Value audit in Scottish local authorities found that Scottish Ministers attempted to colonize local government managers when they introduced the concept of Best Value into public policy. However, the policy failed to transform the culture within local authorities. The auditors also sought to change management culture through their work, but likewise did not succeed. Local authority managers interviewed in the study commonly exhibited "resistance and apprehension" (Arnaboldi and Lapsley, 2008:44) and failed to buy-in to the management philosophies of continuous improvement underpinning the Best Value regime. There was thus evidence of partial or localised colonization only in the case study sites.

An earlier study by Lapsley and Pong (2000) found that value for money audit techniques had permeated the everyday life of public service managers and auditors despite the evidence of implementation difficulties and disconnect between conceptual aims and practical application, leaving it to academics and other commentators to problematize and criticise value for money auditing.

Skaerbaek's research on the introduction of a new accounting system by the Danish Defence Force (DDF) highlights that a new performance management system and associated managerial devices shaped the professional identities of DDF officers. These devices included the demarcation of military and administrative units, the creation of system 'super users' and making use of the system an inherent part of senior officers duties thereby embedding it in career progression (Skaerbaek and Thorbjornsen, 2007:258-260).

Two groups of officers emerged: those who embraced the new system, either for its own intrinsic purpose or because they recognised it as a necessary part of career advancement including career opportunities outwith the DDF (which the authors discuss in the theoretical context of hybridization of professionals), and those who remained sceptical of its benefits and the associated changes it brought to their traditional roles. Although the former group came to outnumber the latter, the existence of a group of officers who resisted the new identities left open the potential for future destabilization of the system.

### 3.7.3 Displacement of core organisational objectives

A third instance of audit failure arises when its dysfunctional effects outweigh its stated intention and so actually undermine the performance of the audited organisation: “the language of indicators takes over the language of service” (Strathern, 2000:314).

Examples of this dysfunction include: “declining organizational trust...; elaborate and wasteful games of compliance which distract professional attention...; excessive concern with representations of individual and collective performance...; defensive strategies and blamism...; and lower employee morale” (Power, 2005:335).

Educational researchers also draw on Power’s work to critique the expansion of performance audit techniques at all levels of the education system (Strathern, 2000). Elliott (2002) offers a personal view of the impact of value for money audit techniques on the teaching profession, highlighting the dysfunctions which can arise when short-term output measures are imposed on professional practice which is judgement-based and focused on longer term outcomes through the development of pupils. He was particularly concerned that the development of the teaching profession could be stifled in a dynamic social world.

Arnaboldi and Lapsley (2008) find that managers often believe that they spend more time making themselves auditable than doing their jobs. This is prima facie evidence of displacement and demonstrates the effects of an increasing audit burden on auditees, as identified by Bowerman et al. (2000:88-90). Managers’ attention and organisational resources are diverted away from achieving strategic objectives.

### 3.8 Trust

“The audit society is not simply a distrusting society; rather, it reflects a tendency not to trust trust. This means a systematic tendency towards uncritical trust in the efficacy of audit processes, a trust which results in the absence of evaluation of the audit process itself... In the audit society, institutionalized trust, which differs from the trust in ordinary individuals, is bestowed on the auditor and is displaced from other organizational locations”

(Power, 1999:136-7)

The rise of audit can displace trust; members of the public place their trust in auditors, rather than professionals at the frontline of service delivery (Power, 1994:1) or, in the extreme case, trust is removed one step further to abstract control systems (Power, 1994:16). The public trusts an organisation or service because an audit has been performed without being aware of the audit process or the nature of the assurance provided by the audit report (Power, 1994:20).

A paradox begins to emerge. One of the accepted rationales for the practice of financial statements audit is that it provides assurance to the owners of companies that managers charged with running the business and generating a return on the investments of those shareholders are upholding their fiduciary duties (Power, 1999:16-17). Audit supports the trust which shareholders have in those managing their investment and maintains order in financial markets.

“Auditors judge and attest to the validity of corporate financial statements, which contain a stylized interpretation of the fiscal health of a corporation. Accountants construct these interpretations, but *auditors reassure the public and other interested parties that the interpretations are trustworthy.*”

(Pentland, 1993:606)

It follows that “in order to generate trust in financial statements, audit practice must generate trust in itself” (Power, 2003b:380). Thus the audit society suggests that rather than restoring trust in management, the audit itself, rather than managers, becomes the object of the owner’s trust.

### 3.8.1 Fallacy of placing trust in audit

Audit is a trusted practice despite there being an enduring ambiguity over what audit delivers. Power (1999:137) questions the extent to which it is appropriate to place trust in a practice which perpetuates an expectations gap against what it actually delivers. Is trust placed in what audit actually provides or in the unrealistic expectation of the outcome of the audit process?

Financial analysts rely, on paper at least, on audited financial statements to generate input data for their analysis; the inherent stamp of trustworthiness conferred on the financial statements by an unqualified audit opinion by extension provides assurance over the trustworthiness of their analysis based on this financial data. The trustworthiness conferred on their own work by audit creates incentives for financial analysts to promote the assurance provided by financial auditors through public pronouncements, such as references on publicity materials including websites (Malsch and Gendron, 2009).

However, interview research conducted by Malsch and Gendron (ibid.) found evidence of a conflicting reality; the apparently objective quantitative data was not the primary basis of analysts' recommendations. These recommendations were in fact judgement-based and drawn in the main from confidence in the management team drawn from judgements formed from face-to-face meetings. Thus despite the popular myth, analysts place primary trust in company managers, not auditors or audited financial statements. To expose trust in auditing as mythical would be to risk destabilising the social order of the market and expose financial analysts to unwelcome scrutiny, as well as expose the lack of scientific rigour underlying their own advice. Audit provides a protective shield for financial analysts; this creates an incentive for analysts to promote public trust in audit, even when analysts themselves place little trust in the audit process.

Harrison and Smith (2004) distinguish between confidence and trust in order to demonstrate how modernization of public services favours the certainty offered by measurement and systematisation over the uncertainty that characterises a relationship of trust between public service providers and users. They draw

examples from New Labour healthcare reforms of the late 1990s and early 2000s to demonstrate that a 'modern' NHS driven by clinical governance has marginalised trust in public service delivery by giving precedence to measurable outputs and control systems. These management tools inspire confidence because service users know that compliance can be enforced. Healthcare reforms make room for trust at a micro-level only, between individual healthcare professionals and their patients.

Some form of account giving will always be required to underpin a relationship of trust. According to Power (1999:138), "the problem is that the audit society eclipses this meta-auditing. In place of reflection on the need for auditable account giving, there are increasingly formalized rituals of accounting and verification. And this means that trust in auditing may be risky."

Lapsley and Lonsdale (2010:91-2) suggest that audit can play an important role in brokering public trust in government and other agencies which deliver services. But in order to effectively fulfil such a role, auditors must look to improve the effectiveness of their own practices (ibid).

The corollary of this proposition must be the potential damage to public trust caused by critical audit findings, particularly performance audits of public services, or selective accounts of audit findings in the popular media (Justesen and Skaerbaek, 2005:340-1). The latter source is likely to be the more potent; very few citizens will read performance or value-for-money audits first-hand and rely on media reports as the primary source of news of audit findings. Thus, trust can even be displaced by third party reports of audit activity.

### 3.8.2 Impact of erosion of trust on professions

O'Neill (2002) describes a paradoxical culture of mistrust which she attributes to the prevalence of managerial forms of accountability, including audit techniques and performance targets. She argues that the perverse incentives created by the culture of central control and compliance-driven accountability mechanisms are evident to the public and these create suspicion and mistrust that public organisations are not focused on their primary substantive aims, instead distracted by games of presentation and compliance. After all, O'Neill points out, the public are still more

than willing to make use of services provided by the same doctors, teachers and so on whom they are claimed to no longer trust. This is not a universally accepted proposition: managerial models of accountability, which prioritise systems and quantitative forms of account-giving, have also been argued to undermine public trust in medical professionals (Checkland et al., 2004).

Tools of managerial accountability ostensibly intended to secure and broker trust actually engender suspicion of, and ultimately mistrust in, those organisations responsible for providing public services.

Thus the public continue to trust professionals, but not the organisations that employ those professionals to provide services.

The proliferation of information on an expert system, which is intended to improve the transparency of that system, can damage trust in professional judgement. This information requires interpretation, which is beyond the competency of the lay observer who has not completed the necessary professional training. The observer's interpretations will almost inevitably conflict with the professional interpretation (Tsoukas, 1997:835), and so the attempt at lay interpretation only further obscures what it purported to make transparent. A full account cannot be given by a lay observer, regardless of how auditable the underlying practice is made.

The relationship between audit and trust thus remains problematic and opportunities remain for further exploratory empirical analysis.

### **3.9 Response to Power: criticism and development**

Power invites further debate on the arguments which he presents in the *Audit Explosion* and *The Audit Society* (1999:143-4). The majority of the ensuing contributions to the academic literature support Power's core arguments and sentiments, but offer refinements and pose further challenges to strengthen the theoretical and empirical foundations of Power's work (for example, Humphrey and Owen, 2000; Bowerman et al., 2000; Pentland, 2000).

Maltby (2008) is among the most direct critics of the audit society thesis and her counter-arguments will be considered in greater detail in the following sub-section. She claims that anyone who disagrees with Power is open to “charges of gullibility and addiction” (2008:11), yet she does not provide a convincing counter-argument to refute these charges or indeed substantiate their original existence.

### 3.9.1 No such thing as ‘audit society’?

Maltby (2008) leads three primary arguments, as identified by Power (2008), in order to make her claim that Power’s audit society is a fiction: the absence of a definition of ‘audit’ in Power’s works; the audit society lacks an empirical base; and Power overlooks the democratic value of audit to members of the public.

The first argument is considered in detail above at Section 3.3.3, as other commentators have also suggested the failure to define ‘audit’ undermines Power’s work. This earlier discussion concluded that these other commentators failed to consider that the ambiguity of ‘audit’ as a programmatic, rather than technical, concept may be the source of its influence.

Power responds to Maltby’s charge that the audit society is without an empirical base by re-framing the question. While he concedes that the work is not underpinned by a systematic analysis of empirical data as demanded by traditional research methodologies, Power (2008:401) suggests that such an analysis would not have been appropriate support for what is essentially a theory-building endeavour, but an attempt to address bigger questions about the growing dominance of the audit idea.

Maltby (2008:16) accuses Power of sympathising with those public servants and others who resist the imposition of accountability upon their traditional practices. However, Power actually rejects a return to the days of untouchable professional privilege (1994a:33) and favours efforts to increase the transparency of public services and the visibility of those who deliver them (2000a:116).

Power argues that the negative consequences of audit call into question its value as an instrument of accountability, not that accountability itself is undesirable. Power even tentatively advances some possible design features of a more positive system of

auditing (Power, 2003a:195-9) which could be more effective in the discharge of accountability than the illusory accountability created by the prevailing audit framework.

Power could perhaps have been more convincing in affirming this position, as other commentators also criticise the *Audit Society* for failing to sufficiently challenge the role of public sector managers (Humphrey and Owen, 2000:47). There is thus scope for future research to explore the role of public sector managers in the discharge of accountability and in particular how they perceive their role in that process.

It is noteworthy that Maltby's paper is based on the first incarnation of the audit society which appeared as a short essay (Power, 1994b), not the more comprehensive set of arguments contained in his later work, despite the publication of her counter-argument coming a decade after the publication of Power's latter work.

Many of Maltby's claims read like a philosophical or political disagreement with Power, are somewhat shrill in tone and lack the support of empirical evidence or an alternative theoretical framework. Maltby uses provocative language in an attempt to discredit Power's work. This is particularly evident in the concluding sentences of her article:

“The Audit Society and its progeny, Power's own papers and the wails of unhappy academics and doctors and civil servants, are ultimately not a protest about the creation of an iron cage [Power, 2003a:200] round society. They are a stifled chorus of fury at being made accountable.”

(Maltby, 2008:16)

Maltby's use of provocative language and emotionally-laden statements<sup>9</sup> creates the appearance of an impassioned counter-position to Power's *Audit Society* and perhaps at first sight disguises the absence of well-developed substantive arguments based on a systematic understanding of Power's work.

However, the lack of reasoned analysis ultimately results in a failure of Maltby's article to present a convincing counter-argument to disprove the existence of the

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<sup>9</sup> See also Power (2008:402): “[Maltby's] is a style which actually prevents her from directly addressing the proposition in the title of her essay, and results in an extended sneer... In the end, the only “chorus of fury” I can find, not at all stifled, is in the tone and language of Maltby's essay itself.”

audit society which enables Power (2008) to rebut her claims in a four-page reply. *The Audit Society* survives Maltby's attack and remains substantively unchallenged by the academic literature.

### 3.9.2 Financial audit is losing influence?

In contrast to Power's picture of a profession in the ascendant capturing new markets and expanding rapidly, other commentators lead evidence that financial auditors were actually being forced to defend their position (Bowerman et al., 2000:85). Audit fees reduced in the 1990s and some professional firms rebranded audit as 'assurance' services (Humphrey and Owen, 2000:40). The balance of power between auditors and managers is shifting in favour of the latter with auditors under increasing pressure to satisfy the demands of their clients in a competitive market (ibid, 43). Commentators argue that there is no clear upward trajectory of audit influence; its influence has fluctuated (Maltby, 2008:12-13) and may not have ultimately increased (Hood et al., 2004).

Power accepts this criticism. He maintains that financial auditing has had a significant influence on the evolution of the audit society, but it "has probably been overstated in previous work as *the* source of the audit explosion" (2003a:188, emphasis in original). For example, the focus on auditable systems probably has its origins in quality assurance practices rather than financial auditing (2003a:189).

It may be useful here to distinguish between the private and public sectors and in particular to note the corporate scandals and (perceived or real) associated audit 'failures' which dominated the popular debate on the role of audit in the private sector in the 1990s. Auditors continued to be allocated blame in the investigation of high profile corporate failures in the early 21<sup>st</sup> century (Fusaro and Miller, 2002; Blyth, 2003), often because of a perception that auditors should have been able to prevent the deviant corporate behaviour which led to the failure (Guénin-Paracini and Gendron, 2010). Although significant reforms to the auditing profession emerge in response to such crises (Sikka and Willmott, 1995), the fundamental functions of audit survive these crises because the legitimacy provided by the audit process underpins the effectiveness of the prevailing economic order.

Organisational scandals on this scale have largely been absent from the UK public sector and very rarely have audit bodies been held to have greater responsibility for organisational or service failings than management. There is potential scope for auditors to have greater influence in the public, than in the private, sector.

### 3.9.3 The role of the accounting profession

When Power returns to consider the causes of the audit explosion, he concedes that he may have over-emphasised the importance of the demand-side factors which created the audit explosion (2003a:191-2). In doing so, he neglected the supply-side factors, primarily the existence of professional groups, mainly accountants, willing and able to redefine themselves to serve the demands of NPM (Humphrey and Owen, 2000:40). Public sector professionals were empowered by NPM, along with private sector consultants (Power, 2005:329).

It would be equally overly simplistic to explain the audit explosion and society only in terms of auditors conspiring to advance their status. Even auditors are increasingly subject to the discipline of auditing, and they are not willing auditees (Power, 2000a:114). Humphrey and Owen (2000:40) consider this a weak explanation of why the audit society is not wholly driven by auditing professionals, noting that at the time of writing audit revenues were of decreasing significance for large accounting firms and the 'audit' function was commonly rebranded as an 'assurance' function.

The larger context in which both sets of comments were made is significant; these were made in a pre-Enron era, before confidence in the financial statement audit function of large firms was shaken by apparent complicity in irregular accounting practices and the alleged destruction of audit evidence (Fusaro and Miller, 2002:124). At that time, large firms often viewed audit services as a gateway to securing more profitable non-audit services from a company, so the margin generated on the audit fee could be sacrificed in exchange for larger margins on tax and consultancy services.

Thus, the assertion by Humphrey and Owen (2000) that financial audit appeared to be in decline, rather than ascendancy, as the audit society emerged is based on a

simplistic view of the potential influence of financial statements audit and the business model operated by large accounting firms at that time.

The stronger argument advanced by Humphrey and Owen (2000:40-1) is that audit-style verification is permeating many professions, such that the role of many professionals has expanded to include the conduct of non-financial audits, including teaching. Humphrey and Owen suggest that the proliferation of non-financial audit is the key driver of the audit explosion, not at the behest of financial auditors seeking to extend their power and influence beyond the traditional base, but because other professions have been attracted to the potential benefits of external verification.

Power has been criticised for failing to hold auditors to account for allowing the audit society to develop (Humphrey and Owen, 2000:47). The accounting profession has not recognised, or at least publicly admitted the existence of, the negative consequences of the audit explosion which it helped to perpetuate. Power later contemplates whether there is scope to build reflexivity into the audit process (2005:340). Self-awareness amongst auditors could help to make the 'externalities' of audit visible, and auditors could start to assume some accountability for the damage which they inflict on trust and transparency in public service delivery.

#### 3.9.4 The performance measurement society?

An alternative interpretation of the drive to make performance auditable is offered by Humphrey and Owen (2000) and Bowerman et al. (2000) – they contend that Power documented the creation of a 'performance measurement society', not an audit society.

Management, and particularly New Public Management (NPM), is the main driver of the 'performance measurement society' (Humphrey and Owen, 2000:43). NPM demands that performance is made measurable. While performance measures may be subject to audit, they were neither designed primarily to be audited, nor in response to demands for external audit (Bowerman et al., 2000:78; Humphrey and Owen, 2000:43). The alternative proposition can be summarised thus: society demands that performance is made measurable, not auditable.

The focus of the academic debate thus shifts: “the task is the more straightforward one of explaining why organisations are so measurement oriented rather than why organisations are making themselves auditable but are not audited in any traditional sense of the word” (Humphrey and Owen, 2000:43). The quest for measurable performance is considered a more dominant force for change than audit. Changes in audit practice and techniques are one side-effect of this quest for measurement, rather than the driver (Bowerman et al., 2000:80). The ‘performance measurement society’ is not concerned with external verification and the role of independent bodies in discharging accountability.

Bowerman, Humphrey and Owen (2003) present two examples from the UK public sector to illustrate their argument: public service agreements and the introduction of resource accounting.

The UK government introduced public service agreements in 1998 to formalise the accountability relationship between ‘spending departments’ and HM Treasury, which had overall responsibility for government finances (Gay, 2005). Although these agreements were underpinned by measurable performance targets to formalise relationships between HM Treasury and the spending departments, the achievement of these targets was not subject to audit. Thus, argue Bowerman, Humphrey and Owen, the imperative was measurement of performance, not audit of the reported results.

Full adoption of resource accounting by the UK government would have seen the inclusion of performance reports, Bowerman, Humphrey and Owen (2003) argue, in the statutory accounts of government departments. Such a move could have brought performance reports within the scope of the external audit of those accounts. However, the government defined resource accounts to exclude performance reports (ibid.). They argue that resource accounting sought to make the performance of government departments measurable, and indeed auditable, but they were not in fact audited.

Advocates of the ‘performance measurement society’ fail to recognise the distinction between being *audited* and being made *auditable*. It is less important in terms of the

effects of the audit society whether performance or underlying systems are actually audited than that they were constructed to be audited, i.e. made auditable. The fundamental question is one of intention – the performance measurement systems may have been designed to facilitate audit, or other means of external verification, rather than merely to be measured for its own sake (Power, 2000a:115). After all, the act of measurement itself is less important than how measures are defined, interpreted, made visible and utilised to further policy agendas.

The introduction of most performance measures in public services has been accompanied by mechanisms to verify the process of measuring performance, usually carried out by an independent body often created solely for that purpose. The act of measurement only gains legitimacy as an apparently neutral practice, and fulfils its aim as a mechanism of control and accountability, through the additional process of external verification (Power, 2004; Free, Salterio and Shearer, 2009).

The ‘performance measurement society’ also fails to explain the transformation of governance style to one characterised by audit and the “transfers of institutional power to audit bodies who decide on a wide range of issues and who, by definition, overstep their purely auditing jurisdiction to become *de facto* policy makers” (Power, 2005:335). While the ‘performance measurement society’ does describe the quantitative dimension of the audit explosion, it is incapable of capturing the qualitative shift which permeated society and changed the language of regulation and oversight.

Furthermore, claims for the ‘performance measurement society’ appear not to have found popular support, or generated a debate, in the subsequent literature. Power’s ‘audit society’ by contrast resonates with commentators outside the realm of accounting and auditing academia. While this may be related to the general negative stereotyping of auditors by non-accountants (Humphrey and Owen, 2000:43), it does substantiate Power’s “hunch” that something systematic about auditing, as opposed to measurement, has permeated society (Power, 2000a:112).

### **3.10 Reflections and concluding remarks**

This chapter has explored the existing literature on the audit society, including Power's original work and subsequent refinements, commentary and empirical works. This body of work presents a comprehensive account of how audit has become a social force with an influence extending beyond the realm of financial accounting.

The following chapters will use this theoretical framework to ground empirical studies of the influence of audit in the development of the NHS in Scotland following devolution and the creation of the Scottish Parliament in 1999. These studies will show how audit has a ritual appeal to politicians and those responsible for the delivery of public services, which has a profound effect on those at the frontline of service delivery and the public image of those bodies.

The next chapter provides an overview of the research design and methods which underpin this study.



# **Chapter 4**

## **Research design and methods**



## **4.1 Introduction**

This chapter summarises the research design and methods employed in this study, and the underlying research strategy.

## **4.2 Research strategy**

### 4.2.1 Qualitative accounting and auditing research

Academic accounting research has tended to follow a positivist tradition, using quantitative methods and focusing on technical accounting practice (Burchell et al., 1980). Behavioural research in accounting traditionally relied upon psychological theories to gain insight into individual behaviours with little evidence that researchers considered the role of accounting in society more generally (Hopwood, 1978).

Research interests expanded into the organisational aspects of accounting during the 1970s (Hopwood, 1978). This interest was complemented by organisational studies researchers who considered the sociological roles of accounting information systems (Burchell et al., 1980; Miller, 1994), paving the way for the development of accounting as a social and institutional practice and drawing on social theory in order to understand the role of accounting in a wider context, including how it is mobilised by organisational and social actors.

Accounting researchers' concerns with the organisational dimensions of accounting practice broadened into the wider social environment in which accounting operates, recognising that accounting technologies are shaped by and, in turn, contribute to the construction of organisational and social reality (Hopwood, 1983). While the positivist and technical traditions continue to constitute the 'mainstream' in accounting research, particularly in the United States, there has been a steady growth in what has been termed 'alternative' accounting research which takes a more contextual approach in order to understand the organisational and social roles served by accounting (Baxter and Chua, 2003; Broadbent and Guthrie, 1992; 2008).

The introduction of qualitative research in auditing occurred at a slower pace. Research continued to focus on the technical practice of auditing, with little

consideration of the context in which auditing operates or the impact of auditing on auditees (Power, 2003a; Humphrey, 2008).

Michael Power's body of work recognises that audit has become a social force with an influence which extends beyond the realm of financial accounting. As well as contributing a theoretical framework on the development of the audit society, Power also established a tradition of qualitative research on the social context and impact of auditing practices. The present study locates itself within that tradition, offering a qualitative perspective on the role of audit in relation to performance management of the NHS.

#### *Criticisms of qualitative accounting research*

Qualitative accounting research is often criticised as 'story telling' so it is important to ensure that such empirical research is supported by a sound theoretical framework and that the aims of the study extend beyond 'understanding' a situation or process (Ahrens and Chapman, 2006). The present study is informed by, and seeks to develop, the theoretical contribution made by *The Audit Society*.

There is an inherent risk of bias and subjectivity in presentation and interpretation of qualitative data (Stake, 1995:41). The qualitative researcher must respond to this challenge and employ alternative disciplinary controls to protect the validity of the findings.

A further criticism levelled at qualitative research is that it is not bound by the rigours of statistical analysis and the well-established tests for determining the validity of analysis. However, it is inappropriate to use the language of quantitative research to evaluate a qualitative research design (Lincoln and Guba, 1985; Guba and Lincoln, 1994). The epistemological assumptions underlying the two approaches conflict; in particular, quantitative researchers believe in an absolute, objective reality whereas qualitative research allows for multiple realities and interpretations. Lincoln and Guba (ibid.) thus propose alternative criteria for assessing qualitative research: trustworthiness and authenticity.

#### 4.2.2 Actor-network theory

The interest in importing sociological theories into qualitative accounting research continued with the emergence of papers influenced by or explicitly adopting actor-network theory (ANT) as a theoretical framework. Justesen and Mouritsen (2011) argue that the advent of ANT studies enhanced the sociological understanding of accounting by bestowing a performative role upon accounting technologies; accounting was no longer explained as an effect of other sociological phenomena but could become an actor in its own right with influence on the construction and development of organisational reality.

Although ANT is increasingly used as a theoretical framework in qualitative accounting research (Baxter and Chua, 2003; Chua, 1995; Justesen and Mouritsen, 2011), the present study draws on ANT as research strategy (Lowe, 2001).

“ANT is *ontologically relativist* in that it allows that the world may be organized in many different ways, but also *empirically realist* in that it finds no insurmountable difficulty in producing descriptions of organizational processes.”

(Lee and Hassard, 1999:392, emphasis in original)

Used in this way ANT provides the tools to analyse associations between actors and to create knowledge through the production of detailed accounts of actor-networks. This is consistent with Latour’s view that ANT is “about *how* to study things, or rather how *not* to study them” (2005:142, emphasis in original).

ANT is a constructivist approach, although not a ‘social constructivist’ approach as Latour makes clear in *Reassembling the Social* (2005:91-2, emphasis in original):

“When we say that a fact is constructed, we simply mean that we account for the solid objective reality by mobilizing various entities whose assemblage could fail; ‘social constructivism’ means, on the other hand, that we *replace* what this reality is made of with some *other stuff*, the social in which it is ‘really’ built.”

Justesen and Mouritsen (2011:165) summarise the implications for accounting research thus:

“the aim is to show, at quite a detailed empirical level, how accounting practices and technologies partake in construction processes and how multiple, and sometimes surprising, effects are generated as a consequence.”

ANT seeks to assemble the active components of the social world and allow actors the space to express themselves (Latour, 2005:142). This makes it especially useful for considering the dynamics of a complex process (Skaerbaek and Thorbjornsen, 2007:245-6) and in particular to demonstrate how public sector organisations make themselves auditable (Skaerbaek and Thorbjornsen, 2007; Vikkelso, 2007).

Actor-network theory allows social scientists to look beyond the actions of humans by defining ‘actor’ in broader terms on the basis that humans are limited by their social skills, when in fact there are many more types of association present in the world (Latour, 2005:69). An object becomes an actor when it makes a detectable difference to the action taken by another agent; the object must leave a trace on human actors. Once an object participates in human action, it becomes an actor. It is the job of the researcher to identify these objects in a network and to find a way to “*make them talk*” (Latour, 2005:79, emphasis in original).

ANT enriches the present research by bringing into focus the role of non-human actors, such as policy documents and performance measurement systems, in shaping the behaviour of human actors charged with implementing these systems.

ANT is a commonly-used research strategy in health organisational research. The creep of managerialism into health care in the United Kingdom in recent decades has diluted the previous polarity of doctors versus managers and seen an increase in the number of stakeholders involved in the delivery of health care. This shift in emphasis from a “binary relationship” to a network of professional groups with overlapping jurisdictions and interests creates a fruitful study ground for actor-network theory with its interest in the fluid associations between actors (Dent, 2003).

ANT principles and ideas underpin this study: ANT enables the present research to consider the influence which inanimate objects, such as audit reports and performance measures, have upon actions at all levels of the NHS from the political sphere down to individual organisations. It also allows the researcher to access a wider range of associations between groups of actors within the NHS, which is a setting populated with multiple stakeholder groups (Greener, 2009).

## **4.3 Research design**

### 4.3.1 Research outline

The research questions will be answered through a multi-level qualitative study which first considers how the Scottish approach to NHS performance assessment differs from its English counterpart through a longitudinal comparative analysis of key policy and guidance documents. This initial comparative study will create a baseline to highlight the key differences between the performance assessment approaches adopted in England and Scotland and show how these approaches evolved.

The focus of the study then shifts to consider the Scottish case in greater depth. The impact which the Scottish approach to NHS performance assessment has upon Audit Scotland, the national audit body, is explored through a longitudinal analysis of its annual NHS overview reports. Two specific cases are then explored in greater detail: the official response to a performance crisis in NHS Lothian's waiting times management and non-participant observation of key governance committees within a Scottish NHS board.

Section 4.4 summarises the methods adopted for each study, before Section 4.5 appraises the existing literature on the use of these methods.

### 4.3.2 Multi-level design

In order to fully understand management reforms in the NHS, it is essential to consider multiple levels: centralised policy formulation and overall control, strategic management responsibility for local healthcare services, and operational delivery of frontline healthcare services. Decisions taken by organisational actors are influenced by the prevailing policy and accountability arrangements promulgated by the central body. Research designs which fail to give full consideration to this relationship will gain only a partial insight into their subject and risk misinterpretation of the data collected by excluding consideration of relevant influences. Furthermore, documents can constitute the foundations of practical behaviour and decision-making so it is necessary to first understand these before embarking on research into behaviour and decision-making through, in this instance, observational case studies (Prior, 2003:121).

This design incorporates research at each level of the NHS: it analyses documents which underpin policy formulation and governance and observes documentary and physical interactions between key actors charged with strategic management and responsibility for delivery of frontline services (see Table 4.1 below).

*Table 4.1: Mapping of research design to research questions*

<i>Research questions</i>	<i>Response</i>	<i>Methods</i>
1. How are audit mechanisms manifest in the performance measurement regimes in the National Health Service in England and Scotland?	Comparative longitudinal analysis (1997-2010) of key policy and guidance documents setting out performance assessment policy and practice	<ul style="list-style-type: none"> <li>• Documentary analysis</li> </ul>
2. What is the effect on the national audit body when there is no formal role for audit within the NHS performance assessment framework?	Longitudinal analysis of 'NHS overview' reports produced annually by Audit Scotland, representing the national audit body's identity as auditor of the NHS	<ul style="list-style-type: none"> <li>• Documentary analysis</li> </ul>
3. How do key actors in the governance and management of the National Health Service respond to performance measurement and audit mechanisms, and which actors exert greatest influence over the response?	Case study of official response to a performance crisis: NHS Lothian waiting times	<ul style="list-style-type: none"> <li>• Documentary analysis</li> </ul>
	Observation of three governance committees at a Scottish NHS board	<ul style="list-style-type: none"> <li>• Non-participant observation</li> <li>• Documentary analysis</li> </ul>

*Source: Researcher*

This multi-level design is not intended to ‘triangulate’ data sources or methods as advocated by Denzin (1978) to validate findings, but rather identifies and applies methods most appropriate to the research questions in order to present the best quality research evidence.

#### 4.3.3 Comparison

Devolution of legislative and administrative powers within the United Kingdom constitutes a ‘natural experiment’ (Propper et al., 2008; Connolly, Bevan and Mays, 2010) in healthcare policy which presents research opportunities to consider how different policy and managerial approaches impact on organisations which were previously part of the same system.

The preceding discussion at Section 2.3 shows that there was limited scope for divergence in the approach taken to NHS policy and management across the United Kingdom prior to devolution. The creation of the Scottish Parliament provided an opportunity for Scotland to pursue a distinctive approach to the NHS which rejected the managerial ideology which permeated the NHS in England (Greer, 2004).

Comparison is fundamental to social science as all understanding is relative (Bechhofer and Paterson, 2000). The present study attempts to understand developments in the Scottish NHS in the context of parallel developments in England, recognising that it is necessary “to consider devolved policy-making within the context of the nation-state” (Keating and McEwen, 2005:420). The comparative approach will promote a more thorough understanding of the Scottish NHS as it highlights the degree of contrast with other dominant approaches (Bryman, 2008:58).

#### 4.3.4 Timeframe

The backdrop for this study is the era of governance of the English NHS by performance management and measurement, which characterised the health policy of the New Labour Government. This research is therefore set against the three terms during which the New Labour Government was in power in the UK Parliament, from May 1997 to May 2010. The two longitudinal analyses, of key policy and guidance documents and of NHS overview reports produced by Audit Scotland, are structured within this time period.

The organisational case study is set in the recent present; the period of observation spanned September and October 2011. The performance crisis in waiting time management at NHS Lothian unfolded during the course of this study, and was analysed in real time by the researcher from its inception in October 2011 through to the culmination of the official response in May 2012 when the national audit body announces that it will conduct an external review of waiting time management in NHSScotland.

#### 4.3.5 Analytical framework

The approach to documentary analysis adopted in this study follows Prior's view that documents are not inert data but "fields, frames and networks of action" (2003:2). As such, documents should be considered as actors within social or organisational life, with an independent existence (Prior, 2003:168).

Following the approach advocated by Prior (2003), documents are analysed as active participants in the performance assessment and audit process by considering not only the content of the document but also what is referenced in the document, the context in which the document is situated and how the document comes to be an actor in a wider network. This approach is also influenced by Latour's account of ANT (1987; 1991; 2005) which recognises non-human objects, such as documents, as actors in a network.

This study attempts to consider three factors in the analysis of documents: the process and circumstances of their manufacture; how they function in specific circumstances, including how they are used by the reader; and the content of the documents (Prior, 2003).

Documents and notes from observation sessions are coded thematically, to search for correspondence and pattern within data (Stake, 1995:78). This qualitative approach draws on Boje's (2001) work on intertextuality in organisational research, which rejects the idea that a pre-defined conceptual grid can be imposed in advance of analysis. Instead, it advocates the identification of key themes in the course of data collection and analysis. This guards against unnecessary restriction of research findings (Prior, 2003:22).

All four studies attempt to present a rich account of interactions within performance management activities.

#### **4.4 Overview of empirical studies**

This study comprises four empirical studies; this section provides a summary of the research design and methods underpinning each of these studies.

##### 4.4.1 Longitudinal analysis of national policy and guidance documents

*Chapter 5: Performance management in the NHS in England and Scotland (1997 to 2010)* presents a detailed longitudinal analysis of national policy and guidance documents relevant to performance management of the NHS in England and Scotland from 1997 to 2010 to provide a baseline assessment of the performance management and structures in NHSScotland, relative to developments in England.

This study analyses key national policy and guidance documents to uncover the ‘official account’ of developments in performance management and audit at the macro level to provide a baseline assessment of the key differences in the respective approaches adopted by the NHS in England and Scotland. The timeframe for the documentary analysis is aligned to the three terms of the New Labour Government, as explained at Section 4.3.4 above.

##### *Selection of documents*

A purposive sample of policy, guidance and audit documents is selected for analysis. Documents include key policy White Papers which relate to the NHS system as a whole, performance assessment guidance for the NHS published by central government and publications from national audit bodies and quasi-audit bodies.

Original copies of policy and guidance documents were sourced via official websites, including the Department of Health and the Scottish Government websites, and the University Library. This provides assurance over the authenticity of the documents studied.

#### 4.4.2 Longitudinal analysis of Audit Scotland NHS overview reports

*Chapter 6: The evolution of Audit Scotland's role in performance managing NHSScotland* presents a longitudinal analysis of annual overview reports of the NHS in Scotland which traces the development of Audit Scotland's position in the financial and performance management networks of NHSScotland. The overview reports were selected as the basis for the study because they are the most public statements which Audit Scotland makes on its audit activity in NHSScotland and they provide a snapshot of Audit Scotland's role in relation to NHS performance. The timeframe for this analysis mirrors that adopted for the longitudinal analysis of policy documents. It runs from the creation of the new audit body for devolved public services through to 2010 and so encompasses eleven financial years from 1999/2000 to 2009/10.

Original copies of reports were sourced through the Audit Scotland website.

#### 4.4.3 Case study of the official response to a performance crisis in waiting time management

*Chapter 7: Audit in times of performance crisis – NHS Lothian waiting time management* presents a case study of the official response to a performance crisis, including recourse to audit technologies.

The researcher analysed these events as they unfolded in real-time, from October 2011, when the scandal was made public by a newspaper report, to May 2012, when Audit Scotland announces that it will perform a national review of waiting time management. The analysis considers the official response to the crisis as embodied by media reports; written parliamentary questions tabled by Members of the Scottish Parliament and answers provided by Scottish Ministers; the Official Report of statements and debates on the issue in the Scottish Parliament; primary audit and management reports; and NHS Lothian board papers and minutes of public board meetings at which waiting time management was discussed.

##### *Selection of documents*

The LexisNexis online database of UK newspapers was used to source relevant articles for analysis. Searches were conducted for articles including the keyword

“NHS Lothian” from 23 October 2011, which is the date of the initial newspaper report which made the performance crisis public, up to July 2012. Later searches also included the keywords “waiting time management” to ensure coverage of stories which related to the wider crisis in waiting time management in NHSScotland. The researcher manually reviewed search results to identify articles which related to the specific performance crisis.

Similar searches were conducted on the Scottish Parliament website to identify parliamentary questions and answers and Parliamentary statements and debates which pertained to the waiting time crisis. The public archive of NHS Lothian board papers on the NHS Lothian website was used to access papers of meetings at which the performance crisis was discussed.

The media articles, Parliamentary material and NHS Lothian board papers highlighted other key documents of interest, such as primary review reports which were then accessed from the websites of NHS Lothian, the Scottish Government or the Scottish Parliament. These initial materials were collated to produce a timeline of key events and interactions, which were cross-referenced to identify linkages and any potential gaps in the analysis.

#### 4.4.4 Organisational case study

*Chapter 8: Observing performance, audit and organisational life in NHSScotland* presents an organisational case study based on non-participant observation of key governance and management committees within a Scottish NHS board.

The researcher gained access to four meetings of three key governance and management committees within a Scottish NHS board. There is further discussion of the case study setting and the committees observed at Section 8.1. The researcher’s status as non-participant observer allowed direct access to interactions between committee members and other attendees at these meetings to develop an understanding of how key organisational actors approach audit and performance issues.

The case study combines non-participant observation of committee meetings with analysis of key documents produced or considered by the committee, including papers tabled and the minutes of meetings under observation.

### *Selection of committees*

Committees can be representative of bodies of expertise within a field or organisation (Lapsley and Pong, 2000) and thus provide a focal point for research interest. The researcher requested access to two main categories of committee: the audit committee and an operational management meeting at which performance issues are considered.

The audit committee, a mandatory sub-committee of NHS Boards (Scottish Executive Health Department, 2001), is the main focus of audit activities within NHS organisations. Committee members are thus uniquely placed to offer insights into how audit issues are handled by each organisation.

The operational management committee was selected in order to fully understand how audit impacts upon the operations of NHS organisations. Such committees typically comprise managers responsible for the delivery of health care services as well as the achievement of corporate objectives, including performance targets.

### *Method of observation*

The researcher was provided with committee terms of reference, details of committee membership and copies of the agenda and meeting papers. This facilitated the preparation of observation grids in advance of each meeting. A standard grid format was used for each meeting, which included individual boxes to record observations of each committee member and meeting attendee. A separate grid was produced and completed for each agenda item. The researcher also made process notes and recorded general observations during each meeting.

Inspired by Latour's (2005) concept of maintaining different 'research notebooks' while in the field, the researcher supplemented observations made in meetings with a record of her reflections on the observed session immediately following each meeting. This is a similar method to that adopted by Parker (2007) in complete member researcher case studies of the operation of the governance boards of not-for-profit organisations.

## 4.5 Research methods

### 4.5.1 Documentary analysis

Few research methods texts specifically address documentary based research (Prior, 2003:3). The use of documents in the present study is informed by Prior's view that documents are not inert carriers of data but active "fields, frames and networks of action" (2003:2).

As such, documents are not mere 'darts' or inert carriers of information (Brown and Duguid, 1996), but should be considered as actors within social or organisational life, with an independent existence (Prior, 2003:168). Such an epistemological stance is consistent with, and a demonstration of the use of, actor-network theory as an overarching research strategy to shape the present study; recognising documents as actors in the social world.

#### *Documents as actors*

Documents do not just appear organically – they are conceived by human actors and are products of their views, experiences and values (Prior, 2003:31). They can construct a particular social reality, an official record manufactured by an actor or a range of actors (Atkinson and Coffey, 2004). This documentary reality is not a representation of some separate social world but actively constitutes or even 'performs' that same world (Prior, 2003).

Furthermore, documents can exert as great an influence on human actors as human actors can upon documents (Prior, 2003:3), potentially to the extent that the very existence of a document can generate human action (ibid, p. 20). Prior (2003:14) refers to the "Frankenstein-like quality of documents", that is their capacity to act independently of their human creator(s).

Latour demonstrates how the actual use of a document can differ from the intention of the author(s) of that document.

"The strength of the statement thus depends in part on what is written on the sign, and in part on what each listener does with the inscription. A thousand different customers will follow a thousand different paths after reading the order."

(Latour, 1991:104)

These factors have implications for how social scientists should analyse documents in the course of qualitative research, looking beyond the content of the documents to consider how social actors use the document, how the text becomes active in a network, who uses the report to legitimate their viewpoint, editorial decisions about what to include or not include in the document and how a document becomes important in a network (Prior, 2003:66).

Policy documents encapsulate government rhetoric and direction at a defined point in time, consistent with Freeman's view that "government is a text-based medium" (2006:52).

#### *Organisational documents*

The minutes and papers of the committees provide insights into how each committee understands its collective identity and how it presents issues to other parts of the organisation. Meeting documentation are important sources of evidence as they can shape relationships within a committee network (Spira, 1999:242).

Administrative records are shaped by the political and organisational context in which they are produced and researchers should be sensitive to this. In a health services setting, this may not be an overtly party political agenda but could involve resistance to policy imposed by government, bid for increased funding, protecting managers and others from personal attack, or trying to shift blame for publicly unpopular decisions.

#### 4.5.2 Case studies

Case studies allow the researcher to examine, refine and substantiate meaning in a bid to "thoroughly understand" the subject of the case (Stake, 1995:9). A case study provides a forum to "seek out and present multiple perspectives of activities and issues" (Stake, 1995:134) so is appropriate for a study which is informed by the ANT view that we should follow the traces left by networks of actors. This ANT-inspired approach provides an opportunity to look inside the black box of an organisation to understand how actions are related: "inspecting various connections, and... examining their stability or fragility as the case may be" (Czarniawska, 2004:106).

Case studies are often criticised for providing insufficient basis to generalise findings. Generalisability is usually considered in terms of statistically robust models, particularly in positivist research. Other models have been suggested in the accounting literature including “contextual generalization rhetoric” and “constructive generalization rhetoric” (Lukka and Kasanen, 1995). However, the necessity of generalisation as a research objective is open to question and is linked to the basis of selection of cases (Blaikie, 2000:222-4).

The primary objective of a case study is to understand a specific case, not to generate or confirm hypotheses relating to the whole population (Stake, 1995; Blaikie, 2000:222-4). Each case exists in its own context and the researcher should bring out the characteristics, differentiating what is unique to that case from what is potentially universal, to provide the reader with sufficient understanding to evaluate the conclusions drawn on the case.

The case studies presented in this thesis seek to provide a deep understanding of two particular contexts in which performance and audit interact: within the official response to a performance crisis and within an NHS board. They do not seek to provide a basis for generalisation.

#### 4.5.3 Non-participant observation of committee meetings

Non-participant observation of committee meetings provides an insight into the interactions between committee members. It contributes to a wider understanding of how key actors consider audit and performance issues. It has been used in health services research to gain access to interactions between different groups of stakeholders, including general practitioners (Fischbacher and Francis, 1998).

Researchers often find access to committee meetings limited and therefore the majority of existing studies on the operation of key governance committees in both the private and public sectors rely on publicly available data or interviews with committee members. The processes which underpin the work of committees, including the audit committee, are under-researched (Gendron et al., 2004:154; Turley and Zaman, 2007:767).

Very few studies of governance committees are based on observation of committee meetings, with even case studies based entirely upon in-depth interviews with

committee members and executive or senior managers who attend committee meetings (for example, Gendron and Bédard, 2006; Turley and Zaman, 2007). Access to audit committee meetings is often restricted, particularly by private companies, and so creates a barrier to pursuing observation, an otherwise relevant and potentially first-choice research method (Gendron and Bédard, 2006). For example, Spira (1999:235) was unable to secure access to observe audit committee meetings on grounds of confidentiality.

Parker (2007) conducted two longitudinal case studies of the governance processes of the boards of two not-for-profit organisations on which he served as non-executive director. He describes his study as “one of the very few observational studies of internal boardroom process and behaviour presently available in the management research literature internationally” (Parker, 2007:923).

A key distinction between the present research study and the existing literature on the operation of governance committees lies in the object of study – the present study views such committees as forums which provide an insight into the inner workings of organisations, bringing together actors with specific expertise into an observable space, whereas other studies view these committees as the research object.

Existing studies designed to explore the effectiveness of audit committees have found that some of the most significant influence which these committees can have upon an organisation are embedded in informal relationships and interactions (Turley and Zaman, 2007; Magrane and Malthus, 2010), but this does not undermine the research design of the present study. While Magrane and Malthus’s study is designed to understand the operation of the audit committee within a New Zealand district health board, the present study is less concerned with the audit committee as an actor in itself than with the audit committee meeting as a network of actors (see also Spira, 1999) with an interest in audit and performance issues within the case study organisations.

Having gained access to a committee meeting, the researcher has to be alive to the potential for the behaviour of committee members to be influenced by the presence of the researcher as well as the potential for the ‘true’ interactions which actually influence decision-making occurring behind the scenes through informal interactions

outwith the formal meeting (Lapsley, 2004). The membership of committees selected for observation in the present study comprised senior management and non-executive board members so such suspicions were unlikely to arise. As these were formal, routine meetings at senior level at which it is not uncommon to have external observers or attendees present, for example to present papers on specific items, the risk that committee members' behaviour would be influenced by the presence of the researcher was greatly reduced<sup>10</sup>.

#### **4.6 Summary**

This Chapter has summarised the research design and methods which support the present study. The next four Chapters present the results of four empirical studies of the role of audit in managing the performance of the NHS.

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<sup>10</sup> Such observation bias is often referred to as the "Hawthorne Effect" in reference to the experiments carried out by Elton Mayo at the Hawthorne Works factory owned by Western Electronics (Chicago, USA) into worker productivity over the period 1924-32.



**Chapter 5**

**Performance assessment in the NHS in**

**England and Scotland**

**(1997 to 2010)**



## 5.1 Introduction

This chapter analyses a series of policy and guidance documents relevant to performance management of the NHS in England and Scotland during the period 1997 to 2010.

As outlined in *Chapter 4: Research Design and Methods*, this analysis is informed by Prior's view of documents as active "fields, frames and networks of action" (2003:2). The analytical approach is also influenced by Latour's account of ANT (1991, 2005) which recognises non-human objects, such as documents, as actors in a network. Thus a qualitative approach has been adopted in analysing the documents, drawing on Boje's work on intertextuality in organizational research (2001). This approach rejects the idea that a pre-defined conceptual grid can be imposed in advance of analysis and instead identifies key themes in the course of data collection and analysis.

The analysis focuses on the broad policy context, evidence of managerialism and in particular developments in performance management, public audit and associated accountability mechanisms.

Findings from the analysis are presented in four thematic periods:

1. A 'new' NHS: modernity versus renewal (1997-2000);
2. Time for action: widening divergences (2000-03);
3. Taking stock (2003-06); and
4. Consolidation and convergence (2007-10).

Each section opens with a brief introduction to key policy developments in the NHS in Scotland and England during that period. The following analysis then explores key points of divergence in the performance assessment approaches adopted in Scotland and England, with a focus on audit-based instruments.

## 5.2 A ‘new’ NHS: modernity versus renewal (1997-2000)

### 5.2.1 Policy context

Tony Blair’s New Labour Government swept to power in 1997 on a manifesto which promised to “save and modernise the NHS” (Klein, 2006:187) following 18 years of Conservative Government in the United Kingdom. There was a popular perception that the NHS suffered from years of under-investment under the preceding Thatcher and Major Governments (1979-97), resulting in lengthy waits for hospital treatment, an aging NHS estate and low staff morale. The ‘internal market’ was introduced by the Thatcher Government in an attempt to improve efficiency in the use of NHS resources through market discipline, including competition (Department of Health, 1989).

*The New NHS: Modern, Dependable* (Department of Health, 1997) was the first health policy white paper issued by the New Labour Government. Published in December 1997, it explained how the Government planned to deliver its manifesto commitments and introduced a ‘third way’ of governance into the NHS which rejected the internal market in favour of a performance-based governance framework. The foreword to *The New NHS* was made by the Prime Minister, not the Secretary of State for Health, illustrating that healthcare reform was central to the government’s overall policy agenda.

Just one day later<sup>11</sup>, the Scottish Office published *Designed to Care. Renewing the National Health Service in Scotland* (1997c), a sister white paper setting out planned reforms for the NHS in Scotland.

It is important to note that Scottish politics and public services were in a period of transition when *Designed to Care* was published. The Scottish electorate had voted in favour of the creation of a Scottish Parliament in September 1997. A little over a week after publication of *Designed to Care*, the Scotland Bill would be introduced to Parliament to begin the process of translating the referendum vote into a new constitutional settlement.<sup>12</sup> The proposed devolution settlement included full

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<sup>11</sup> *The New NHS* was published by the Department of Health on 8 December 1997 while *Designed to Care* was published by the Scottish Office on 9 December 1997.

<sup>12</sup> The Scotland Bill was introduced to the United Kingdom Parliament on 17 December 1997.

legislative and administrative responsibility for the National Health Service in Scotland (The Scottish Office, 1997a).

So while it was not unusual for The Scottish Office to publish its own interpretation of UK health policy documents prior to 1997, any variation in approach was marginal (Woods, 2004). As the first health white paper published by The Scottish Office after the devolution settlement had been approved by the people of Scotland, *Designed to Care* was the first real opportunity for the Scottish Office to present health policy which diverged substantively from that of the United Kingdom government. The referendum result provided an initial mandate for a Scottish solution to the challenges of delivering healthcare, although the Secretary of State for Scotland remained bound by principles of collective decision making as a member of the United Kingdom Government.

This is explicitly recognised in *Designed to Care*:

“There have always been differences in the way the NHS is organised in the different parts of the UK to take account of different needs. But sometimes changes have been made in Scotland to reflect changes in England rather than in response to specifically Scottish needs. The NHS will continue to provide a common service throughout the United Kingdom, but the advent of the Scottish Parliament will mean a Scottish NHS *more finely tuned and more rapidly responsive to Scottish needs.*”

(Scottish Office, 1997c:2, emphasis added)

### 5.2.2 Presentation of the 1997 White Papers

The titles of the White Papers signal the different policy directions favoured by the Department of Health and the Scottish Office. *The New NHS: Modern, Dependable* sets the scene for a change in direction or a departure from what has gone before.

*Designed to Care. Renewing the National Health Service in Scotland* puts patients at the forefront through the reference to ‘care’, while ‘renewal’ implies a more incremental approach to change through giving fresh life to an existing institution.

There are significant differences in the presentation of the two 1997 White Papers. *The New NHS* is the visually more appealing document, adopting a uniform colour scheme, with colour photographs and text boxes punctuating the body of the text to highlight key concepts, developments or milestones. ‘Key themes’ are presented in

bullet point format at the beginning of each chapter. Each chapter has a sub-title composed in management jargon and superfluous to the chapter heading. For example, the sub-title for Chapter 5 Primary Care Groups is ‘going with the grain’ and for Chapter 8 Measuring Progress is ‘better every year’.

*Designed to Care* adopts a more traditional format, with a simple presentation of text and no graphics other than an organisational chart. The white paper is structured in sections with functional titles and without the jargon or sub-titles which populate its Department of Health counterpart. The cover of the Scottish White Paper contains photographs of four interactions between healthcare professionals and patients, supporting the vision of the White Paper that the NHS should offer patients “the treatment they need, where they want it, when they want it” (Scottish Office, 1997b).

This presentational review of the two documents reinforces the divergence in policy direction: the presentation of *The New NHS* strives to encapsulate modernity, while the functional presentation of *Designed to Care* supports the emphasis on regeneration of a previously successful service.

### 5.2.3 Content of the 1997 White Papers

The White Papers are linked by a statement from the then Prime Minister Tony Blair, which serves as the Foreword to *The New NHS* and the Preface to *Designed to Care*. Perhaps unsurprisingly given that both White Papers were issued by the UK Government, the statement is virtually identical in the two documents save for:

- inserting the actual monetary values for budget increases for the NHS in England and Scotland in the five months since the Government took office and savings which will be delivered by a reduction in transaction costs;
- “more money for breast cancer and children’s services” promised by *The New NHS* becomes “more money is going into improving family doctor and hospital services” in *Designed to Care* and likewise “a nurse-led helpline to provide *advice* round the clock” becomes “a nurse-led help line to provide *local information* round the clock”<sup>13</sup>; and

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<sup>13</sup> Emphasis added

- inserting “in Scotland” after some references to the NHS in *Designed to Care*.

The replication of the Prime Ministerial statement creates the appearance of a unified policy stance. This is challenged by a review of the Foreword to *Designed to Care* provided by Donald Dewar, then Secretary of State for Scotland.

Dewar’s Foreword focuses on the practical implications of the policy proposals, in contrast to the rhetoric which characterises the Prime Minister’s Preface. Where the Prime Minister introduces the concepts of modernisation and efficiency, the Secretary of State invokes the language of restoration, cooperation and effectiveness. Unlike Blair<sup>14</sup>, Dewar does not make personal promises but adopts the more traditional language of government and honours manifesto commitments.

Modernisation would become a key theme of New Labour policy (Addicott, 2008), but the proposals set out in *The New NHS* do not seek to fundamentally alter the operation of the NHS. Once the presentational gloss is stripped away, the White Paper adopts a practical and incremental approach to reform, emphasising that “what counts is what works” (Department of Health, 1997:11). This is echoed by the Scottish Office in *Designed to Care*: “there will be no ‘big bang’: we want to build on what we have” (Scottish Office, 1997c:11).

The key policy development is the proclaimed rejection of the Conservative Government’s internal market, which the new Government perceives to be unfair and fragmentary. They offer an alternative, which is not a return to a command and control culture,<sup>15</sup> but the adoption of a ‘third way’ “based on partnership and driven by performance” (Department of Health, 1997:10).

This last phrase recurs throughout *The New NHS*. It is not replicated in *Designed to Care* but partnership is a motif which runs through the Scottish document, often in a more basic and personal sense. For example, there are repeated references to ‘teamwork’. The ‘third way’ label is not referenced in *Designed to Care* and so the

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<sup>14</sup> For example, Blair’s foreword to the White Papers includes the line “in my contract with the people of Britain I promised that we would rebuild the NHS”.

<sup>15</sup> There is no consensus that a ‘command and control’ system has ever existed within the NHS (see Klein, 2006:206)

divergences between the Department of Health and Scottish Office White Papers become more apparent.

The White Papers are united by their rejection of the internal market, but the Department of Health and the Scottish Office offer different structural replacements. The NHS in England maintains a clear distinction between planning and purchasing healthcare on one hand, and providing it on the other (Department of Health, 1997:12), although the price competition which characterised the internal market is replaced by a contractual model of governance, underpinned by performance measures. *Designed to Care*, by contrast, heralds the return to geographic-based provision of health services in Scotland. The number of Acute Trusts which existed in the single market will be reduced to strengthen clinical networks and reduce transaction costs, with an expectation that there should ultimately be a single Acute Trust in each of the 15 Health Board areas (Scottish Office, 1997c:21).

#### *Performance assessment*

Both White Papers propose the adoption of a six-dimensional performance assessment framework (see Table 5.1 below). These dimensions combine to define performance more broadly than the internal market model of governance, which emphasised financial performance and activity measures over clinical effectiveness and outcomes.

*Table 5.1: Multi-dimensional performance frameworks proposed in 'The New NHS' and 'Designed to Care'*

England: <i>The New NHS</i>	Scotland: <i>Designed to Care</i>
1. Health improvement	1. Clinical effectiveness of services
2. Fair access	2. Quality of services
3. Effective delivery of appropriate healthcare	3. Efficiency of services
4. Efficiency	4. Access to services
5. Patient / carer experience	5. Inequalities in health
6. Health outcomes of NHS care	6. Appropriateness of services

*Sources: Department of Health (1997:64); Scottish Office (1997c:28)*

Different dimensions of performance are selected for the respective frameworks in England and Scotland. Both frameworks make reference to efficiency, access, effectiveness and appropriateness, but the same substantive dimensions are given different names. A stronger clinical focus is evident in the Scottish framework, which makes explicit reference to 'clinical effectiveness' and 'quality', although both are implied in the English model. The English model is more overtly managerial – one dimension of performance not replicated in Scotland is 'patient / carer experience' which introduces a customer perspective to healthcare in keeping with the NPM ideology (Hood, 1991; 1995).

This comparison of the dimensions included within each framework strengthens the emerging idea that the English definition of NHS performance is more management-focused than its Scottish counterpart, which prioritises clinical effectiveness and patient care. It could also be argued that semantic differences are being introduced merely for their own sake, an example of the Scottish Office seeking to distinguish the Scottish NHS from the rest of the UK. The English Performance Assessment Framework nevertheless identified its focus as improving outcomes for patients (NHS Executive, 1999:7).

The NHS Executive (1998) subsequently launched a consultation on developing a national framework for NHS performance, which proposed a set of 37 high level performance indicators across the six dimensions of performance. The final Performance Assessment Framework included 41 indicators, with the number of health improvement indicators doubled following the consultation period (NHS Executive, 1999). Meanwhile, there was not yet a formal Performance Assessment Framework in NHS Scotland and annual planning guidance for the NHS asked Boards to develop plans to deliver national strategic aims and clinical priorities, with no reference to performance indicators (Scottish Office Department of Health, 1998). Performance measurement in *The New NHS* is set in a managerial context, supported by a framework of incentives and sanctions which are considered necessary to motivate results.

“There will be clear incentives available to help NHS Trusts succeed. They will be backed by a *tough approach to performance management* to drive improvements in quality and efficiency.”

(Department of Health, 1997:44, emphasis added)

Performance measures underpin contractual relationships at every interface between tiers of the accountability hierarchy, from Trusts through Primary Care Groups and Health Authorities to the Regional Offices of the NHS Executive (Department of Health, 1997:67; NHS Executive, 1999:13-14). Performance targets replace price competition between providers as the primary driver of resource allocation and source of discipline, but they are also intended to reduce unnecessary variations in performance across the country and improve overall standards of performance.

*The New NHS* outlines actions which may be taken against Trusts which do not perform satisfactorily. A scale of intervention is introduced, ranging from investigation by the NHS Executive Regional Offices to removal of the Trust Board by the Secretary of State for Health (Department of Health, 1997:49). The consequences of under-performance are clear and provide evidence of a continuing thread of managerial accountability despite the rejection of the internal market. There is an emerging tension between setting a tough performance framework for Trusts and a desire to empower Trusts to take full responsibility for planning resources to best deliver patient care.

In *Designed to Care*, performance measures are framed as a mechanism for discharging accountability to the general public and are not intended to support accountability between organisational layers of the NHS (Scottish Office, 1997c:13) and for driving improved efficiency and effectiveness of health services through benchmarking (Scottish Office, 1997c:28).

*Designed to Care* does not give performance measures a strong managerial purpose; unlike *The New NHS*, there are no efforts to build sanctions or incentives into the performance framework. The primary aim of data collection is to improve patient care, not to provide management information.

“[Accurate management] information should be a by-product of information collected for patient care purposes, and the NHS should be relieved of the need to supply variations on the same data to its many different users.”

(Scottish Office, 1997c:5)

This is a strong indication that clinical drivers will triumph over managerialism in the post-internal market Scottish NHS. The primary role of management is to support the clinical process, not to determine or control it.

This divergence in approach is consistent with Greer’s (2004) view that the Scottish NHS is characterised by a stronger and more concentrated clinical power base, which equips medical practitioners in Scotland with stronger defences against managerial reforms than those at the disposal of their English counterparts.

Both Scottish and English Trusts are expected to publish performance data annually, but the means and purpose of publication differ.

“NHS Trusts will be expected to publish annually details of their performance explicitly reflecting the six new dimensions of performance.”

(Department of Health, 1997:53)

“Trusts will also be required to publish a range of specified clinical performance indicators which will be aggregated on an annual basis as part of the Annual Report of NHS Scotland.”

(Scottish Office, 1997c:13)

There are two key distinctions between the two approaches. First, the English Trusts must publish results across all six dimensions of performance whereas Scottish Trusts need only publish clinical performance indicators, implicitly giving clinical performance precedence over managerial performance. Second, aggregate performance data will be published for the whole of the NHS in Scotland which emphasises the national unity of the Scottish NHS. This is consistent with the argument that performance measurement is used as a driver of overall improvement rather than a basis for transacting or a means to distinguish between providers competing to deliver the same services.

### *Independent verification*

*The New NHS* announces the creation of the Commission for Health Improvement – an arm’s length body to provide independent assurance over clinical quality of NHS

services (Department of Health, 1997:59). No equivalent body is created in Scotland, where the Clinical Resource and Audit Group will continue to support the delivery of clinical audit within Trusts<sup>16</sup> but is not given an expanded role in verifying Trust performance.

The creation of the Commission for Health Improvement establishes the idea that independent assessment of a Trust's presentation of quality is required to render that presentation credible and legitimate (Power, 1999; Free, Salterio and Shearer, 2009). By implication, Trusts cannot be trusted to install measurement and reporting systems without the threat of a third party to check up on them. The public is invited to place its trust primarily in the new Commission, rather than in the Trusts which deliver patient care (Power, 1994a).

One of the Commission's main roles is to verify that Trusts' clinical governance systems are operating effectively. The Commission's role is not to provide assurance over clinical quality but over the existence and operation of *systems* designed to deliver clinical quality. This is a direct replication of the financial audit model, which gives precedence to the testing of internal control systems over substantive results (Power, 1999:82). The Commission can therefore be regarded as a quasi-audit body, despite having no financial remit.

The systematisation of clinical practice is, inadvertently or otherwise, creating an environment, and conditions, in which clinical decision making can be opened up to external scrutiny (Power, 1999; Humphrey and Owen, 2000:35). Managers can understand and relate to control systems without possessing clinical or medical expertise.

The remit of the Commission for Health Improvement extends beyond provision of an assurance function. The Commission is also required to support local clinical developments, "offer targeted support on request to local organisations facing specific clinical problems" (Department of Health, 1997:59) and even intervene<sup>17</sup> in

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<sup>16</sup> The equivalent role in England is to be undertaken by the newly created National Institute for Clinical Excellence (NICE).

<sup>17</sup> The Commission can only intervene under the direction of the Secretary of State for Health or by invitation from Primary Care Groups, Health Authorities and NHS Trusts.

serious or persistent clinical issues (ibid.). This echoes the trend for national audit bodies to extend their role from an independent assurance function to a provider of consultancy services, offering advice and sharing expertise with public bodies (Gendron et al., 2007; Skaerbaek, 2009). The next chapter will analyse the changing role of Audit Scotland, the national audit body responsible for devolved Scottish public services.

### *Clinical governance*

The creation of the Commission is part of a wider trend to promote ‘clinical governance’ (Scully and Donaldson, 1998; Goodman, 1998) whereby managerial disciplines, including internal control systems, are introduced to clinical practice to improve effectiveness through standardisation and systematisation.

Clinical governance essentially remodels clinical accountability in the image of the traditional model of financial accountability. This remodelling is more explicit in *The New NHS* which elaborates a more detailed framework of clinical governance than *Designed to Care*. An executive lead will be appointed to report on clinical governance and table monthly and annual performance reports to the board of English Trusts. Clinical governance arrangements must also be detailed in English Trust annual accounts, a document which traditionally conveys purely financial information and somewhat remote from clinical governance (Department of Health, 1997:53).

In Scotland, clinical governance builds on existing professional practices, including established evaluation mechanisms such as clinical audit.

“The intention is to build on existing patterns of professional self-regulation and corporate governance principles, but offer a framework for extending this more systematically into the local clinical community...”

(Scottish Office, 1997c:18)

The distinctive Scottish approach is reinforced by the stated intention to impose a statutory duty on Trusts to deliver quality care, supplementing existing duties on Trusts which emanate from managerial and financial conceptions of accountability.

“Trust Chief Executives will carry ultimate accountability for the quality of care provided by their Trust, in the same way as they are already accountable for their Trust’s proper use of resources.”

(Scottish Office, 1997c:17)

Scottish NHS Chief Executives are expected to evidence compliance with the new statutory duty through implementing and maintaining clinical governance systems and controls.

#### 5.2.4 Summary and reflections

The first period of analysis is characterised by incremental reforms to create a ‘new’ form of governance for the NHS to replace the internal market. Performance measures are established as central to the new governance framework for the English NHS, replacing price as the currency underpinning the NHS system and supported by incentives and sanctions to motivate good performance. Scotland seeks to distinguish itself from the UK Government proposals, particularly the more managerial aspects of proposed reforms. Performance assessment is seen as a mechanism to promote improvement in patient care and to discharge accountability to the public, not as a management tool.

An arm’s length body, the Commission for Health Improvement, is created in England to provide independent assurance of clinical quality. This is a practical example of the audit society idea that independent assessment is required to bestow legitimacy and credibility on a system or organisation, in this case on the results of NHS Trusts (Power, 1999; Free, Salterio and Shearer, 2009). The new body will also verify clinical governance systems; it is not charged with directly assuring quality but with assuring the systems and controls which Trusts put in place to safeguard quality (Power, 1994a; 1999).

### **5.3 Time for action: widening divergences (2000-2003)**

#### 5.3.1 Policy context

The Chancellor of the Exchequer announced a significant increase in NHS resources in his Budget Statement on 21 March 2000:

“Since its creation, National Health Service spending has risen by an average 3.3 per cent a year above inflation. Under the last Government, it rose by 2.9 per cent.

“We have decided that in the years from now until 2004 the NHS will grow by twice as much – by 6.1 per cent a year over and above inflation; by far the largest sustained increase in NHS funding of any period in its 50-year history.”<sup>18</sup>

The Prime Minister subsequently commissioned Sir Derek Wanless, former chief executive of National Westminster Bank, to conduct an in-depth review of NHS resources. The Chancellor of the Exchequer accepted the recommendation of the Wanless Report (Wanless, 2002) and announced annual real terms increases in the NHS budget of 7.4% for five years from 2002/03<sup>19</sup>. The New Labour Government had demonstrated a commitment to provide the NHS with sufficient funding to provide high quality services, and the next Health White Papers would detail the improvements which the Government expected this investment to deliver.

*The NHS Plan – a plan for investment, a plan for reform* (Department of Health, 2000a) was published in July 2000 by Alan Milburn, the second Secretary of State for Health of the New Labour Government<sup>20</sup>. *The NHS Plan* was reportedly personally drafted by the Secretary of State, in close discussion with the Prime Minister and the Chancellor of the Exchequer (Klein, 2006:215). It is unusual for a Minister to be the primary author of a White Paper – civil servants would normally draft the White Paper before submission to Ministers for editing and approval. The direct authorship of this White Paper places it at the heart of government policy.

*Delivering the NHS Plan: next steps on investment, next steps on reform* (Department of Health, 2002) introduced two significant policy developments: greater use of the private and voluntary sectors to increase NHS capacity, particularly for elective surgical procedures; and the introduction of “patient choice”, with patients and their

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<sup>18</sup> HC Deb 21 March 2000 at Columns 871-2. Hansard accessed online at: [http://www.publications.parliament.uk/pa/cm199900/cmhansrd/vo000321/debtext/00321-06.htm#00321-06\\_spm1](http://www.publications.parliament.uk/pa/cm199900/cmhansrd/vo000321/debtext/00321-06.htm#00321-06_spm1) (23 August 2013)

<sup>19</sup> HC Deb 17 April 2002 at Column 589. Hansard accessed online at [http://www.publications.parliament.uk/pa/cm200102/cmhansrd/vo020417/debtext/20417-04.htm#20417-04\\_spm1](http://www.publications.parliament.uk/pa/cm200102/cmhansrd/vo020417/debtext/20417-04.htm#20417-04_spm1) (23 August 2013)

<sup>20</sup> Alan Milburn succeeded Frank Dobson MP as Secretary of State for Health in October 1999.

GPs able to choose where the patient will receive treatment, including an option to be treated in a private hospital. So while the “internal market” had been publicly rejected by New Labour, market-based reforms continued to be evident in NHS policy development.

This develops and expands the reforms set out in *The NHS Plan*. By this time, the New Labour Government had entered its second term of office following a general election in June 2001, although Alan Milburn remained as Secretary of State for Health.

Meanwhile, *Our National Health: A plan for action, a plan for change* (Scottish Executive, 2000), the first Health White Paper of the newly-formed Scottish Executive, was published in December 2000. Although the Labour party won the largest number of seats in the first election to the Scottish Parliament in May 1999, they fell short of an overall majority and so entered a coalition with the Liberal Democrat party in order to form an administration.<sup>21</sup> The Scottish Executive was freed from the formal constraints of collective decision making which previously applied to the Secretary of State for Scotland as a UK Government Cabinet member. However, the same political party effectively controlled both the Westminster and Scottish Parliaments, setting an expectation that the policies of each administration would be broadly aligned within an overarching ideological framework.

All three documents are blueprints for action, developing earlier proposals into more detailed implementation plans. The Foreword to *Our National Health* from then First Minister of Scotland, Henry McLeish, emphasises that this is not another policy paper but a practical document:

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<sup>21</sup> The Labour Party won 56 of the 129 seats in the Scottish Parliament elections in May 1999. They entered a coalition with the Liberal Democrat party, which won 17 seats, to form the Scottish Executive for the four-year session of the first Parliament which had a working majority of 8 members. The remaining seats were won by the Scottish National Party (35), the Conservative party (18), the Green party (1) and the Scottish Socialist Party (1), with one independent MSP returned. Source: House of Commons Library Research Paper 99/50, 8 September 1999, “Scottish Parliament Elections: 6 May 1999”, available online at <http://www.parliament.uk/documents/commons/lib/research/rp99/rp99-050.pdf> (accessed on 4 May 2012).

“it aims to bring these policies to life... to make them happen... its emphasis is to translate policy into tangible, practical measures which will deliver results”

(Scottish Executive, 2000:3).

Similar points are made in the Introduction by then Minister for Health and Community Care, Susan Deacon:

“The challenge is to translate policy into practice... This Plan signals a shift from the development of policy to the delivery of change.”

(Scottish Executive, 2000:5)

### 5.3.2 Presentation of the 2000 White Papers

As with the 1997 White Papers, a high-level comparison of the presentation of the 2000 White Papers provides an insight into the different approaches to NHS reform adopted in Scotland and England.

The full titles of the White Papers follow the same basic structure (*The NHS Plan: a plan for investment, a plan for reform* and *Our National Health: a plan for action, a plan for change*), giving the appearance of unity between two administrations led by the same political party.

However, the adoption of different vocabulary provides evidence of a stronger managerial focus in England than in Scotland, which favours a communitarian approach. The prosaic and impersonal *NHS Plan* presents itself as a no-nonsense management document, whereas the collective *Our National Health* promotes shared ownership of both the document and its proposals. ‘Investment’ and ‘reform’ also have bolder connotations than their cousins ‘action’ and ‘change’.

Partnership is one of the five key challenges which the Prime Minister sets for the NHS in return for the investment of significant additional resources over the life of the Parliament (Department of Health, 2000a:2). However, ‘partnership’ pervades the Scottish document with the rhetoric embodied in a more tangible and communitarian tone than the English counterpart document.

For example, the Introduction by the Minister for Health and Community Care emphasises that “it’s *your* NHS” (Scottish Executive, 2000:6, emphasis added), “we must work *together* to build a *national effort* to improve health” (Scottish Executive,

2000:6-7, emphasis added) and “at the *heart* of our approach is *partnership*. *Everyone* has a right, and a responsibility, to *join together* in a *national effort* for improvement and change” (Scottish Executive, 2000:7, emphasis added).

While slickly presented, *The NHS Plan* is functional in appearance. It does not contain any graphics and it adopts the format of a traditional business report. The White Paper includes an executive summary, clearly demarcated sections and numbered paragraphs. *Our National Health*, by contrast, is populated with photographs of everyday people in everyday situations. Even the photographs of the First Minister and Minister for Health and Community Care accompanying the Foreword and Introduction are ‘action shots’ showing them interacting with children in an educational and healthcare setting respectively. This provides a visual representation of the collective ethos heralded by the inclusion of ‘our’ in the title of the Scottish White Paper.

The two White Papers make different use of illustrative examples: *The NHS Plan* favours short organisational case studies of 6-13 lines of text highlighting good practice, whereas *Our National Health* not only contains organisational examples but is littered with short quotes from patients and staff giving their views and experiences of the health service (see Table 5.2 below). The Scottish Executive document gives precedence to ‘real-life’ cases.

*Table 5.2: Count of organisational examples and patient / staff quotes included in substantive chapters of ‘The NHS Plan’ and ‘Our National Health’*

	<i>The NHS Plan</i>	<i>Our National Health</i>
Organisational examples	8	16
Quotes from patients and staff	0	25

*Sources: Department of Health (2000a), Scottish Executive (2000)*

These presentational differences not only embody different policy styles, but also imply differences in the intended audiences of the documents. The Scottish White Paper is more accessible to the general public,<sup>22</sup> while the design of the English document is likely to appeal more to NHS professionals than patients.

<sup>22</sup> “[This Plan] is addressed directly to communities and patients” (Scottish Executive, 2000:9)

It is beyond the scope of the present research to consider who actually read or made use of these respective documents. However, it is important to recognise the symbolism. The English document is presented in a similar fashion to a corporate document and so indicative of a managerial policy approach. The Scottish document has a less formal style, reflecting the key message that the public, professionals and politicians will work together to improve the NHS.

### 5.3.3 Making the case for change

#### *Mandate and support for change*

The preface to *The NHS Plan* sets out core principles to underpin both the policy proposals within the White Paper and their implementation. These 10 principles recognise the traditional values underlying the NHS as well as the need for modernisation to reflect social changes and medical advances.

The final principle makes an indirect reference to performance management: “The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and *performance*” (Department of Health, 2000a:5, emphasis added). This shows that the provision of performance information is a key strand of NHS policy in England.

There are 25 signatories to the preface, including the heads of the Royal Colleges, trade union and other staff-side bodies, the Local Government Association and a number of large voluntary organisations which play a significant role in the NHS, including Macmillan Cancer Relief and Diabetes UK.

The preface thus has a symbolic role in demonstrating support for the proposed reforms from a diverse range of influential stakeholders. This provides a mandate for change and depicts the reforms as the product of consensus reached with the professions, as opposed to reforms imposed upon an unwilling NHS by the Government of the day (Klein, 2006; Greener, 2009).

Wider support for the planned reforms is evidenced through references to a public consultation exercise carried out with NHS staff and patients (Department of Health, 2000a:25-26). The White Paper thus creates an impression of consensus and wide support for the proposed reforms.

While the Scottish document, *Our National Health*, does not contain a declaration signed by professional bodies, the First Minister's foreword states that the White Paper "reflects a widespread consensus for improvement and change" (Scottish Executive, 2000:3). The results of a MORI quantitative survey of the public's views and experiences of the NHS are summarised in an Annex to the White Paper and the main body of the paper repeatedly refers to meetings which Ministers held with patients and staff to listen first hand to their views and experiences of the NHS (Scottish Executive, 2000:9).

Perhaps there is less need to openly demonstrate agreement with professional bodies in Scotland, where the medical profession in particular has a long history of influence over health policy (Nottingham, 2000; Spry, 2002) so their approval is implicit.

The very creation of the Scottish Parliament is cited by the First Minister as providing a mandate for the pursuit of a distinctly Scottish health policy:

"We now have the chance to address Scotland's needs with greater determination and focus than ever before, and to do so in a way that is truly open and accountable to the Scottish people."

(Scottish Executive, 2000:3)

This sets an expectation of more significant policy divergence between the 2000 White Papers than was evident between their 1997 counterparts, despite the same political party constituting, or effectively controlling, the executive branch of government in both Westminster and Holyrood.

### *Funding change*

As with *The New NHS* (Department of Health, 1997), the 2000 Department of Health White Paper contains a foreword by the Prime Minister. Blair again makes statements in the first person which demonstrate both a personal political commitment to the NHS reforms and the importance of health policy to the Government's wider policy agenda. More importantly, the Foreword sets the latest policy reforms in the context of the unprecedented increase in NHS funding announced by the Government in March 2000 and goes so far as to impose terms on the NHS for provision of this increased funding:

“In March... we offered the nation and those in the NHS *a deal*. We would spend this money if, but only if, we also changed the chronic system failures of the NHS. *Money had to be accompanied by modernisation, investment, by reform*. For the first time in decades we had to stop debating resources, and start debating how we used them to best effect.”

(Department of Health, 2000a:8-9, emphasis added)

The New Labour Government effectively upped the ante for the NHS in England to implement change – the increased funding for the NHS legitimated demands for significant performance improvements and the introduction of more challenging reforms. By couching the increase in funding as a key moment in the life of the NHS, the Government exerts additional pressure on staff and stakeholders to embrace the proposed changes.

The presentation of a ‘deal’ to the NHS is symptomatic of a managerial approach to healthcare. It seeks to evoke a contractual arrangement between the Government and the NHS which is in keeping with the principles of New Public Management (Hood, 1991; 1995).

That is not to suggest that the objectives of the reforms were managerial – there is a clear commitment to improving health care and health outcomes in *The NHS Plan*. It is, however, of interest that the Government selected managerial tools and methods to achieve improvements in the delivery of healthcare.

In contrast to the offer of a ‘deal’ from a remote government to the people, *Our National Health* recognises the increased investment made in the NHS by the new Scottish Executive<sup>23</sup> and the need to “spend better and to ensure that investment is matched by reform” (Scottish Executive, 2000:6). The Scottish Executive does not use contractual language to strike a bargain with the NHS. The emphasis is on government, NHS staff and the public working together to improve the health service, rather than government providing additional cash subject to NHS staff delivering reforms and improved results.

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<sup>23</sup> Under the established funding mechanism for devolved services, the Scottish administration budget received a population-based share of increases to the Department of Health budget. The Scottish Parliament and Executive were not bound to apply this increase to the NHS and have full discretion over allocation of the overall grant funding accruing under the funding agreement.

This distinction is important in characterising the different approaches to performance measurement taken in England and Scotland which become clear later in the White Papers.

*The case for change*

Having made clear that the NHS must change, *The NHS Plan* builds the case as to why that change is required. It identifies five ‘underlying problems’ which the NHS must address, including “a lack of national standards” and “over-centralisation” (Department of Health, 2000a:27-28). The tension inherent in designing a performance and accountability framework which balances national control with local autonomy is again evident in *The NHS Plan*.

These five underlying problems are transformed into nine “profound and historic weaknesses” in *Delivering the NHS Plan*, including “weak or perverse incentives that inhibit performance” and “weak local and national accountability” (Department of Health, 2002:11).

The absence of national standards for care is cited as the primary reason why standards of care and access to services vary widely across the country. The New Labour Government contends that this situation has arisen “because the 1948 settlement left [the NHS] with inadequate means to drive up performance” (Department of Health, 2000a:27).

It is important to note that the stated absence of formal national standards does not mean there were no standards of care or service prior to *The NHS Plan*: doctors, nurses and other healthcare professionals had, and continue to have, professional duties for delivering patient care. What is highlighted as absent is a set of *nationally-mandated* standards and a formal system to check that such standards were being upheld.

*Our National Health* takes a different perspective on the same issue, citing the fragmentation of the health service caused by internal market as the main driver of the erosion of national standards and values.

“The NHS in Scotland has a proud record of achievement, both as a distinctive service serving Scotland’s needs, and as an integral part of the wider NHS across the UK. But over many years, much of the cohesion and the traditional values of the NHS have been eroded...

“The internal market fragmented the NHS. It undermined the principle of a National Health Service. It drained money away from direct patient care. The emphasis on activity and efficiency savings took the focus away from standards, quality and service improvement.”

(Scottish Executive, 2000:22)

The Scottish argument is that the reversal of internal market reforms will help to re-establish national standards and achieve the stated aim to “rebuild the NHS as a truly *National* Health Service. The NHS across Scotland should work together to deliver universally high standards of care and it must work in partnership with the NHS across the UK in the interests of patients. The traditional public service ethos and values of the NHS must be put back at its core” (Scottish Executive, 2000:22-23, emphasis in original). This contrasts sharply with the English view that national standards never existed, which allowed a ‘postcode lottery’ of healthcare to develop.

One of the proposals put forward to improve the cohesiveness of the health service is to re-establish a national identity for the NHS in Scotland. It is argued that this will strengthen staff loyalty and affiliation and ensure that the public can relate to a unified national service. The new unified Health Boards are to be known simply as, for example, NHS Grampian, to promote the sense of a national health service with local presence (Scottish Executive, 2000:31).

Meanwhile we are told of the English NHS that:

“The relationship between central government and the NHS has veered between command-and-control and market fragmentation. Neither model works... A new model is needed where intervention is in inverse proportion to success.

“Clinicians and managers want the freedom to run local services. They want to be able to shape services around patients’ needs. Inspection, incentives, information and intervention, operating under the umbrella of clear national standards, will help reshape services around the patient.”

(Department of Health, 2000a:30)

There is implicit rejection of a national identity to unify the NHS in England, yet there is an inherent tension in seeking to prioritise both standardisation and decentralisation. Within two years “these structural changes are beginning to shift power and resources from the centre to the frontline in the NHS” (Department of Health, 2002:19), but power and resources must be applied in the context of a demanding performance framework imposed by the Department of Health.

*Our National Health* recognises that it is difficult to balance accountability for providing a national service with the space to deliver services at a local level. It aspires to “set clear national standards and national priorities for the NHS, to be delivered within a local context” (Scottish Executive, 2000:23).

The Scottish Executive plans to develop and uphold clinical standards of care through existing mechanisms such as clinical governance and peer reviewed quality assurance (Scottish Executive, 2000:23-25) and to introduce national standards for services, including hospital cleanliness, hospital food and infection control (Scottish Executive, 2000:26-28). Compliance with national standards will be monitored by the Clinical Standards Board through a programme of annual reviews (Scottish Executive, 2000:8).

*The NHS Plan* appears to present a political and managerial solution to weaknesses in the NHS. The Government, in conjunction with the professional bodies and other stakeholders who signed the preface to the White Paper, is telling the public and the NHS what is going to, or at least what it expects to, happen in the coming years. Not only is reform inevitable but the nature of the reform is also pre-ordained by a central power base.

In contrast, *Our National Health* details over 220 actions which the Scottish Executive will take forward to reform the NHS, but it also leaves space for further debate on the proposals and paves the way for stakeholders to influence policy through “full and effective involvement of the public” and a “well-informed, mature public debate” (Scottish Executive, 2000:9).

### 5.3.4 Performance assessment

#### *Overview*

*The NHS Plan* (Department of Health, 2000a:61-2) announces five changes to the Performance Assessment Framework (PAF): extension in scope to cover all NHS Trusts and Primary Care Trusts providing community health services, not just health authorities, and so introducing an element of direct accountability from healthcare providers to central government; improved quality and integrity of constituent performance measures; the Commission for Health Improvement becomes responsible for publishing results against the PAF via a 'report card' for each NHS organisation; strengthened performance data on primary care services; and introduction of new efficiency measures.

A guidance document for NHS bodies on implementation of *The NHS Plan* was issued by the Permanent Secretary and Chief Executive of the NHS in December 2000. This document, *NHS Plan Implementation Programme* (Department of Health, 2000b), provides a national framework for implementation of the *Plan* and sets provisional milestones and outcomes for 2001-02.

There is little discussion of practical performance management arrangements for NHS Scotland in *Our National Health*. The White Paper announces the introduction of a new performance framework and accountability review process (Scottish Executive, 2000:35). Detailed arrangements are subsequently confirmed in *Rebuilding our National Health Service* (Scottish Executive Health Department, 2001), a guidance document on the implementation of governance, accountability and planning reforms issued by the Chief Executive of NHS Scotland to NHS Chairs and Chief Executives.

The main objectives of the new performance and accountability arrangements for NHS Scotland are (Scottish Executive Health Department, 2001:40):

- “to encourage collaboration and joint working between health and other key partner organisations locally;
- “to place patients and the public at the centre of planning and delivery of care;

- “to stimulate public interest in and understanding of the performance of NHSScotland; and
- “to promote consistent standards of performance across Scotland.”

These objectives emphasise that the Scottish approach to performance assessment prioritises consistency and public understanding, in contrast to the emerging English system which begins to emphasise managerial accountability and individual organisational performance.

The new Scottish PAF encompasses seven strands of performance. Three new dimensions of performance were introduced: patient experience, involving the public and communities and staff governance. Patient experience, representing a ‘customer’ perspective, had been included in the English framework since 1997. The new definition of performance is broader than the initial framework (see Table 5.3 below).

There are to be two reporting mechanisms to support operation of the Scottish PAF (Scottish Executive Health Department, 2001:42). NHS Boards are required to report to their local communities on performance, although they have local discretion over the nature of report. Boards are also required to submit an annual performance statement to the Scottish Executive.

*Table 5.3: Comparison of Dimensions of Performance in 'Rebuilding our National Health Service' and 'Designed to Care'*

<i>Rebuilding our National Health Service</i>	<i>Designed to Care</i>
<ul style="list-style-type: none"> <li>• Health improvement and reducing inequalities</li> <li>• Fair access to healthcare services</li> <li>• Clinical governance, quality and effectiveness of healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Inequalities in health</li> <li>• Access to services</li> <li>• Clinical effectiveness of services</li> <li>• Quality of services</li> <li>• Appropriateness of services</li> </ul>
<ul style="list-style-type: none"> <li>• The patient's experience, including service quality</li> </ul>	N/A
<ul style="list-style-type: none"> <li>• Involving the public and communities</li> </ul>	N/A
<ul style="list-style-type: none"> <li>• Staff governance</li> </ul>	N/A
<ul style="list-style-type: none"> <li>• Organisational and financial performance and efficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Efficiency of services</li> </ul>

*Sources: Scottish Office (1997c); Scottish Executive Health Department (2001)*

#### *Managing performance*

Priority or national targets are introduced in the English NHS to provide focus for NHS providers which were overwhelmed by the number and diversity of measures in the PAF (Department of Health, 2000a:130). These core targets are drawn from the Department of Health's Public Service Agreement with HM Treasury (Department of Health, 2000a) and so set up a chain of accountability for NHS performance that now extends up to HM Treasury.

The *NHS Plan Implementation Programme* states that "outcome focused targets" will be set for the NHS in England "aimed at delivering fast, convenient and people centred services that provide the highest standards of care and tackle the major causes of disease and inequalities" (Department of Health, 2000b:8). However,

many of the performance targets and national commitments are input-focused (Department of Health, 2000b:25). For example:

- 7,000 extra NHS beds by 2004, of which 2,100 will be general and acute beds;
- 50 new MRI scanners, 200 new CT cancer scanners, 80 new liquid cytology units and 45 new linear accelerators by 2004; and
- 7,500 more consultants, at least 2,000 more GPs, 20,000 extra nurses and 6,500 extra therapists by 2004.

By contrast, the new Scottish PAF included over 90 indicators and assessments across seven dimensions of performance to support delivery of 33 strategic objectives.<sup>24</sup>

#### *Rankings, sanctions and incentives*

*The NHS Plan* introduces the concept of publicly classifying NHS organisations based on performance against the PAF, with the rating verified by the Commission for Health Improvement (Department of Health, 2000a:63). While the White Paper outlines a traffic light system of ‘red’ / ‘yellow’ / ‘green’ ratings, this would become the star ratings system in practice. Receipt of a ‘red’ rating would be the trigger for intervention and sanctions, while ‘green’ rated organisations would benefit from reduced intervention and greater autonomy (Department of Health, 2000a:63-64).

The first set of NHS Performance Ratings of English Trusts was published by the Department of Health in September 2001 (Department of Health, 2001), covering the performance of non-specialist acute Trusts in 2000-01. This initial publication (*ibid.*) provided the star rating of each Trust as part of a matrix showing the Trust’s performance against 10 key targets and a further second set of 12 “balanced scorecard” measures across three dimensions of performance (clinical focus, staff focus and patient focus). The number of indicators had reduced slightly from the previous PAF. Later publications of star ratings (Healthcare Commission, 2005b)

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<sup>24</sup> See, for example, Performance Assessment Framework for 2002/03 – Scottish Executive Health Department NHS HDL(2002)78, published online at [http://www.sehd.scot.nhs.uk/mels/hdl2002\\_78.pdf](http://www.sehd.scot.nhs.uk/mels/hdl2002_78.pdf) (accessed on 23 August 2013).

provided only the star rating. Thus, the reader's ability to build a nuanced understanding of a Trust's strengths and weaknesses becomes obscured by a composite measure of performance.

The new scale of intervention (Department of Health, 2000a:65-66) builds on that announced in *The New NHS* (Department of Health, 1997), but goes further by indicating that the very existence of a Trust is under threat if it persistently underperforms. The management team of a low-performing Trust is at risk of replacement and the Trust could be subject to takeover by a 'green' rated Trust or even a non-NHS organisation (Department of Health, 2003:7).

*Delivering the NHS Plan* (Department of Health, 2002:19) recognises that incentives built into NHS performance assessment must reflect the motivations of professionals who want to use their skills to improve patient care. However, the performance assessment framework is underpinned by primarily financial incentives. The new framework is accompanied by changes to the way in which money flows between NHS organisations. The main source of funding will shift from block contracts for services to 'payment by results', a standard tariff system which remunerates Trusts for patients treated (Department of Health, 2002:20-21).

*Delivering the NHS Plan* also introduces the concept of 'foundation trusts'; top-rated (three star) organisations which can apply for foundation status which provides organisations with enhanced financial freedoms (including borrowing powers to support capital investment), greater operational flexibility and reduced government intervention (Department of Health, 2002:29-30).

The Government reforms presume that financial incentives are essential to complement professional motivation in order to deliver performance improvements, i.e. managerial models are required to deliver clinical improvements.

Significantly, neither *Our National Health* (Scottish Executive, 2000) nor *Rebuilding our National Health Service* (Scottish Executive Health Department, 2001) provide explicit sanctions for under-achievement against the PAF. The Scottish Executive explicitly rejects financial sanctions, on grounds that they would be to the likely detriment of patients and compound the impact which poor performance is likely to have had on patients and the public (Scottish Executive Health Department,

2001:48). The focus of the Scottish PAF and associated accountability framework is on working together to improve performance, not on naming and shaming poor performers.

There is limited discussion of potential incentives for strong performance. NHS Boards with “strong” performance may be subject to less onerous requirements to obtain capital funding or may be selected as a pilot site for new initiatives, but do not attract financial rewards or enhanced autonomy of the scale provided by the English framework (Scottish Executive Health Department, 2001:47).

### *Trust*

The tension between standardisation and decentralisation has implications for trust within the NHS. Although the English White Paper proclaims that the proposed new delivery system is “based around the NHS as a ‘high trust’ organisation” (Department of Health, 2000a:56), there is significant evidence to the contrary in changes made to the performance management framework.

The main evidence of trust is at a micro level – between NHS staff and patients (Department of Health, 2000a:57) – which is credited with providing motivation for health professionals to deliver high quality care.

This trust is less evident in the macro level relationship between the Department of Health and NHS providers. Despite boldly stating that:

“because we trust people on the frontline, the centre will do only what it needs to do; then there will be maximum devolution of power to local doctors and other health professionals” (Department of Health, 2000a:57),

the White Paper goes on to list checks and balances that it will put in place to control the exercise of this local power and a demanding system of performance assessment which will hold professionals to account.

Modernising reforms tend to marginalise trust in public service delivery through the precedence given to measurable outputs and control systems and allow for trust only in the interactions between professionals and service users (Harrison and Smith, 2004).

### 5.3.5 Independent verification

#### *Verifying performance reports*

*The NHS Plan* transfers responsibility for publication of performance measures from the Department of Health to the Commission for Health Improvement. This is intended to “demonstrate to the public that the results are independent and genuine” (Department of Health, 2000a:62), the implication being that neither NHS organisations in England nor the Department of Health could be trusted to accurately report on performance without independent verification. This rather undermines the description of the NHS as a ‘high trust’ organisation (Department of Health, 2000a:56), and suggests that audit mechanisms serve to displace trust from professionals to auditors (Power, 1994a; 1999).

Audit approaches increasingly feature in the national initiatives to manage the NHS in England. The *Implementation Programme* also announces that all parts of the NHS will be subject to a “performance and modernisation audit” which will inform the development of service plans (Department of Health, 2000b:8). NHS organisations are also “expected to audit themselves against the National Beds Inquiry templates... [to] help health authorities... assess their future requirements for beds” (Department of Health, 2000b:24).

By contrast, the new Scottish Performance Assessment Framework (PAF) relies upon self-assessment by NHS Trusts with performance management overseen by unified NHS Boards (Scottish Executive Health Department, 2001:42). There is no role in the Scottish performance framework for either auditors or quasi-audit bodies.

*Rebuilding our National Health Service* also announces revised accountability reviews, to be held annually between Scottish Executive officials and unified NHS Boards (Scottish Executive Health Department, 2001:46-49).

“The purpose of the reviews will be to reach a *shared view* between the NHS Board and the Executive of the level of performance reached by each local NHS system, across a range of areas of activity, on the basis of measures and indicators recorded in the PAF, of published reviews by bodies such as CSBS<sup>25</sup>, and of progress against objectives and actions set out in published Local Health Plans and community plans.”

(Scottish Executive Health Department, 2001:46, emphasis added)

The main output from the accountability reviews is a public letter to the Chair of the NHS Board, setting out the main findings and agreed actions to be addressed by the Board (Scottish Executive Health Department, 2001:48).

So PAF indicators are merely one element of wider performance to be considered in assessing the overall performance of the unified NHS Boards. The idea of collaboration and partnership is emphasised by the main purpose: it is a joint assessment, not an independent assessment by an external party.

#### *Expanding the role of the Commission for Health Improvement*

*The NHS Plan* (Department of Health, 2000a) expanded the role of the Commission for Health Improvement (CHI). In addition to assuming responsibility for the publication of performance results discussed above, CHI was to become the main quality assurance body for the NHS, supported by the Audit Commission. Every NHS organisation would be subject to inspection at least once every four years (Department of Health, 2000a:62).

CHI and the Audit Commission are also required to undertake national studies and inspections (Department of Health, 2000a:63) in addition to maintaining the existing role of trouble-shooter sent into under-performing organisations by the Government (ibid.).

To support this expanded remit, the size of CHI “is set to double over the next few years” (Department of Health, 2000a:62).

In Scotland, the Clinical Standards Board for Scotland (CSBS) remained responsible for quality assurance of clinical practices, including national standards of care.

Although CSBS was required to report on individual NHS Trusts, it was also asked

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<sup>25</sup> Clinical Standards Board for Scotland

to “provide a national perspective central to the development of a new national performance management process” (Scottish Executive, 2000:25). This reinforces the finding above that the Scottish NHS prioritised the creation of a nationally strong system over the ranking of individual NHS organisations.

In *Delivering the NHS Plan*, the Department of Health recognised that multiple bodies, including CHI, the Audit Commission and the National Care Standards Commission, were involved in inspecting and regulating NHS performance and that this could place a significant administrative burden on organisations being inspected and be confusing for the public (Department of Health, 2002:38). To address this burden, the Department proposes the formation of a single independent body, the Commission for Healthcare Audit and Inspection (CHAI), to incorporate the existing functions of CHI, responsibility for value for money reviews conducted by the Audit Commission and regulation of private health care providers previously undertaken by the National Care Standards Commission (*ibid.*). Ministers would no longer have the power to appoint members to the body, increasing its structural independence from government (Department of Health, 2002:39).

Yet again, the public is being invited to look to an independent body for evidence of the performance of the NHS rather than those bodies actually delivering healthcare.

“The Commission [for Healthcare Audit and Inspection] will have the key role in particular in explaining to the public how NHS resources have been deployed and the impact they have had in improving services, raising standards and improving the health of the nation...

“...for the first time, citizens will have *independently validated information* about how their money has been spent on healthcare in their own area and what progress has been made.”

(Department of Health, 2002:39-40, emphasis added)

The role of bodies providing independent verification of NHS performance is strengthened in England, but continues to be rejected by a Scottish system which relies on self-assessment.

### 5.3.6 Summary and reflections

This second period of analysis is characterised by growing and significant divergences in approach to performance assessment, including the need for independent verification.

The most managerial and arguably brutal NHS performance assessment framework is introduced in England, accompanied by an increased role for the Commission for Health Improvement to add credibility to reported performance (Free, Salterio and Shearer, 2009). Managerial incentives and sanctions are absent from the performance assessment framework in Scotland which is positioned as merely one part of an overall assessment of performance to be carried out jointly by each NHS body and the Scottish Executive. It is arguable whether the Scottish PAF fulfilled any real “management” function, containing over 90 indicators in pursuit of over 30 strategic objectives, with no prioritisation or focus.

The Commission of Health Improvement is given a strengthened role in performance assessment to “demonstrate to the public that the results are independent and genuine” (Department of Health, 2000:62). The implication is that neither NHS organisations nor the Department of Health can be trusted to accurately report on performance without independent verification. This is a clear example of audit mechanisms serving to undermine trust in professionals and to displace trust from public service providers to their de facto auditors (Power, 1994a; 1999).

## **5.4 Taking stock (2003-2006)**

### 5.4.1 Policy context

The third period of analysis sees the Labour-led administrations in both the UK Parliament and Scottish Parliament re-elected in 2005 and 2003 respectively, to what would prove to be their last term in government.

The Scottish Executive published *Partnership for Care: Scotland's Health White Paper* (Scottish Executive, 2003), in February 2003, less than three months from the end of the first term of the Scottish Parliament and therefore the second election.

*Partnership for Care* also brings to a conclusion the structural changes to dismantle the internal market, which commenced with *Designed to Care* in 1997 and continued under *Our National Health*. The White Paper announces the formal abolition of NHS Trusts to create single organisations responsible for local NHS systems in each of the 15 unified Board areas. This is intended to enhance strategic planning and accountability but not to centralise decision making where this is best conducted at local level (Scottish Executive, 2003:58).

Malcolm Chisholm, the second Minister for Health and Community Care in the Scottish Parliament, invited Professor David Kerr to chair an Advisory Group on Service Change in NHSScotland. The Group was charged with developing a national framework for service change and setting the strategic direction for service redesign in line with the principles of *Partnership for Care*.

In May 2005, Professor Kerr reported the Group's findings to Andy Kerr MSP, who succeeded Malcolm Chisholm as Minister for Health and Community Care in the Scottish Executive in November 2004. The findings contained in *Building a Health Service Fit for the Future* (Kerr, 2005) provided the basis for the next Health White Paper published by the Scottish Executive in October 2005. *Delivering for Health* (Scottish Executive, 2005) was heralded as bringing “radical, transformational change”<sup>26</sup> to the Scottish NHS and firmly shifting the focus of health services to preventative and continuous care.

In his Foreword to *Delivering for Health*, Andy Kerr references the very first health White Paper of the devolved Scottish Executive:

“This is a plan for the long-term. A plan for a national service that promotes *our national health*. A plan with patients at its core. *A plan for action, a plan for change.*”

(Scottish Executive, 2005:v, emphasis added)

This sets the latest reforms as the next stage of an evolving long-term policy programme and once again places an emphasis on action or making the change. A stronger desire to push the implementation phase of the policy cycle is evident in the

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<sup>26</sup> Andy Kerr MSP, Minister for Health and Community Care, quoted in Scottish Executive press release “‘Radical’ shift in healthcare priorities”, 27 October 2005 available at <http://www.scotland.gov.uk/News/Releases/2005/10/27092350>

document, with performance assessment established as a key component of the delivery plan (Scottish Executive, 2005:vii). This is supported by the identification of ‘key actions’ to demonstrate what the White Paper will achieve and how those achievements will be secured.

Meanwhile, the final whole system Health White paper produced by the New Labour Government *The NHS Improvement Plan: Putting People at the Heart of Public Services* (Department of Health, 2004) was published in June 2004, during the second of its three terms in Government. By this time, a third Secretary of State for Health was in post, following the resignation of Alan Milburn in June 2003.

*The NHS Improvement Plan* recognised that significant improvements had been made to NHS performance since 1997, highlighting in particular the reduction in patient waiting times. This sustained improvement is presented as an opportunity to turn attention to preventing ill health and reducing health inequalities. Patient choice and personalised services continued to be key themes running through the White Paper.

#### 5.4.2 NHSScotland: the introduction of performance management

##### *A “new” partnership*

The 2003 White Paper was the first to explicitly refer to ‘partnership’ in its title and the Ministerial Foreword from Malcolm Chisholm MSP explains that this is a “new” partnership between patients, staff and Government (Scottish Executive, 2003:5). This “new” partnership heralds a more managerial approach to performance assessment in NHSScotland.

There is a distinct change in the tone of *Partnership for Care*.

“The drive to define national standards for healthcare is still a relatively new feature of the health service and is now being taken forward in a more integrated way by NHS Quality Improvement Scotland. National standards are being set, performance is being *independently inspected* and the findings are being reported publicly for the first time. This will be *backed up by effective intervention* by the Executive, where necessary, to ensure that standards are met.”

(Scottish Executive, 2003:8, emphasis added)

This is the first indication that the Scottish approach to NHS performance is starting to embrace some of the managerial features implemented by the NHS in England.

The change in tone is echoed in the presentation of this White Paper. Gone are the friendly photographs and local anecdotes from *Our National Health*. They are replaced by a more traditional report format, with numbered paragraphs, which highlights key points at the beginning of each section in bullet point form. The presentation implies that the Executive is now more serious about driving improvement and the policy content has a more managerial flavour.

#### *The birth of performance management?*

*Partnership for Care* provides the first evidence that performance measures will be used as a management tool in NHSScotland, to direct local operations to achieve political priorities. This is supported by the identification of a set of 12 priorities for NHS Boards in 2003-04, supported by a wider Performance Assessment Framework comprising 60 quantitative measures and a further 30 qualitative measures (Scottish Executive, 2003:28-29).

The Executive further commits to two actions which provide further evidence that performance assessment is being used as a management tool: development of a new Performance Incentive Framework and a review of how to link senior managers' pay to delivery of national priorities (Scottish Executive, 2003:29).

The concluding chapter of the White Paper recognises that there is now a greater emphasis on performance management in NHSScotland (Scottish Executive, 2003:62). Yet again, there is an emphatic rejection of a centralised 'command and control' approach to governance of the NHS amid the rhetoric of supporting and empowering staff to improve performance and standards of care (ibid.).

If *Partnership for Care* started NHSScotland on a trajectory towards performance management, *Delivering for Health* completes the journey by introducing measures more akin to those seen in the Department of Health reforms of the previous period.

“A new Delivery Group will draw together and strengthen the performance management function by agreeing annual Local Delivery Plans with each NHS Board, providing *systematic monitoring* of performance, and playing a *more assertive role* in supporting or intervening.”

(Scottish Executive, 2005:vii, emphasis added)

The Delivery Group will have responsibility for:

- “ensuring a renewed and explicit focus on key objectives, targets and measures across the health portfolio
- “strengthening performance management arrangements between each NHS Board and the Scottish Executive
- “working with more timely and reliable management data, enabling accurate tracking of NHS Boards’ performance against all the agreed local delivery plan targets
- “making specific interventions to support and improve performance where the need arises” (Scottish Executive, 2005:53).

Local delivery plans are introduced as the primary mechanism to underpin the relationship of accountability between NHS Boards and the Minister and as such are intended to “maintain a ‘line of sight’ from strategy through to delivery on the ground... NHS Boards will use local delivery plans to demonstrate how they will deliver key targets for all their patients within the resources available. By including clear performance milestones, these plans will help to set and track the pace of change and ensure the delivery of objectives is affordable and sustainable” (ibid.). The Local Delivery Plans are thus not unlike public service agreements between HM Treasury and UK Government Departments to underpin spending plans.<sup>27</sup> They were also already part of the NHS performance framework in England (Department of Health, 2003:6) and so it appears that the Scottish Executive had begun to import management tools which had supported performance improvements in England.

The Scottish Performance Assessment Framework previously relied on professional values to deliver improvement, and shied away from introducing a strong system of

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<sup>27</sup> See section 5.3.4

incentives for good performance. *Partnership for Care* recognises that further incentives are required to support good and improving performance (Scottish Executive, 2003:28). While the incentives are not specified in the White Paper, it signals that the Scottish NHS is moving closer to the position of the NHS in England that professional motivations alone will not deliver improvements desired by politicians.

The Scottish Executive's stance on intervening in local NHS performance and operations undergoes a significant shift between 2001 and 2003. While in 2001 the Scottish Executive undertook to work with poorly performing NHS boards to agree how improvements could be delivered (Scottish Executive Health Department, 2001:47), by 2003 the Executive is prepared to "intervene where necessary to correct significant service failures" (Scottish Executive, 2003:24). The Scottish Executive signals a clear intent to take immediate action where performance falls short of expectations, including strengthening its legislative powers. The shift in tone and purpose is self-evident. A more managerial approach is being introduced to performance management of the NHS in Scotland.

But the Scottish Executive has not entirely abandoned its commitment to work with NHS organisations to support improvement.

"We are not interested, however, in a culture of blame but in a culture of improvement."

(Scottish Executive, 2003:63)

And so while the overall approach to performance assessment can now be characterised as central *management* of performance, rather than intelligence gathering or supporting improvement, the Scottish Executive stops short of replicating the English 'star ratings' system. There will be neither public ranking of NHS organisations, nor financial sanctions for poor performance.

The Scottish PAF continued in operation until 2006, when it was replaced by the HEAT system. HEAT measures performance across four dimensions: Hhealth improvement; Efficiency and governance; Access to services; and Treatment appropriate to individuals. HEAT contains fewer targets than the PAF and so it directs NHS Boards to prioritise delivery of key government policies.

This change in approach in Scotland comes as the Department of Health takes a step back from driving performance improvements in the NHS in England.

#### 5.4.3 NHS in England: a softening approach to performance management

*The NHS Improvement Plan* (Department of Health, 2004) places a reduced emphasis on strong performance management to drive improvement. Professional standards and the NHS ethos are recognised as powerful drivers of improvement (Department of Health, 2004:73), where previously the sole emphasis was on the performance management regime.

Up to now, performance frameworks were centred on ‘access’ to treatment or the number of patients waiting for NHS treatment and how long they have to wait for that treatment. Both of these factors are easily measured and therefore easily audited. There is limited, if any, discussion in successive White Papers as to whether clinical outcomes are improved by reducing waiting times, which necessitated not insignificant investment in expanding capacity in those specialties where long waits were previously the norm.

All investment in the NHS has an opportunity cost and so by focusing on improving what was easily measurable, and by extension auditable, the Government must have foregone investment in other services or treatments provided by the NHS. This is not to deny the political attractiveness, aside from the managerialist considerations, of being able to demonstrate improvement in areas which the majority of voters can easily relate to.

*The NHS Improvement Plan* also signals that the Department of Health will step back from active management of the NHS:

“now that improvements are being delivered, we are moving on to a second phase in order to further engage front-line staff and patients in building on these successful reforms”

(Department of Health, 2004:74).

While still not admitting to commanding and controlling the NHS in England via the performance management regime, the White Paper states that “the Department of Health will not, in future, micro-manage local-level commissioning or delivery

decisions” (Department of Health, 2004:76). This paves the way for a less aggressive performance assessment framework.

Yet again in *The NHS Improvement Plan* we are told that “financial incentives and performance management will drive delivery of the new commitments” by the English NHS (Department of Health, 2004:11). But the Government commits to setting “far fewer national targets” (ibid.) which are implicitly becoming less critical now that overall performance has improved. These incentives are built around ‘payment by results’, introduced by *Delivering The NHS Plan* (Department of Health, 2002) under which a fixed tariff for patient activity creates market discipline and is considered to drive efficiency in the provision of healthcare. It is claimed to provide incentives to reduce costs and maximise activity to maximise the ‘financial gains’ under the tariff.

#### *The annual health check*

The rhetoric of a shift in the focus of NHS performance management which is evident in *The NHS Improvement Plan* translates into the introduction of the “annual health check” (Healthcare Commission, 2005a): a new holistic performance assessment regime which replaces the star ratings system and clinical governance reviews. It is promoted as the “most comprehensive assessment ever made of the NHS in England” (Healthcare Commission, 2006). The annual health check is owned by the Healthcare Commission, the latest incarnation of the Commission for Health Improvement.

The new approach to performance assessment marks a shift towards greater self-assessment of performance by English NHS bodies (Healthcare Commission, 2005a), but more significantly seeks to develop a broader picture of organisational performance than its predecessor.

The language of performance assessment changes – the annual health check assesses performance by reference to ‘standards’ rather than ‘targets’ (Healthcare Commission, 2005a:3). This suggests a departure from a principally quantitative approach to defining performance, and a greater likelihood that qualitative performance will be given equal weighting.

The health check also incorporates financial performance as a separate dimension of overall performance, linked to core standards. The score for financial performance will be derived from the findings of the external audit of NHS Trusts by the Audit Commission and the financial risk assessment of Foundation Trusts conducted annually by Monitor<sup>28</sup> (Healthcare Commission, 2005a). The role of the Audit Commission in relation to the annual health check is considered further below at Section 5.4.5.

The stated aim of the annual health check is to “promote improvements” (Healthcare Commission, 2005a:3). There is a renewed emphasis on improving patient care as opposed to meeting political targets:

“[The annual health check] will help people to make better informed decisions about their care, lead to healthcare professionals developing and sharing better information on good practice, provide organisations with clearer expectations, enable managers to focus on areas of concern and learn from good practice, and tell the Government more about the quality and equity of services provided.”

(Healthcare Commission, 2005a:3-4)

There is recognition of the burden which performance assessments have upon auditee organisations and an intention to reduce that burden through more risk-based interventions (Healthcare Commission, 2005a:4) and working more closely with other regulatory bodies, including sharing information (Healthcare Commission, 2005a:19).

The health check, like its predecessor, is still intended to distil organisational performance into a single score on a four-point scale. However, this is now supplemented by scores for individual components of the assessment framework and more detailed information on how that score has been arrived at (Healthcare Commission, 2005a:11;45). In the event, the first annual health check gives two

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<sup>28</sup> The Independent Regulator of NHS Foundation Trusts was established on 5 January 2004 under the Health and Social Care (Community Health and Standards) Act 2003. The Regulator became known as “Monitor” from August 2004.

performance ratings<sup>29</sup> for each NHS organisation: quality of services and use of resources (Healthcare Commission, 2006).

The new performance assessment approach appears to look beyond controls to consider patient outcomes (contrast Power, 1999:84).

“When the standards require outcomes for patients, we will not consider the existence of processes as sufficient evidence that the standards are being met.”

(Healthcare Commission, 2005a:26)

There is also an indication that the annual health check has been designed to provide patients with information to support decisions where they wish to receive treatment.

“You will also be able to look at the results in relation to six questions<sup>30</sup> that we developed during discussions with patients and the public.”

(Healthcare Commission, 2006:7)

The annual health check represents a less managerial approach to performance assessment than the preceding star ratings system: it builds a more comprehensive definition of performance, it considers compliance with standards for delivering healthcare, and places greater emphasis on clinical quality than on systems and controls.

#### 5.4.5 Independent verification

##### *Scotland*

During this period, independent verification becomes important in NHSScotland for the first time in securing the legitimacy of reports of organisational performance (Power, 1999; Free, Salterio and Shearer, 2009).

NHS Quality Improvement Scotland was established on 1 January 2003 as an authority on clinical practice and an independent inspectorate of NHS performance. It superseded previous bodies, including the Clinical Resource and Audit Group (CRAG) and the Clinical Standards Board for Scotland (CSBS).

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<sup>29</sup> Each rating is based on a four-point scale: excellent; good; fair; weak.

<sup>30</sup> The questions are: How long will I wait? How safe and clean is it? How good is the care I will receive? Will I be treated with dignity and respect? Does the organisation help me stay healthy? How well is the organisation managed?

“[NHS Quality Improvement Scotland] has the skills, access, resources and power necessary to identify areas of weakness and ensure that NHSScotland is improving quality where that is necessary. It also has a tough new remit to investigate serious service failures and make clear recommendations for remedial actions.”

(Scottish Executive, 2003:24)

Audit is also explicitly recognised as an institution which supports public confidence in the NHS and *Partnership for Care* is the first of the Scottish Executive health White Papers to make direct reference to the work of Audit Scotland.

“There is a close working relationship between Audit Scotland and NHS Quality Improvement Scotland to achieve rigorous standards of inspection and monitoring. This will *help to ensure patient confidence* in the quality and safety of healthcare provision...

“Audit Scotland has an important role in relation to the efficiency and effectiveness of NHS organisations, independently of NHSScotland and government.”

(Scottish Executive, 2003:24)

At the same time, Audit Scotland’s role in relation to NHS performance was evolving towards the production of an overview report on operational as well as financial performance (Audit Scotland, 2004a). This will be considered further in the following chapter.

As well as the increasing role given to formal audit and quasi-audit institutions, the Scottish Executive promotes increasing use of audit-inspired technologies at organisational level (Scottish Executive, 2005). These technologies require performance improvements to be measurable and are applied to support implementation of new policies or improvement activity in clinical as well as managerial domains. A few examples are listed below.

- Introduction of a Community Health Partnership self assessment toolkit to benchmark provision of services to patients with long term conditions, based on “clearly measurable criteria” (Scottish Executive, 2005:21)
- “To inform our future decision making [on provision of specialist services], we need to do more audit, data collection and evaluation to collect information we can use to compare and contrast outcomes according to

individual clinicians' and hospitals' workload, improving the quality of our own health care and contributing to the international debate on specialisation.” (Scottish Executive, 2005:41)

- Intention to carry out a two-year audit of paediatric high dependency units to support decisions on future provision of such units (Scottish Executive, 2005:47)
- “the creation of a common minimum data set and a planned audit programme” for neurosurgery and neuroscience (Scottish Executive, 2005:48)

It is unclear from the White Paper as to whether these assurance exercises can be considered “audits” in a technical sense, but the increased volume of references to their use is significant and suggests that audit plays a legitimating role in the more managerial approach to the performance of the Scottish NHS (Power, 1999; Free, Salterio and Shearer, 2009).

The increased recognition of the assurance provided by formal audit institutions and organisation-level audit initiatives coincides with a strengthening of the approach to performance management in NHSScotland. Thus, elements of Power’s audit society, which were previously absent from the performance assessment regime in Scotland, begin to emerge.

### *England*

The previous section highlighted the role of the Healthcare Commission in developing and implementing the “annual health check” as a replacement performance assessment framework for the star rating system.

The remit of the Healthcare Commission was also expanded to include responsibility for independent sector providers of healthcare, who would be subject to the same inspection arrangements as NHS bodies (Department of Health, 2004:10). Audit and inspection regimes are now arguably being used to support the reintroduction of market mechanisms to the NHS, now more closely resembling an ‘external’ market in which NHS organisations compete with independent, or private, sector providers.

There is also evidence of increasing awareness on the part of central government of the volume of audit and inspection activity within the NHS in England.

“The Department of Health’s arm’s length bodies are currently under review... to ensure that the regulatory burden on local NHS delivery organisations does not exceed that essential to promote quality and effective delivery of care.”

(Department of Health, 2004:76)

This supports the emerging picture that the NHS in England is taking action to reduce the reliance on audit technologies and alleviate their impact on delivery of frontline services.

As discussed at Section 5.4.4 above, the Audit Commission was given a formal role in the new “annual health check” through responsibility for the evaluation of the use of resources by NHS Trusts.

The Audit Commission introduced the Auditor’s Local Evaluation (ALE) to produce the use of resources assessment. ALE consists of scored judgements in five areas (financial reporting, financial management, financial standing, internal control and value for money), which are aggregated to calculate an overall use of resources score.

“Auditors *made judgements* on a total of 13 key lines of enquiry (KLOEs) across these five areas. The KLOEs take the form of a series of high-level questions underpinned by more detailed audit criteria and evidence required to enable auditors to reach their *judgements* on the performance of NHS bodies during 2005/06.”

(Audit Commission, 2006:4, emphasis added)

The use of a single measure gives the impression of an objective measurement system but the quote above shows that this single measure is the product of subjective audit judgement albeit based upon generally accepted professional standards (Power, 1999). The national audit body is actively defining financial performance of the NHS in England (Power, 1996; Lindeberg, 2007).

Despite the increased prominence of audit in supporting performance management in NHSScotland, the Scottish Executive has not asked Audit Scotland to formally

evaluate the financial performance of NHS Boards. The next chapter explores the role of Audit Scotland in relation to performance management in Scotland.

#### 5.4.6 Summary and reflections

After the significant differences evident in approach to performance measurement in Scotland and England identified from review of the 1997 and 2000 White Papers, we see the first signs of convergence and the creep of the audit society into the Scottish framework.

### **5.5 Consolidation and convergence (2007-2010)**

#### 5.5.1 Policy context

This final period of analysis saw a change in administration in Scotland. The Scottish National Party (SNP) won the largest number of seats in the May 2007 election but did not win an outright majority of seats. Choosing to govern as a minority administration, rather than entering coalition as the Labour party had done in the two previous parliaments, the SNP would face new challenges in winning parliamentary support for its legislative and policy programme, including the annual Scottish Budget.

This period also sees different political parties in power in the United Kingdom and Scottish Parliaments, although both the SNP and the Labour Party are traditionally left-of-centre. At first sight, this might create an expectation that they would adopt similar policy orientations, but the primary cause of the SNP is securing Scotland's independence from the United Kingdom and so more marked differences in political direction are likely during the period.

One of the first acts of the SNP administration was to re-brand the Scottish Executive as the Scottish Government. This did not have any substantive or legal effect but the Scottish administration was thereafter widely referred to as the Scottish Government.<sup>31</sup>

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<sup>31</sup> The Scotland Act 2012 formally renamed "The Scottish Executive" as "The Scottish Government", enabling the use of the term "Scottish Government" in legal documents.

Shortly after taking office, the SNP administration set an overarching purpose and five strategic objectives to structure and provide focus to its governance of Scotland. The strategic objectives were underpinned by 15 National Outcomes and 45 National Indicators to measure progress towards achievement of the Outcomes and ultimately the overall purpose.<sup>32</sup> The SNP Government thus showed an early predisposition for using performance measures to support assessment of progress in delivering outcomes.

Health was a key issue for the main political parties during the 2007 election campaign. The SNP's election manifesto promised to reverse decisions taken by the Labour-led coalition to close two Accident and Emergency units in Central Scotland (Scottish National Party, 2007).

Shortly after taking office, Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, launched a national consultation on priorities for NHSScotland under the banner *Better Health, Better Care* (Scottish Executive, 2007). This consultation, or 'discussion', was positioned as a follow up to the earlier review led by Professor David Kerr (Kerr, 2005) which became the basis for the final health White Paper of the Labour / Liberal Democrat administration, *Delivering for Health* (Scottish Executive, 2005). It was also intended to support the new administration's strategic vision for the NHS and the expansion of the ministerial portfolio to include wider social drivers of health, including sport, housing, regeneration, social inclusion and poverty (Scottish Executive, 2007:3).

The *Better Health, Better Care* White Paper was published in December 2007 (Scottish Government, 2007), within five months of the launch of the discussion document and associated consultation period. The key theme of the document was the establishment of a mutual NHS with patients, staff and the public co-producers of health services, each with their own responsibilities to improve health and deliver care.

Meanwhile, the New Labour administration was already part-way through its third, and last, period in Government. In June 2007, Gordon Brown succeeded Tony Blair

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<sup>32</sup> <http://www.scotland.gov.uk/About/purposestratobj> (accessed on 2 June 2011)

as leader of the Labour Party and Prime Minister of the United Kingdom. This was effectively a planned succession, with no serious challenge to Brown's bid for leadership when Blair announced his intention to step down after 10 years as Prime Minister.

As highlighted in the previous section, *The NHS Improvement Plan* (Department of Health, 2004) was the final whole system health White Paper produced by the New Labour Government.

In July 2007, the Prime Minister and Alan Johnson, then Secretary of State for Health, invited Professor Sir Ara Darzi, a practising surgeon and recently appointed Parliamentary Under Secretary of State for Health in the House of Lords, to conduct a "once-in-a-generation" review of the NHS ahead of the sixtieth anniversary of its creation in 2008. The review was intended to ensure that the NHS was "properly resourced... clinically led, patient-centred and locally accountable"<sup>33</sup>.

Lord Darzi subsequently led the NHS Next Stage Final Review, the report from which *High Quality Care For All* (Department of Health, 2008) was published in June 2008.

### 5.5.2 The SNP approach to the Scottish NHS

The Cabinet Secretary for Health and Wellbeing made the new Scottish Government's ideological position on the NHS very clear when she launched *Better Health, Better Care* in December 2007:

"We have set out a plan for a National Health Service based on the values of collaboration and cooperation, not the whims of the market. We affirm a unified structure in which decisions are made in the interests of the people we serve and not by the demands of internal competition. A public service, used by the public, paid for by the public, and owned by the public.

"*Better Health, Better Care* sets out a vision for a National Health Service that is not only true to its founding principles but that has the confidence to extend those principles through a commitment to involving the public,

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<sup>33</sup> Statement made by Alan Johnson, Secretary of State for Health, in the UK Parliament on 4 July 2007. Quotes taken from Hansard transcript of the statement at Columns 961-3, published online at <http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070704/debtext/70704-0004.htm#07070441000007> (accessed on 22 August 2013).

patients and staff in shaping its future direction. It delivers a national health service for the Scottish nation – a truly Scottish Health Service.”<sup>34</sup>

This statement summarises some important themes in SNP health policy: outright rejection of market-based delivery of health services, which sets an expectation that other strains of managerialism are unlikely to be embraced; that the NHS should be primarily and directly accountable to the public; and that there will be a distinctly Scottish NHS, based on Scottish values and principles.

The White Paper is described as an ‘Action Plan’, emphasising implementation over ideology or rhetoric. The extensive discussion or consultation exercise is seen as key to securing a mandate for the proposed changes among the public, NHS staff and even NHS organisations.

#### *Performance management*

The continued importance of performance targets to the NHS is made explicit in *Better Health, Better Care*: targets will be used “to provide a sense of purpose, drive continuous improvement and focus the decisions [NHS organisations] make” (Scottish Government, 2007:9).

The HEAT system is to be retained with some modifications, which will ensure that it is aligned with the Scottish Government’s strategic objectives and that short term operational targets are more clearly aligned to long term strategic direction. The content of measures would reflect a greater political focus on health improvement and anticipatory care rather than access to acute treatment (ibid.). Patient experience indicators would be included in HEAT for the first time, reinforcing the shift to a mutual NHS with patients at the heart of decision making and service delivery (ibid.).

The White Paper recognises the need to maintain and enforce a strong performance assessment framework to deliver the Scottish Government’s commitment to an accountable and patient focused NHS (ibid.). The new administration intended to use existing accountability mechanisms and organisations to support management and delivery of HEAT targets (Scottish Government, 2007:11).

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<sup>34</sup> Scottish Government News Release “Patients at heart of new health strategy”, 12 December 2007 available at <http://www.scotland.gov.uk/News/Releases/2007/12/12143009>

The White Paper introduces new mechanisms to make the NHS more accountable to patients and the public, including a new patient experience programme to involve patients in service redesign; a Patients' Rights Bill to enshrine legal rights and responsibilities of the NHS and patients; independent scrutiny panels to provide assurance over local proposals for major service change; direct election of non-executive board members to NHS Boards; and an annual "ownership report" to be distributed to all Scottish households summarising rights and responsibilities of patients and carers and setting out key information about accessing local health services (Scottish Government, 2007:6-7). The accountability relationship was being redefined to reflect the ethos of a mutual NHS.

Although *Better Health, Better Care* rejects the use of the market to deliver healthcare, efficiency is still considered a key component of performance. However, efficiency is re-positioned as a driver of high quality health care rather than a measure of financial health. The reforms include new efficiency targets which encompass the use of all organisational resources, including sickness absence, patient attendance and online triage of GP referrals as well as traditional cash efficiency targets (Scottish Government, 2007:60).

There is little detail in the White Paper on how performance against HEAT will be 'enforced' and no direct references are made to the Delivery Group, trumpeted by the previous administration in *Delivering for Health* (Scottish Executive, 2005) as the primary mechanism for securing performance improvement in NHSScotland.

*Better Health, Better Care* reverts to the language of "improvement" (Scottish Government, 2007:71), last seen in *Our National Health* (Scottish Executive, 2000) and *Rebuilding Our National Health Service* (Scottish Executive Health Department, 2001). There are no explicit 'sanctions' for poor performance – just offers of assistance to improve performance.

The focus of the HEAT system was sharpened under the SNP administration; the number of targets gradually reduced and remaining targets were framed in terms of

factors which were controllable by NHS Boards.<sup>35</sup> Individual Boards were still required to publish a review of performance against HEAT targets in their annual accounts. Latest HEAT performance data was also now published on the Scottish Government website<sup>36</sup>, so it was widely available to the public.

### 5.5.3 Managing the performance of the NHS in England

#### *Next Stage Review Report*

In contrast to earlier policy documents, the Final Report of the *Next Stage Review* (Department of Health, 2008) led by Lord Darzi is presented as owned by the NHS. Although Milburn's *NHS Plan* (Department of Health, 2000a) contained a foreword signed by various professional organisations and other bodies who work in close partnership with the NHS (including local government and third sector), the introduction to the *Next Stage Review* is signed by the Clinical Leads of each of the 10 Strategic Health Authorities; practising clinicians working at the heart of clinical service delivery.

The introduction challenges the popular rhetoric of previous White Papers and acknowledges a lack of involvement of frontline staff in the development of previous reforms (Department of Health, 2008:1).

Photographs showing the provision of health services in a range of settings feature prominently in the report. Each chapter is introduced by a full page photograph and caption explaining the nature of the service being provided and where in the country that service is being provided. There are echoes here of the Scottish White Paper *Our National Health Service* (2000), which was peppered with photographs of healthcare delivery. The visual images reinforce that these policy developments are intended to be clinically-centred.

The Introduction also announces a shift in the balance of power between the Department of Health and the NHS delivery bodies (Department of Health, 2008:1),

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<sup>35</sup> See *HEAT Targets Due for Delivery 2006/07 to 2011/12* published by NHSScotland Performance and Business Management for a full list of targets over the period – published online at <http://www.scotland.gov.uk/Resource/0040/00401613.pdf> (accessed on 23 August 2013)

<sup>36</sup> See <http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance> (accessed on 23 August 2013)

reflecting the loosening of the Department's grip on controlling and managing NHS performance as evidenced by the abolition of star ratings.

There is a shift in the tone of the political prefaces to the Next Stage Review. Prime Minister Gordon Brown (Department of Health, 2008:2) highlights the achievements of the past 10 years in improving basic standards of care and increasing the capacity of the NHS to address the "chronic underinvestment" which the NHS had suffered under the previous Government. The new vision is one of a renewed NHS delivering "truly world class" health standards, which "requires Government to be... committed to trusting frontline staff", thus sending a message that top-down control and micro-management of the NHS is no longer appropriate.

The over-riding message is that the last 10 years of reforms, from *The New NHS* (1997) through *The NHS Plan* (2000) to *The NHS Improvement Plan* (2004), have restored core services following apparent years of neglect of the NHS. The NHS was in such bad shape when the Labour Government came into office that drastic and immediate action was required to ensure it was equipped to meet the demand for health services, hence the need for the discipline of star ratings. Now these basic standards of service have been secured, the emphasis can shift to improving the quality of those services.

But how successful were the years of tough performance management in bringing genuine substantive improvements? Lord Darzi has gathered views from frontline staff that "the programme of reform that has been put in place has been unevenly applied and can go much further" (Department of Health, 2008:8). So governance by performance management, at least on the basis of this evidence, perhaps did not yield universal improvements in health services. Lord Darzi goes on to refer to independent research findings that the NHS has improved the quality of patient care in recent years (Department of Health, 2008:11) but acknowledges that these improvements were "focused primarily on waiting times, as basic acceptable standards of access to A&E and secondary care were established, and on staffing levels and physical infrastructure" (ibid.). There is now a need to focus on standards of care across the board.

In contrast to earlier English reforms, measurement is to be used as a tool to support clinicians and not as an indicator of organisational performance: (Department of Health, 2008:49). Measurement is intended to support improvement, through identifying opportunities and monitoring the success of changes, not to define improvement. This resonates with the early approaches to performance information taken by the Scottish Office (1997c) and the Scottish Executive (2000; 2001).

The development of measures is to become a collegiate process involving patients, the public and staff (Department of Health, 2008:50). While the Department retains the ultimate decision over the set of measures used, this approach differs from earlier approaches which imposed performance measures upon the NHS. There is no stated role for auditors or arm's length bodies in the setting of metrics – this is a process squarely within the clinical domain.

Significantly, Lord Darzi emphasises that “*no new national targets* are set in this report” (Department of Health, 2008:14, emphasis in original). The focus of accountability has switched: accountability is no longer discharged by demonstrating achievement of targets imposed from above, but is defined by the achievement of patient outcomes (Department of Health, 2008:64). While there are no national quality targets, NHS bodies continue to publish reports on quality which become the key instrument of accountability to the public and a basis for peer-to-peer challenge (ibid.).

The Care Quality Commission, the latest incarnation of the body which started life as the Commission for Health Improvement, is given a role in verifying quality information published by healthcare providers and reporting on performance (Department of Health, 2008:51). Thus, there is a continuing role for independent verification of NHS performance (Power, 1994a; 1999).

*End of an Era: Burnham's Speech to the NHS Confederation (June 2009)*

Andy Burnham made headlines<sup>37</sup> with a speech to the NHS Confederation<sup>38</sup> announcing a purge of NHS performance targets just days after his appointment as

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<sup>37</sup> See for example reports in the Guardian (“Burnham promises cull of NHS targets” <http://www.guardian.co.uk/society/2009/jun/11/nhs-targets-burnham-pledges-cull>) and The Times (“Health Secretary Andy Burnham promises NHS targets massacre” [http://www.timesonline.co.uk/tol/life\\_and\\_style/health/article6479588.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article6479588.ece)).

Secretary of State for Health following a Cabinet re-shuffle in June 2009. In reality these statements were a natural progression from Lord Darzi's statement that former performance targets would become minimum standards and there would be no more centrally imposed national targets (Department of Health, 2008:63).

Burnham identifies three stages of the New Labour healthcare reforms:

“Centralised targets and top-down controls were right to galvanise a failing system, but the middle phase of the Government's reform journey became about pushing power and control downwards... Now, with Ara Darzi's Review, we've got a chance to open up a new era in NHS reform – moving us away from the focus on numbers and systems towards people and experiences.”

This third stage re-characterises accountability so that patients, not central government or even their elected representatives, “become the pre-eminent force holding the NHS to account”. A strong *national* health service can only be achieved by “moving beyond the era of targets, beyond the era of systems and processes, and towards a new era where every NHS institution is held to account by the quality of the patient's experience and the rights set out in the Constitution”. Burnham thus promises a “deep clean” of the targets regime, mainstreaming important targets as minimum, evidence-based service standards and removing others that are surplus to the achievement of core outcomes.

Burnham attempts to reconcile the removal of targets with the introduction of Quality Accounts: “while we can remove targets, we can't remove information”. Thus the production of performance information is central to effectively managing the NHS, but that information will be used in a less aggressive way.

#### *The NHS Performance Framework*

The Department of Health brought performance assessment of the NHS in England back in-house from arm's length bodies for the first time since 2001 when it launched “The NHS Performance Framework” in 2009 (Department of Health, 2009). The Framework was “co-produced” with the NHS and regulators and spans

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<sup>38</sup> Transcript of speech downloaded from [http://www.dh.gov.uk/en/News/Speeches/DH\\_100754](http://www.dh.gov.uk/en/News/Speeches/DH_100754) on 25 February 2010

clinical and managerial performance with reported buy-in from both groups (Department of Health, 2009:5-6).

The principle of subsidiarity is re-introduced into performance management. The NHS Performance Framework is to be managed as part of the contractual relationship between commissioner and provider, with performance issues escalated to strategic health authorities and ultimately the Department only if they are serious and persistent (Department of Health, 2009:6).

The NHS Performance Framework is positioned as an internal management tool to set “clear thresholds for intervention in underperforming organisations and a rules-based process for escalation”. The implementation guidance contains a long list of what it is *not* intended to do (Department of Health, 2009:10). For example, the Framework does not exhaustively measure all aspects of organisational performance, or produce independent information to support public accountability, or reward good performance (*ibid.*).

#### *Independent verification*

The Care Quality Commission (CQC) was established as the independent regulator for health, mental health and adult social care in England on 1 April 2009. It assumed responsibility for work previously carried out by the Healthcare Commission.

The role of the CQC differs significantly from predecessor quasi-audit bodies such as the Commission for Health Improvement. All health and social care providers operating in England, from the public and independent sectors, are required to register with CQC. The registration process requires applicants to demonstrate that they meet fundamental quality and safety standards. Organisations no longer receive a score for achievement of core standards, as they did under the annual health check.

The Final Report of the *NHS Next Stage Review* (Department of Health, 2008:51) not only introduces the concept of ‘Quality Accounts’ to be prepared by healthcare providers in parallel to statutory financial accounts, but gives the Care Quality Commission a prominent role in relation to verifying the information published by NHS bodies.

Despite the continuing appeals to professional clinical motivation and introducing clinically-led reforms, the policy of requiring independent verification of published performance continues to cast a shadow over claims that the Department trusts healthcare professionals to deliver high quality care. The public is yet again invited to look to an independent quasi-auditor for evidence that published performance data is reliable.

#### 5.5.4 Reflections and summary

As the English system began to reject an extreme managerial approach in favour of a more comprehensive assessment of performance, the Scottish approach became more outcomes-focused and managerial, although never reaching the extreme embodied by star ratings.

There is still no formal role for independent verification in the Scottish performance assessment framework, while the body which started life as the Commission for Health Improvement comes to fulfil a more traditional regulatory role as the Care Quality Commission, charged with registering NHS bodies to deliver health services subject to satisfaction of prescribed standards.

### **5.6 Reflections and concluding remarks**

#### 5.6.1 Key findings and reflections

This chapter summarises the evolution of performance assessment in NHSScotland, relative to developments in the NHS in England. It presents the “official” account of performance assessment, while later chapters will explore the operational manifestations of these policy reforms.

Performance assessment was selected as a replacement for the price-based competition which sat at the heart of NHS governance for the duration of the internal market. For the majority of the period of study, one political party effectively controlled both the Scottish and UK Parliaments and so one might expect broadly similar policy solutions to be adopted in both the Scottish and English NHS. However, this study shows that despite an early shared use of language, the two

administrations applied very different interpretations of performance assessment in redesigning the governance and accountability of the NHS.

The English NHS continued to be dominated by managerialist policies and approaches to performance assessment while the NHS in Scotland entered a period of re-aggregation and communitarian policy-making which resulted in a “softer” approach to performance assessment.

The period of this study marks the beginning of a new constitutional settlement in the UK, with the creation of the Scottish Parliament providing a mandate for identifying policy response which better suited Scottish circumstances. From 1997 onwards, it is evident that Scotland is a less enthusiastic adopter of managerial language and tools than England.

It would be overly simplistic to link the differing level of enthusiasm for managerial reforms to underlying political or cultural values, particularly when both Parliaments were ruled by the same political party. The answer is more nuanced and the present author has sympathies for findings elsewhere that the strength of the medical profession in Scotland, underpinned by a relatively large number of medical schools and a smaller population which facilitates tighter policy networks which have more direct access to government (Hazell and Jervis, 1998; Nottingham, 2000; Spry, 2002; Greer, 2004; Greer, 2005; Kerr and Feeley, 2007).

Furthermore, the smaller population allowed the NHS in Scotland to revert to a geographic governance structure when it abandoned the internal market. By the end of the period of study, there were 14 territorial NHS boards in Scotland, responsible for delivering healthcare to the local population, which were supported by eight national organisations. It is thus feasible for Ministers and senior government officials to build up personal relationships with each organisation and for these interactions to play an equally significant role as formal management technologies in supporting governance and accountability.

Replicating the same structure in England, serving similar sized populations, would have seen almost ten-fold increase in the number of organisations and rendering it near impossible to build up the same richness of personal relationships and informal organisational understanding. In such an environment, more formal mechanisms are

required to support the effective discharge of accountability and performance management provided such mechanisms during the period of this study.

Nevertheless, the differences in approach to performance assessment were most pronounced in the early years of the first term of the Scottish Parliament, which echoes with findings elsewhere in the literature that Scotland sought to exaggerate differences in policy approach almost to justify devolution itself (Woods, 2004; Blackman et al., 2006).

This chapter has drawn out oscillations in the official embodiment of performance assessment across the period of study. The most managerial and severe features of the star ratings system in England, which represented the peak of aggressive performance assessment, are diluted by successor assessment systems.

Organisational performance is no longer distilled into a single score and strict sanctions are no longer imposed solely on the basis of the score generated by the performance assessment system. Meanwhile, Scotland's initial exploration of performance assessment becomes more structured over time until it ultimately resembles a traditional management system which directs the operations of NHS bodies towards the delivery of national policy priorities.

### 5.6.2 Implications for the *Audit Society*

One of the most striking differences between the performance assessment regimes adopted in Scotland and England is the recourse to independent assurance in order to verify the reported performance of NHS organisations. This is a constant theme in the English approach to performance assessment: an independent assurance body, the Commission for Health Improvement, is created for England in 1997 and survived in various forms beyond the period of study. The English policy narrative thus reinforces one of the most significant elements of Power's audit society: that independent assurance is necessary to render accounts of performance credible (Power, 1999:82).

This form of independence assurance places greater emphasis on the operation of clinical systems and controls than it does on patient care or patient outcomes. Again, this resonates with Power's finding that the audit society tends to promote controls over substantive performance (Power, 1994a; 1999).

These assurance bodies are increasingly called upon to define performance and are eventually given the task of designing the performance assessment system, as well as reviewing reported performance against those systems. Even the Audit Commission, a statutory audit body, is called upon to create a definition of financial performance in NHS England as part of the annual health check. Assurance and audit bodies define performance, as well as review it, which empowers them to exert significant influence over the operation of the NHS (Power, 1996; 1999).

By contrast, the official policy narrative in Scotland does not create a space for independent verification of performance. The following chapter will explore how the national audit body nevertheless created its own space in the Scottish performance assessment framework. However, it is significant for present purposes that the official narrative of NHSScotland did not prioritise independent verification of performance, although micro-level audit technologies became increasingly evident from 2005 onwards. This is symptomatic of the “softer” incarnation of performance assessment in Scotland which exhibited few characteristics of the audit society, particularly in its earliest manifestation.

Later chapters will consider how the lack of evidence of the audit society in the official policy framework contrasts with operational reality.

### 5.6.3 Further issues to be explored

This chapter has, by necessity, presented a summarised account of key developments in performance assessment in the NHS in Scotland and England between 1997 and 2010. It is beyond the scope of the present study to consider in depth the implications of the different operating structures which emerged in the two systems and these would benefit from further study in order to more thoroughly understand the interactions between accountability, performance assessment, governance and organisational structure in the NHS.

The following chapters will present three in-depth case studies which explore different dimensions of performance management in action in NHSScotland. The next chapter studies the evolution of the role of Audit Scotland, the national audit body, in relation to NHS performance.

## **Chapter 6**

# **The evolution of Audit Scotland's role in performance managing NHS Scotland**



## 6.1 Overview

This chapter presents the findings from a thematic analysis of annual overview reports of NHSScotland produced by Audit Scotland, from the first report produced in 1999-2000 to the 2009-10 overview report. The period of study coincides with the time period for the analysis of policy documents, spanning the three terms of the New Labour Government in the United Kingdom Parliament from May 1997 to May 2010.

The previous study of policy documents found that Audit Scotland was not given a formal role in successive performance measurement schemes adopted by NHSScotland, in contrast to the role given to the Audit Commission in relation to the NHS in England (Bowerman et al., 2003). Audit Scotland therefore has to make its own voice heard in the NHS performance network, and the annual overview reports are the primary instrument through which Audit Scotland expresses that voice. The reports summarise the work which Audit Scotland has performed in the health sector during the year. On a more symbolic level, they provide a snapshot view of the role of Audit Scotland in the financial and performance management networks of NHSScotland.

This chapter adopts the same analytical approach as the previous chapter, which explored the evolving role of audit in performance management through an examination of government policy and guidance documents. The approach is inspired by the work of Prior (2003) and Latour (1991, 2005); both authors recognise the active role that documents can play in a network and encourage the researcher to look beyond the content of documents to also consider what is referenced in a document and the wider context in which the document is situated. Further discussion of the analytical approach adopted can be found in *Chapter 3: Research Design and Methods*.

## 6.2 Introduction

### 6.2.1 Selection of NHS overview reports

Audit Scotland first produced an annual overview report of the NHS in Scotland<sup>39</sup> in 2000 (Audit Scotland, 2000), covering the 1999/2000 financial year. These reports are significant for research purposes as they represent a major contribution from Audit Scotland to NHSScotland financial and performance management network.

Furthermore, the overview reports are the most public statements made about the external audits of NHSScotland bodies. The annual audit reports of individual NHS bodies are available on the Audit Scotland website once their annual accounts have been laid before Parliament<sup>40</sup>. However, they receive comparatively little public attention and in all likelihood are read by few people outwith the audited organisation.

By contrast, the publication of each overview report is accompanied by a press release, prompting national media coverage. The launch of the overview report is the main platform from which Audit Scotland can send a message to the Scottish Government, the Scottish Parliament, the NHS and to the public, about financial, governance and performance issues affecting the health service in that year.

These reports provide a snapshot view of the role of Audit Scotland as a national audit body in managing the performance of NHSScotland. By analysing these reports over the decade following the creation of the Scottish Parliament, it is possible to study the evolution of the identity of the national audit body within financial and performance networks in NHSScotland.

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<sup>39</sup> Hereinafter referred to as “overview reports”.

<sup>40</sup> Available at [http://www.audit-scotland.gov.uk/work/health\\_audit.php?year=2011](http://www.audit-scotland.gov.uk/work/health_audit.php?year=2011) (accessed on 4 September 2013)

### 6.2.2 Evolution of the overview report

The early reports (Audit Scotland, 2000; Audit Scotland, 2001; Audit Scotland, 2003a; relating to financial years 1999/2000 to 2001/02, inclusive) constitute a consolidation of the individual annual audit reports produced by the external auditors of NHS bodies and the national value for money audit reports<sup>41</sup> produced by Audit Scotland. The scope of the overview is expanded in 2000/01 to include the audit of the summarised annual accounts of the NHS and those of the Scottish Executive Health Department (Audit Scotland, 2001). The reports focus on financial statement production and audit issues, with frequent references made to the findings of local auditors.

Two overview reports are produced for the 2003/04 financial year: the conventional financial overview report (Audit Scotland, 2004b) is preceded by an overview report on broader NHS performance issues (Audit Scotland, 2004a). As well as being a first for Audit Scotland, this latter report is presented as the first consolidated performance report produced for the devolved NHS in Scotland.

“This... is the first report of its kind. It draws together different sources of published information which have never been brought together before.”

(Audit Scotland, 2004a:1).

Audit Scotland publishes an integrated report on financial and operational performance of the NHS for the 2004/05 financial year (Audit Scotland, 2005). In 2005/06, the Auditor General returns to producing a report focusing on financial performance (Audit Scotland, 2006), thus commencing a two-year cyclical pattern of alternate overview reports on the overall performance of the NHS and more detailed analysis of the financial performance.

A key feature which distinguishes public sector audit from its private sector counterpart is the ability to report collectively and authoritatively on a sector and to have access to detailed audit findings across a whole sector. This arguably strengthens the influence of a national audit body vis-a-vis the external auditors of private companies. The national audit body has unparalleled access to audit findings

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<sup>41</sup> Audit Scotland now refers to “performance audits”, rather than “value for money audits”.

which can provide an evidence base for the overview report; no single private sector firm would have access to the detailed audit findings of non-client companies. This unimpeded level of access to audit findings is a key enabler of the national audit body's evolution to trusted expert.

## **6.3 Report content**

### 6.3.1 Source data

The primary source of data underpinning early overview reports is “information contained in reports prepared by appointed auditors at the conclusion of their audits of individual Trusts and Health Boards” (Audit Scotland, 2000:11). The evidence base is firmly rooted in the external audit process for health bodies, providing a clear link back to the traditional statutory financial statements audit process. However, the Auditor General “supplemented this with other relevant, contextual information” (ibid). This includes national value for money studies carried out by the national audit body.

There are repeated references to the findings of the “appointed auditors” which remind the reader that the annual audit reports constitute the primary data source for the overview report. This reinforces the role of the Auditor General as the narrator of a summary report, drawing on individual, autonomous audit reports. It also makes clear that the overview report is anchored by the professional opinions of auditors working in the field.

While the annual audit reports produced by the appointed auditors of NHS boards continue to be the primary information source for the overview reports, they increasingly draw on published statistical information (Audit Scotland, 2007:3; Audit Scotland, 2009b:3) and specific “interviews with staff from the SGHD” (Audit Scotland, 2009b:3).

The overview report becomes more than a consolidation of the findings of statutory audits. It evolves into an independent and additional study, with an identity which is greater than the sum of its constituent audits.

The 2009/10 overview quotes external research or reports on NHS performance, by independent research institutes including the Nuffield Trust and the Centre for Public Policy for Regions, in order to support its arguments that information on activity, cost and quality requires improvement (Audit Scotland, 2010c:17). This is a shift away from the traditional reporting function of an auditor and associates the overview report with academic or other research work. The use of external references can also legitimate the views of the author organisation.

### 6.3.2 Narrative

#### *Style of narration: from first to third person*

The overview reports transition from first person narration, including a personal introduction from the Auditor General for Scotland, through the use of personal pronouns to universal use of third person narration.

The overview reports are a channel through which to broadcast the voice of the Auditor General for Scotland, both as an individual and, more importantly, as a statutory office-holder. Early overview reports are written in the first person and appear to convey the personal views of an independent expert.

*“I have prepared this overview of the main issues arising from the 1999/2000 NHS audits. My report also summarises the results of value for money studies undertaken during the year. The overview has been prepared under section 23 of the 2000 Act<sup>42</sup>, under which I may initiate examinations into the economy, efficiency and effectiveness with which prescribed public bodies have used their resources.”*

(Audit Scotland, 2000:1, emphasis added)

It is unlikely that the Auditor General personally wrote the reports but the actual scribe is less important than the appearance that the reports express his own views.

While there is no personalised introduction to the 2002/03 overview from the Auditor General, personal pronouns are used in the body of the report. For example, “my overview reports in 2000/01 and 2001/02...” (Audit Scotland, 2003b:19), “I have previously reported to Parliament...” (Audit Scotland, 2003b:25), “I will be

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<sup>42</sup> Public Finance and Accountability (Scotland) Act 2000, asp 1

expecting the auditors...” (Audit Scotland, 2003b:27). This marks the beginning of a transition in the narrative style of the overview reports which shifts to the third person in the overview report for 2002/03.

The 2003/04 overview reports (Audit Scotland, 2004a; 2004b) mark the formal transition in narrative style from first to third person narration – the voice of the Auditor General has been replaced by that of the omniscient narrator. From then on, the overview reports are almost universally narrated in the third person. Third person narration bestows an air of objectivity onto report findings, strengthening their standing as authoritative critiques of NHSScotland.

### *Passive voice*

The Auditor General and Audit Scotland are distanced from core NHS service delivery through the use of passive language, yet can still influence future action. Careful use of language is a subtle means by which to influence the wider NHS performance network.

The overview report uses passive language to comment on how some Trusts achieved their financial targets. For example:

“the practice of early payments should be discouraged”

(Audit Scotland, 2000:17)

“The [Scottish Executive Health] Department summarises the financial results of Health Boards and Trusts separately but there is considerable scope to reflect a more comprehensive picture of the NHS in Scotland’s overall financial performance.”

(Audit Scotland, 2000:19)

The Auditor General comments on how NHS bodies achieved their financial targets in 2002/03 by referring to “tools” identified by auditors which the bodies deployed to secure financial balance (Audit Scotland, 2003b:34-6). Although the Auditor General does not overtly pass judgement on these tools, passive language is again used to influence the reader’s views on the actions taken by the audited organisations.

“However, *the fact that* this re-routing of underspends was necessary at all, is indicative of the financial pressures which continue to face NHS bodies. *There is still a need* to identify and address underlying recurring deficits if financial balance is to be achieved in the foreseeable future...

“*It is important that* NHS bodies continue to review the way in which services are provided and to seek efficiency savings whenever possible. At the same time, the extent to which NHS bodies can continually make efficiency savings *is finite* without impacting on the quality of service provided. The auditors of several NHS bodies *have concerns* about their ability to deliver savings plans and thus, the viability of financial recovery plans.”

(Audit Scotland, 2003b:36, emphasis added)

The lack of a value judgement can also convey veiled criticism and create doubt in the mind of the reader. When it is reported that “the SEHD does not know precisely the implications of future cost pressures” (Audit Scotland, 2003b:6), the reader is not offered any reassurance that it is reasonable not to know the implications and so could conclude that SEHD should have done more to understand the implications of certain policy decisions.

The latter point is expanded upon in the discussion of the new contract for junior doctors, known as the ‘New Deal’. The reader is told that “SEHD does not know the cost of implementation of New Deal or how many additional junior doctors have been recruited as a result” (Audit Scotland, 2003b:37) before the Auditor General estimates the number of additional junior doctors required and the cost of employing them (*ibid.*). By using a relatively simple set of assumptions to generate an approximate calculation, the Auditor General immediately undermines the Department’s failure to quantify the impact of the New Deal.

The use of passive language can thus undermine NHS organisations or central government, without the national audit body levelling a direct criticism of actions which they have taken, or failed to take.

### 6.3.3 Areas of emphasis

#### *Financial accounting*

The early reports consider financial statement production and audit process issues in depth. Some examples from the 1999/2000 and 2000/01 overview reports are highlighted in Table 6.1 below. These issues are the traditional domain of financial statements audit in both the private and public sectors, reinforcing the image of early overview reports as consolidated summaries of the findings of the external audits of NHS bodies.

*Table 6.1: Examples of financial statement production and audit process issues highlighted in Audit Scotland overview reports in 1999/2000 and 2000/01*

- Preparation of draft accounts in line with audit timetable and the quality of those draft accounts
- Adjustments made to draft financial statements during the audit process
- Adherence to the timetable for the submission of audited financial statements set by the Scottish Executive Health Department
- Asset registers
- Accounting for assets procured via the Private Finance Initiative (PFI), specifically a change in technical standards impacting treatment of the new Royal Infirmary of Edinburgh under construction at the time of the report

*Sources: Audit Scotland (2000:12,24,32); (2001:8)*

The next detailed consideration of technical accounting issues comes in the 2008/09 overview report (Audit Scotland, 2009b:19-21); this is surprising as this report is characterised by a broader financial commentary on the NHS rather than an overview of ‘audit’ findings<sup>43</sup>. The report contains a section on accruals, provisions and contingent liabilities. Each concept is defined in the report and an example presented of each. Although there are no explicit recommendations emanating from this

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<sup>43</sup> See section 6.8.3 below

section, the definitions and examples are presented in such a way as to invite the reader to question the treatment adopted by NHS bodies.

“Auditors reported that by the end of March 2009, most NHS bodies had transferred nearly all relevant staff to Agenda for Change. Some NHS boards, however, set aside considerable amounts in their 2008/09 accounts to pay for staff who may be entitled to additional pay. NHS Greater Glasgow and Clyde included nearly £40 million in provisions and accruals, NHS Lothian nearly £25 million and NHS Tayside £14 million.”

(Audit Scotland, 2009b:19)

Apparently objective and passive language is again harnessed to implicitly question the treatment adopted by NHS bodies. The overview report suggests that accrued pay modernisation costs could not be fully substantiated. Management appear to have exercised their judgement on the level of accrual within reasonable constraints; otherwise the auditors could not have issued an unqualified opinion on the financial statements. The national audit body faces a tension between its formal role in verifying the truth and fairness of the financial statements, and its own opinions on the judgements assumed by NHS organisations in complying with principles-based technical accounting standards.

The introduction of International Financial Reporting Standards from 1 April 2009 represented a significant change in the financial reporting framework for NHS bodies. The 2009/10 overview report gives this issue very little coverage. It does not offer an explanation of its substantive effect, but notes that “on the whole, NHS bodies managed this well” (Audit Scotland, 2010c:6). The lack of comment may indicate that extensive technical accounting changes are now considered relatively insignificant by the national audit body, compared to broader performance issues.

#### *Financial control*

The 1999/2000 overview report (Audit Scotland, 2000) makes explicit reference to financial control issues. The Auditor General provides an explanation of the evaluation of the internal financial control (‘IFC’) statement which the Health Department requires directors of health bodies to sign annually. The role of the auditor in relation to these statements is explained thus:

“Health Board and Trust auditors are required to review the IFC statement and provide an opinion which takes the form of a ‘negative assurance’. Provided weaknesses in internal control are disclosed appropriately in the IFC statement and the statement is not inconsistent with the information arising from the audit, appointed auditors are able to provide an unqualified opinion on the IFC statement.”

(Audit Scotland, 2000:23)

Auditors do not provide positive assurance that the organisation has effective control systems in place; a clean audit opinion may mean only that the organisation has itself identified and disclosed weaknesses in internal financial controls. These weaknesses could be fundamental in nature but still the auditors would issue a ‘clean’ audit opinion, as was the case with Tayside University Hospitals Trust in 2000/01 (Audit Scotland, 2001:10). The 1999/2000 overview reports that there were no qualifications on IFC statements that year, but “across the 50 NHS bodies, additional disclosures [of internal control weaknesses] were made in most cases” (Audit Scotland, 2000:23-4). A clean bill of audit health is not equivalent in this case to a clean bill of health for the internal control system. This echoes the finding of Bowerman (1995) that audit may present an impression of assurance which exceeds its technical value. It also highlights a key characteristic of Power’s audit society whereby the quality of systems outranks underlying substantive performance (Power, 1999:84).

The opinion likewise does not guarantee that the audit process has identified all weaknesses; it is not clear if weaknesses highlighted in the IFC were identified by the organisations themselves, or came to light through the audit process. This illustrates that audit attention can be displaced from actual performance (Power, 1999). Indeed, this approach may be symptomatic of a ‘tick box’ mentality; organisations need only report that a weakness exists, they do not need to address it.

The IFC was replaced by the Statement on Internal Control (SIC) in 2001/02. The SIC is wider in scope than the IFC which was solely concerned with financial control; the latter statement also considers operational and compliance controls and risk management. There was no change to the form of audit assurance provided in the transition from IFC to SIC.

Auditors did not qualify any of the SICs included in the 2001/02 financial statements of NHS bodies, but the overview report reproduces the most common weaknesses in the implementation and effectiveness of internal control systems disclosed by management, along with a short explanation of the relevance and operational consequence of the disclosed weakness (Audit Scotland, 2003a:17). The names of individual health bodies making these disclosures are not reported; the overview report prioritises the reporting of general issues at national level over weaknesses within individual organisations. This is an early indication that the focus of the overview reports is shifting away from a consolidated summary of individual audit findings.

#### *Value for money reviews*

The early overview reports adopt the same reporting approach for value for money auditing as to the traditional financial statements audit; they summarise the findings of each report produced during the year (Audit Scotland, 2000:34-40; Audit Scotland, 2001:32-37).

A more subtle approach to the reporting of value for money studies is adopted in the 2002/03 overview report (Audit Scotland, 2003b), which weaves references to performance audit studies into the main sections of the report. For example, the Auditor General identifies GP prescribing costs as a major cost pressure for NHSScotland and links this to a performance audit of primary care prescribing (Audit Scotland, 2003b:38). Later reports continue to integrate coverage of value for money and performance audit reviews into the main body of the overview report

This approach embeds performance audit work in the mainstream of NHSScotland financial performance, highlighting its relevance to the NHS. It provides a further opportunity to remind the reader that the work of the Auditor General and Audit Scotland is influencing action taken by central government.

The discussion of performance audit findings in the overview reports highlights the interrelationship between two key elements of Audit Scotland's NHS work programme. They can become mutually reinforcing: the performance audit

programme provides support for findings in the overview report, but may also be the driver of the issues included in the overview report.

### *Clinical and medical negligence*

Early overview reports devote significant attention to clinical and medical negligence provisions. These receive four pages of coverage in the 40-page 1999/2000 overview report, a further four pages in the 41-page 2000/01 overview and five pages in the 66-page 2001/02 overview, despite there being no reported weaknesses in control or evidence of disagreement between auditor and auditee over accounting treatment.

While payments made to settle negligence claims are purported to divert NHS resources away from frontline patient services (Audit Scotland, 2002:29), the level of annual expenditure by the NHS on such claims is relatively low<sup>44</sup> compared to other costs which are not singled out for consideration in the overview reports.

Continued coverage in the overview reports gives greater prominence to accounting for clinical negligence than other categories of cost, which could also be argued to divert resources away from frontline patient care, such as depreciation and other property charges. The Auditor General and Audit Scotland can direct the public debate on NHS finance by selecting the key financial issues for inclusion in a report which would be reviewed in the media and by Parliament.

In doing so, the Auditor General also places himself at the centre of the public discussion on how to address these issues.

“Following its consideration of the Auditor General’s 1999/2000 overview report, the Scottish Parliament’s Audit Committee recommended that the [Scottish Executive Health] Department reassess the basis on which health bodies reflect negligence claims in their accounts. The Auditor General’s 2000/01 overview report noted that, after consultation with Audit Scotland, a review was underway.”

(Audit Scotland, 2003a:30)

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<sup>44</sup> Exhibit 8 at page 27 of the 2001/02 overview report reveals that the value of clinical negligence claims arising in the financial year was £15.4m which represents less than 0.5% of NHS expenditure in Scotland.

The selection of clinical and medical negligence claims for attention in a financial overview report also highlights the potential inter-relationships between financial management and clinical practice, traditionally beyond the direct control of management. Clinical practice has been rendered auditable (Power, 1996; 1999), or at least within the scope of interest of the national audit body.

The continuing creep of controls methodology into healthcare is evident in the advice which the Auditor General provides to the NHS to minimise clinical negligence claims:

“It is important that trusts and health boards act promptly to put in place the risk management standards envisaged under CNORIS<sup>45</sup>”.

(Audit Scotland, 2003a:29)

The language and methodology of internal control systems grant auditors access to the clinical domain. This is similar to the experiences reported in other professional domains, including criminal justice (Jones, 1993) and social work (Munro, 2004).

Although the definition of clinical negligence provided in the overview report makes explicit the underlying duty of care on the part of health care practitioners in the delivery of health services (Audit Scotland, 2003a:25), there is no discussion in the report of the relationship between high quality patient care and the level of negligence claims.

Clinical negligence is constructed by the auditor as a problem of financial management and operational control; no consideration is given to the role of clinical leadership or continuing professional training. Clinical quality has been transformed into a management problem to be solved through the application of managerial tools, in this case risk management controls.

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<sup>45</sup> The Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) was introduced by the Scottish Executive Health Department in 2000 as a mechanism to pool the financial risks borne by NHSScotland in relation to clinical negligence and to embed risk management standards to reduce the incidence of negligence in the delivery of patient care.

#### 6.3.4 Life through a financial lens

The overview reports consider predominantly substantive operational issues through a financial lens. This reflects the traditional focus of the national audit body on financial issues, but also illustrates that the auditor imposes a financial frame of reference on operational issues.

For example, the discussion of the European Working Time Regulations in the 1999/2000 overview report (Audit Scotland, 2000:31-2) centres on how NHS bodies should calculate financial provisions to recognise the potential liability arising from failure to implement the regulations in full when they came into force in October 1998. It does not discuss the practical challenge to comply with requirements for rest periods, annual holidays, night working and weekly hours worked.

This contrasts with the focus of later overview reports on operational performance.

#### *Clinical governance*

The overview reports refer to clinical governance (Audit Scotland, 2005:39), which at the time was overseen by NHS Quality Improvement Scotland (NHS QIS), a special health board. Audit Scotland did not have any specific responsibilities in this area. The overview report reproduces the findings of the clinical governance assessments undertaken by NHS QIS (Audit Scotland, 2007:22-3) and so Audit Scotland can position itself as the only body presenting a comprehensive report on the performance of NHSScotland.

The 2006/07 overview report reproduces the scores awarded to each Board by NHS QIS in the first round of assessments against its clinical governance and risk management standards (Audit Scotland, 2007:24). National clinical governance assessments score NHS Boards across a four-point range against three Standards. The scores awarded for each Standard are aggregated to calculate an overall score for the Board out of a total of 12. The overview report reproduces the individual scores for each Standard and the total score achieved by each territorial and special NHS Board.

The public can now effectively rank Boards against one another in terms of their provision of “safe and effective care and services (e.g. risk management)”, “the health wellbeing and care experience (e.g. access, referral, treatment and discharge)” and “assurance and accountability (e.g. clinical governance and external communication)” (Audit Scotland, 2007:22). The new arrangements for assuring clinical governance and risk management have gone where the performance management system for NHSScotland did not – they distil each organisation’s performance into a single score awarded by an independent body.

Audit Scotland links the results of the NHS QIS assessments to its own audit work:

“NHS Western Isles and NHS Orkney were the poorest performing boards. This is confirmed by auditors’ annual reports for these boards, which also identified the need for significant improvements to clinical governance and risk management, and corporate governance.”

(Audit Scotland, 2007:23)

The findings of the NHS QIS assessments are triangulated with external audit findings in order to consolidate the legitimacy of each assessment process. The organisations’ own assessments are not published. Each assurance or assessment process is made credible by association as they reach similar conclusions.

#### 6.3.5 Summary

This analysis of the content of annual NHS overview reports shows that the initial focus of the reports was on financial accounting and control, which are traditional audit concerns. The national audit body could emphasise particular issues by referring to them in the overview report. The transition from first to third person narration created an air of objectivity which could give greater weight to audit pronouncements, while use of passive language enables the national audit body to undermine statements made by central government and NHS bodies.

## 6.4 Auditor as expert

The overview reports contain much evidence of the national audit body promoting its own expertise across a range of disciplines, expanding beyond financial management.

### 6.4.1 Nature of audit assurance

The discussion of the “negative assurance” provided by the auditor’s opinion on the IFC, and later SIC, at Section 6.3.3 above, introduces the potential for ambiguity in the nature of assurance provided by the audit process.

From 2000/01, auditors of Scottish public bodies were required to provide an opinion on the regularity of transactions entered into by the audited organisation<sup>46</sup>. This ‘regularity opinion’ is in addition to the ‘true and fair’ opinion traditionally provided by external auditors on annual financial statements. It requires the auditor to consider whether transactions entered into by the auditee organisation are in accordance with legislation and guidance issued by the Scottish Ministers.

There followed repeated qualified ‘regularity opinions’, as auditors could not obtain appropriate evidence to support payments made to primary care contractors.

“... not all aspects of [a post-payment verification] framework were in place during 2001/02. In the absence of such a framework, there were no satisfactory audit procedures which the appointed auditors could adopt to form an opinion as to whether the associated expenditure and income was incurred in accordance with relevant enactments and guidance.”

(Audit Scotland, 2003a:13)

The auditor struggles to apply technical audit procedures in the absence of a robust internal control system of which it can test the design, operation and implementation. The regularity audit exists as a second order control system (Power, 1999:82-4) which falls into crisis when there is no control system to audit. Audit could not function without the prior existence of an internal control system and there is no indication that alternative substantive audit procedures have been attempted or even considered.

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<sup>46</sup> Section 22 of the Public Finance and Accountability (Scotland) Act 2000

In some circumstances, the level of assurance provided by the audit review can at best be considered qualified. For example:

“Auditors reported that the new [structural] arrangements *appear to have contributed to* enhanced budgetary control and financial monitoring.”

(Audit Scotland, 2003a:14, emphasis added)

The auditors are only comfortable suggesting a causal link; they do not have sufficient evidence to substantiate the claim so couch findings in cautious language. This has the dual effect of giving an assertion credence by attaching the auditors’ views to it while the auditors distance themselves from making the assertion with absolute certainty.

#### 6.4.2 Expert on financial management

In early overview reports, there is a reluctance to offer judgement on financial management decisions. Instead, the auditor provides a factual account of actions taken by NHS organisations.

For example, the 1999/2000 overview report (Audit Scotland, 2000) includes a short section on ‘Year 2000 compliance’, also known as the much feared ‘millennium bug’ which was expected to impact upon computer systems and items of equipment at the moment the date changed from 31 December 1999 to 1 January 2000. Audit Scotland reports that “the NHS in Scotland had prepared for the event and invested some £43 million in ensuring that its services were not disrupted” (Audit Scotland, 2000:27) and that this “investment in service continuity planning, system testing and system upgrades undertaken to counter the Millennium Bug ensured that its healthcare services were fully maintained at the required level and no patient was exposed to risk” (ibid.). The auditor stops short of providing an opinion as to whether this significant investment represented value for money for the NHS. The auditor presented a factual account and left it to the reader to evaluate the effectiveness or otherwise of the investment.

As the overview report develops, it increasingly makes claims that Audit Scotland is active in solving financial management problems highlighted by the audit process, such as shaping the terms of a review of accounting treatment applied to clinical and

medical negligence claims (Audit Scotland, 2001:22). The national audit body signals a shift in its role from the identifier of control and financial weaknesses to problem-solver, capable of designing solutions to remedy those weaknesses.

The report ultimately shies away from asserting that audit findings directly contribute to policy changes, despite earlier emphasising the auditor's contribution to the review.

“Ultimately, of course, this is a policy matter for NHSScotland. Auditors will assess the effect of changes to accounting provisions.”

(ibid.)

The overview report is also used to position Audit Scotland and appointed external auditors as superior to other sources of assurance or expertise. The 1999/2000 report asserts the relative superiority of appointed auditors over internal auditors by undermining the latter's work.

“In a small number of cases, appointed auditors considered that there was a need for Trusts to review their internal audit strategy to ensure that the main financial systems... are receiving adequate coverage.”

(Audit Scotland, 2000: 24)

The overview reports similarly highlight instances where auditee organisations have invited the auditor to perform additional reviews to support management.

“[At] the request of the chief executive of Fife NHS Board, the appointed auditor reviewed financial monitoring and the recovery planning process within the NHS Fife system. The auditor also commented on specific aspects of corporate governance in the NHS Fife system associated with its financial management.”

(Audit Scotland, 2003b:30)

The Auditor General goes on to report that “NHS Fife has welcomed the auditor's report” (Audit Scotland, 2003b:45), harnessing an independent viewpoint to add weight to the assertion that the auditor can provide valuable expert advice to the NHS.

The overview report also highlights instances where the Scottish Executive invites Audit Scotland to undertake specific pieces of work or assume a particular role, such

as inviting the national audit body to comment on guidance notes on reporting efficiency savings (Audit Scotland, 2005:32-33).

As discussed at Section 6.3.2 above, the overview reports use passive language to highlight organisational deficiencies. This can also serve to promote the expertise of the national audit body. The 2006/07 overview report notes that external auditors “would have expected” NHS boards to have sufficient information to estimate the potential financial liability arising from equal pay claims and so had “encouraged each board to work with the Scottish Government to resolve the matter” (Audit Scotland, 2007:30).

By the following year, NHS boards were still not able to quantify the potential liability. Audit Scotland mobilises the experience in local government to level indirect criticism at the NHS in Scotland, noting that local authorities “have been more successful in estimating the potential value of equal pay claims” (Audit Scotland, 2008:14).

These examples show different ways in which the national audit body promoted its own expertise on financial control and management issues: by leading examples of other bodies requesting advice from Audit Scotland, and by undermining competing sources of expertise.

#### 6.4.3 Expert on future financial outlook: organisational level

By including future performance within the scope of audit reports, the national audit body signals a departure from the traditional retrospective function of audit and lays claim to more extensive expertise on assessing financial performance than the ability to verify reports of historic performance. This interest is initially focused at organisational level but later manifests itself as a growing interest in the overall financial environment in which the NHS operates. This is discussed at Section 6.8.3 below.

The Auditor General presents three case studies of high risk organisations in the 2001/02 and 2002/03 overview reports (Audit Scotland, 2003a:46-53). Each case study provides a factual account of the financial challenges facing each organisation,

details of action taken by each organisation to address these challenges and the auditor's assessment of the risks and organisational response. He returns to these organisations in the 2002/03 overview report to provide an update on actions which the organisations have taken to secure financial balance in the past year.

The overview report relates the concerns of the external auditor of one such Trust that "the financial plan may not be deliverable, and therefore, the potential deficit may exceed the levels projected" (Audit Scotland, 2003a:47-8). The subsequent report notes similar reservations about the Trust's ability to deliver financial balance: "the implementation of components of LUHT's financial plan represent a significant management challenge" (Audit Scotland, 2003b:42). The reports do not elaborate on the risks informing this assessment, or the likelihood or severity of those risks. Nevertheless, there is a clear message that the external auditor is concerned about the future financial performance of the Trust.

The LUHT case study shows how the overview report can elevate the professional judgement of the auditor above the judgement of management of the audited organisation by highlighting risks underlying management actions.

The second case study, on Argyll and Clyde Acute Hospitals NHS Trust, highlights five risks which the external auditor believes could threaten delivery of the Trust's financial recovery plan (Audit Scotland, 2003a:49). However, the report also states that the Minister for Health and Community Care appointed an expert support group to assist the Board in addressing the financial weaknesses in September, some months after the annual audit process concluded and the auditor identified the aforementioned risks. The overview report confirms that this support group has now reported its findings, the chief executives of the Board and local Trusts have resigned, and an interim management team has been appointed by Ministers (Audit Scotland, 2003a:50-1). By reporting the original auditor's assessment alongside the subsequent action taken by central government to intervene in the financial management of the Trust, the overview report legitimates the concerns expressed by the appointed auditor.

However, the risks identified by Audit Scotland do not always materialise. NHS Western Isles failed to meet financial targets to deliver in-year balance for a number of years and the 2006/07 overview report relayed the appointed auditor's view that management may not be able to deliver an improvement in position in the following financial year, as set out in the Board's financial plan (Audit Scotland, 2007:27). In the event, the risk identified by the auditor did not materialise: "...for the first time in five years, [NHS Western Isles] generated an in-year surplus [in 2007/08] to set against its cumulative deficit" (Audit Scotland, 2008:6).

#### 6.4.4 Expert on the production of data

Audit Scotland positions itself as an actor in the development of data modelling exercises, rather than a neutral ex post observer or verifier of the data produced.

"Audit Scotland is currently carrying out a joint project with ISD<sup>47</sup> to model the whole system for delayed discharges in Tayside."

(Audit Scotland, 2004a:43)

Audit Scotland is thus established as a key actor in the production of performance data, and in the wider NHS performance network.

In the same way as Audit Scotland sought to undermine the failure of the NHS to estimate the cost of the New Deal for junior doctors<sup>48</sup> or to quantify the potential liability arising from equal pay claims<sup>49</sup>, the overview report seeks to undermine published national data on the number of attendances at outpatient clinics by presenting its own competing evidence.

"According to national data, there were nearly 4.7 million attendances at outpatient clinics in 2002/03... But a recent census carried out by Audit Scotland indicates that the real scale of activity is significantly greater with more than ten million attendances."

(Audit Scotland, 2004a:30)

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<sup>47</sup> Information Services Division of NHSScotland

<sup>48</sup> See Section 6.3.2

<sup>49</sup> See Section 6.4.2

This is an example of the national audit body implicitly inviting the public to place their trust in them as the guardians of accurate data on the performance of the health service.

#### 6.4.5 Directing parliamentary scrutiny

The 1999/2000 overview report (Audit Scotland, 2000) summarises an in-depth value for money review of the Scottish Ambulance Service, published by the National Audit Office in December 1999<sup>50</sup>. It explains how the Scottish Parliament Audit Committee responded to publication of the report, holding its own examination of the performance of the Scottish Ambulance Service, which included taking evidence from key individuals within the service and the Health Department (Audit Scotland, 2000:35). The report also outlines the Health Department's response to the findings of the Audit Committee, setting out specific actions taken including additional financial investment (Audit Scotland, 2000:35-6). The subsequent overview report (Audit Scotland, 2001:37) offers a further update on actions taken by the Department in response to the original value for money review.

This extended analysis demonstrates the influence which the initial value for money study exerted on the Scottish Parliament and the Scottish Executive. It sets out a clear causal link between audit findings, scrutiny exercised by Parliament and actions taken by the Executive.

Coverage of the financial difficulties experienced by the NHS in Tayside in the overview reports reinforces this link between audit reports, Parliamentary scrutiny and Executive actions.

“On the basis of the Auditor General's report, the Scottish Parliament's Audit Committee considered the management and use of resources by the NHS in Tayside.”

(Audit Scotland, 2001:30)

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<sup>50</sup> Published online at [http://www.nao.org.uk/publications/9900/the\\_scottish\\_ambulance\\_service.aspx](http://www.nao.org.uk/publications/9900/the_scottish_ambulance_service.aspx) (accessed on 31 August 2013)

The auditor's report was a trigger for parliamentary scrutiny, in line with the constitutional role of the national audit body in supporting the discharge of democratic accountability (Hollingsworth et al, 1998).

The overview report quotes the conclusions of the Parliament Audit Committee, which include criticism of the financial monitoring and accountability procedures of the Scottish Executive Health Department (SEHD).

“The Audit Committee concluded that... [SEHD] failed to ensure that fundamental performance and management issues were addressed. Annual accountability reviews failed to address financial issues adequately and there is a need for more robust systems for monitoring financial performance of NHS bodies.”

(Audit Scotland, 2001:30)

The overview report also allows the national audit body to indirectly criticise the Department by quoting the findings of another scrutiny function, in this case the Audit Committee of the Scottish Parliament. This places the Auditor General at some distance from criticism of policy issues.

The Department responds to the weaknesses uncovered in Tayside by reviewing national procedures. The Auditor General notes that the Department subsequently introduced:

“a new Performance Assessment Framework from October 2001 for the new NHS boards which is intended to provide a broader picture of operational performance over time and which will be used as the basis for the annual accountability review meetings with the Department.”

(Audit Scotland, 2001:31)

The national audit body portrays itself as influencing performance management by uncovering financial issues which are symptomatic of broader organisational weaknesses. Furthermore, a link is established between the work of the national audit body and the creation of the Performance Assessment Framework.

#### 6.4.6 Trusted source of reference

The 2001/02 overview report (Audit Scotland, 2003a) considers the implementation of structural reforms<sup>51</sup> to NHSScotland introduced by *Our National Health: a plan for action, a plan for change* (Scottish Executive, 2000) and associated changes to governance and accountability regimes. In the course of auditing the 2001/02 financial statements of NHS bodies, external auditors reviewed the operation of the newly created unified Boards against the specifications set by the SEHD. The Auditor General reports the broad findings of these reviews, but also identifies where the arrangements introduced by the Department need to be clarified or strengthened (Audit Scotland, 2003a: 43).

The SEHD had announced changes in the financial framework to the NHS in the usual way via an official circular<sup>52</sup>, but the discussion in the overview report is likely to have been the most public communication of these changes. The circular was written in technical language and addressed to a professional readership, whereas the overview report seeks to translate this into language accessible to a non-expert in public finance.

Audit Scotland has established the overview report as the main conduit for reporting to the public on fundamental changes in the financial management of NHSScotland. The auditor, not the NHS, is the main source of public information on these changes, potentially giving the public the impression that they should look to the auditor for authoritative information with regard to financial management of the NHS.

The 2002/03 overview report (Audit Scotland, 2003b) heralds the advent of the transformation of the overview report. Rather than merely consolidating the findings of external audit activity across the NHS at this point, the overview report begins to comment upon the wider operation of NHS, providing a long background section on how the NHS is organised and the impact of ongoing reforms, including the dissolution of Trusts. Furthermore, a short description of the work of each special

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<sup>51</sup> The most significant change was the creation of unified NHS boards, streamlining the previous board structures within NHS boards and trusts – see also Section 5.3.

<sup>52</sup> SEHD HDL 2002(9), March 2002

health board and national organisation is provided in an appendix to the 2002/03 overview. This consolidates the emerging impression of Audit Scotland and the overview report as authoritative sources of information on the operation of the NHS in Scotland.

The individual financial results of NHS areas in 2003/04 are published as an appendix to the financial overview report (Audit Scotland, 2004b). There is no easily accessible summary of financial performance of local bodies published by the Scottish Executive and so Audit Scotland has to discharge this key plank of accountability on the Executive's behalf in order that the public understand the financial results of the NHS.

## **6.5 Directing action**

The overview reports show how the national audit body attempted to direct action within NHSScotland in the years following devolution.

### 6.5.1 Identifying action and highlighting inaction

Early overview reports identify future actions or changes to improve, for example, the financial statement production process (Audit Scotland, 2000:13) although these are not explicitly presented as 'recommendations'. These actions are directed not only at individual NHS organisations but also at the SEHD and national agencies which provide information to support production of the financial statements.

The overview report also uses emotive language to express a judgement on the lack of action taken by audited organisations to remedy known weaknesses.

“However, while the overall number of disclosures [of weaknesses in internal financial control statements] in 2000/01 has reduced substantially, *it is disappointing* that a number of cases were identified where action has yet to be taken to address control weaknesses first disclosed in 1999/2000.”

(Audit Scotland, 2001:10, emphasis added)

The overview reports are further used by the national audit body to express frustration at instances when audited organisations have not taken action to remedy control weaknesses identified in prior reports.

As highlighted above at Section 6.3.3, NHS bodies were required to disclose control weaknesses in the IFC, and later the SIC, but were not penalised for the existence of the weaknesses. Audit Scotland seeks to provide an additional sanction by threatening to report on bodies which fail to remedy control weaknesses in future overview reports (Audit Scotland, 2002:16). The auditor appears to believe that repeated emphasis of an organisational weakness in a national audit report is a more effective threat to incentivise remedial action than the continuing requirement to report the weakness in the annual SIC. This could stem from a perception that the overview report is more widely read and thus a more prominent publication than the organisation's own annual accounts which contain the SIC.

These early examples demonstrate that the national audit body lacked the influence to compel action in the early years of its existence, supporting the proposition that it fulfilled a traditional external audit function in the years immediately following devolution. This may be related to a lack of sanctions which could be exercised to compel action.

While the 2002/03 overview report (Audit Scotland, 2003b:2-7) still falls short of making explicit recommendations for improvement to the Scottish Executive or NHS bodies in general, the summary at the beginning of the report highlights key messages in text boxes. As in previous reports Audit Scotland adopts passive language but examination of the content of these text boxes reveals that the national audit body is using these to make the case for a specific change or to suggest how the Department or NHS bodies should focus efforts in the coming year. For example, phrases such as "it is important that..." are used to emphasise certain activities or objectives. By noting that "further improvements are... necessary if auditors are to avoid qualifying their [regularity] opinion", Audit Scotland effectively recommends that remedial actions are taken. Similarly, by reporting that "there is still a need to identify and address underlying recurring deficits", Audit Scotland calls for action to be taken to improve the long term financial sustainability of NHS organisations.

The 2003/04 performance and financial overview reports identify ‘key messages’ in the summary of the report findings and at the beginning of each section of the report. While these are principally factual in nature, reporting on actual events or activities, they again convey to the NHS, Scottish Executive and others that the auditor has identified scope for improvement in NHS financial management or wider performance.

“The SEHD *will need to* demonstrate in future that services are improving and that the NHS in Scotland is achieving value for money from the investment in pay modernisation. The SEHD *needs to* set clear objectives for each of the new contracts and specify how they will measure performance against the objectives. For example, the SEHD should make it clear whether it expects to see an increase in activity or better outcomes.”

(Audit Scotland, 2004a:4, emphasis added)

The practice of highlighting inaction on the part of the NHS continues in the overview reports, even after specific recommendations have been introduced. For example, the 2007/08 overview report (Audit Scotland, 2008:20-1) highlights that there has been no formal evaluation of the introduction of Community Health Partnerships, a new forum for planning and delivering health and social care services at local level. It then goes on to state that the Scottish Government had recently announced a review of the operation of CHP. By leading with a criticism, then acknowledging the action underway, albeit delayed, the auditor can undermine the auditee. However, it may also reflect the ex post nature of the audit process – by the time the finding was reported in the overview report, action had already been taken.

### 6.5.2 Recommendations

Audit Scotland begins to make specific recommendations to the Scottish Government Health Directorates<sup>53</sup> (SGHD) and to NHS organisations in the 2006/07 integrated overview report (Audit Scotland, 2007). These recommendations are separately identified at the end of each section and consolidated in the executive summary. The inclusion of specific, direct actions now makes the auditor’s views on weaknesses in NHS systems and processes overt to the reader.

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<sup>53</sup> Formerly the Scottish Executive Health Department

The overview reports show how Audit Scotland seeks to bolster its legitimacy in the NHSScotland performance network by taking credit for actions taken by the NHS to implement recommendations made in previous audit reports. The overview reports provide Audit Scotland with an opportunity to promote the effectiveness of prior audit recommendations and lead evidence that audit work has directed executive action, thereby reinforcing its own influence. Furthermore, reporting on the implementation of previous audit recommendations legitimates the original recommendations; if a recommendation is subsequently adopted then that recommendation must have been appropriate.

Action taken by health bodies and the SEHD or SGHD in later years is often related back to earlier audit recommendations, originating either in the annual audit reports of individual organisations or in the overview reports. For example:

“In a number of cases, auditors reported significant improvements in the preparation of accounts, often following the implementation of recommendations arising from the 2000/01 audits. This resulted in a more effective and efficient audit and is to be encouraged.”

(Audit Scotland, 2003a:12)

“Audit Scotland published a review of the management of waiting lists in Scotland in June 2002. Our main recommendations were that all patients waiting for services should be entered on to a common waiting list and waiting times on the deferred list should be monitored routinely. In November 2002, following a Scottish Executive action plan, the Minister for Health and Community Care announced that a single list system would come into force on 1 April 2003.”

(Audit Scotland, 2004a:32)

“Our 2003/04 financial overview report highlighted that the current format of annual accounts does not disclose some important information about the funding of services, such as the use of non-recurring funding or savings to achieve financial targets. The SEHD has recently updated its monthly monitoring returns for NHS bodies to include non-recurring funding and their use.”

(Audit Scotland, 2005:36)

“The 2007 Audit Scotland follow-up report on ward nursing emphasised the need to review the appropriate use of bank nurses. The Scottish Government recently wrote to chief executives setting out the improvements needed to meet the recommendations included in the Audit Scotland report...”

(Audit Scotland, 2007:21)

“There is limited evidence of any large-scale transfer of resources, including money and staff, from secondary to primary care. We have previously reported there was no evidence of a change in the balance of health expenditure to match the move towards more community-based care.”

(Audit Scotland, 2009b:14)

By adopting the presentation that “we said... then this happened”, the national audit body creates the impression that the audit process was the main driver of the subsequent action / improvement.

### 6.5.3 Audit “failure”

The preceding section shows that the national audit body can be quick to infer its own success from implementation of prior recommendations or findings by audited organisations.

The absence of any reference to the external audit process in the following case study from the 2005/06 overview report is equally noteworthy, and provides an insight into the apparent immunity of audit from direct criticism (Power, 2000:114; 2003a:194).

“NHS Lothian’s five-year financial plan and monthly reporting continually forecast that the board would achieve a balanced financial position in 2005/06. The board discovered, late in 2005/06, that Family Health Services (FHS) income had been incorrectly identified and disclosed in 2004/05. This meant that the £19.6 million cumulative surplus brought forward from 2004/05 was reduced by £10 million. NHS Lothian brought this to the attention of the SEHD which agreed that the board could retain this additional RRL.”

(Audit Scotland, 2006:18)

Unlike other examples of audit ‘success’ which litter the overview reports, there are no references to the auditor in this part of the case study and the NHS organisation is the principal actor.

It is implicit in the case study that the auditor issued a clean audit opinion on financial statements in 2004/05 which double-counted income of £10 million, and thus failed to identify a weakness which was later identified by management. While this sum represents only 1% of the overall revenue resource limit in 2004/05 and so may not be considered fundamental in a technical accounting sense, it does have the potential to undermine confidence in the external audit process and level of assurance which it provides.

The remainder of the case study, by contrast, highlights the role of the auditor in identifying errors in the draft financial statements and weaknesses in financial control systems.

“The auditor queried the nature of these transactions and NHS Lothian reversed the accounting treatment for both items...”

“The auditor reported that the nature and value of the changes between reported positions and final financial statements this year, and in previous years, introduces a level of unnecessary volatility and risk into NHS Lothian’s overall financial position. The auditor has recommended that NHS Lothian review its financial recording processes, particularly at the acute operating division.”

“The auditor’s work on systems and controls found important areas where basic internal controls were, in the auditor’s view, absent or not operating as intended...”

“The auditor also encountered a number of other problems during the audit, which stemmed from the board’s failure to address previously reported limitations in operational systems.”

(Audit Scotland, 2006:18)

The value of the transactions referred to in the first quote above was £5.7 million, compared to the £10 million mis-statement of FHS income in the prior year financial statements.

This case study illustrates how selective reporting of the role of the auditor can influence the appearance of the success of audit. The overview report tends to highlight audit successes, while remaining silent on issues which the audit process failed to identify. The primary function of the national audit body is to scrutinise the financial statements and financial management of public sector organisations,

including NHS organisations. However, the performance of the auditor is not subject to equivalent scrutiny (Power, 2000:114). Coupled with the systematic tendency to trust audit (Power, 1999:36-7), this creates an environment in which there is little opportunity for audit ‘failures’ to be made public.

## **6.6 Financial performance**

The changing definition of NHS ‘financial performance’ adopted by the audit process can be traced through the overview reports. Financial performance is initially defined in terms of achievement of statutory financial targets, but eventually also incorporates how those targets are achieved and broader measures of performance, including those introduced into the performance network by Audit Scotland.

### 6.6.1 Achievement of statutory financial targets

Early overview reports provide an objective account of the financial performance of NHS bodies, defined as the achievement of statutory financial targets. These reports state the number of Trusts which achieved the three annual financial targets set by the SEHD. Reported performance against targets provides an objective evidence base upon which the auditor can make comment on the general financial health of the NHS in Scotland.

The 1999/2000 overview (Audit Scotland, 2000:13-19) explains the practical significance of the financial targets, helping a lay audience to understand the purpose of these targets but also positioning the national audit body as gatekeeper to public understanding of NHS finances (see Section 6.4.6). However, the report also explained the reasons why targets were not achieved by some Trusts and identified potential threats to achievement of targets in future years, including specific risk factors for individual Trusts as highlighted by the appointed auditor.

The 2000/01 overview report (Audit Scotland, 2001) takes a more objective stance, reporting factually on the achievement of targets without reference to the role of the auditor in delivering a return to financial balance. We also learn that the SEHD is introducing measures to promote greater consistency between Board and Trust

accounts (Audit Scotland, 2001:17). There are more references to action taken by SEHD, including an announcement by the Health Minister that £90m additional funding was to be awarded to NHS organisations in 2001/02 although the Auditor General provides the following advice to NHS organisations:

“Trusts will require to continue monitoring closely their financial position and ensure that plans to secure financial balance are pursued rigorously.”

(Audit Scotland, 2001:18)

The financial position of health board areas is summarised in an appendix to the 2000/01 overview report, including the retained surplus or deficit of each of the 15 Boards and their 27 constituent Trusts in the current and preceding financial years. This is an early attempt to bring a summarised account of the financial performance of the NHS together in one place. Such a national financial summary was not produced at the time by SEHD, despite an overarching performance narrative in NHSScotland which prioritised ‘national’ over individual performance.

In the 2001/02 overview report, the Auditor General reports that there has been an improvement in the financial position of NHSScotland, evidenced by a reduction in the number of Trusts recording a cumulative deficit at year-end and the overall value of that cumulative deficit. Indeed, Trusts recorded an overall surplus in 2001/02 following two years of reporting an overall deficit. The Auditor General presents analysis to show that this improved position was a direct result of the in-year injection of funding of £90 million provided by the Scottish Executive, rather than any significant improvement in financial management. The majority of the additional funding was used to eliminate cumulative deficits, including £10.8m provided to one Trust<sup>54</sup> to clear its cumulative deficit, and not to increase overall NHS spending.

The Auditor General does not express a view on this use of resources but uses passive language to convey that the improved financial position was not sustainable:

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<sup>54</sup> Tayside University Hospitals NHS Trust – the Trust which had been subject of specific interest in previous overview reports and a Parliamentary inquiry.

“...it is clear that the one-off funding does not represent a long-term solution to the financial problems faced by NHS bodies. Underlying financial pressures remain which need to be addressed.”

(Audit Scotland, 2003a:23)

The 2001/02 overview report (Audit Scotland, 2003a) devotes far less coverage to the financial position of NHS Boards, relative to the discussion of NHS Trusts’ financial position. This may reflect the relatively good health of the Boards, with all but one achieving breakeven against all three annual targets. Special health boards command only one paragraph (Audit Scotland, 2003a:25) and the two special boards reporting “slight overspends” are not named.

The report highlights weaknesses, rather than praising or noting successes. This distinguishes the overview reports from traditional company audit reports and illustrates how performance audit reports can be a source of “discomfort” for the audited organisation and stakeholders (Justesen and Skaerbaek, 2005; 2010).

The reporting of financial performance develops one stage further in the 2002/03 overview report (Audit Scotland, 2003b). This report not only summarises the financial results of each NHS organisation but also provides a commentary on the results of each organisation and a commentary on changes made to the NHS financial regime by the SEHD during the year. The commentary on the results of the Boards and their constituent Trusts runs to over seven pages, over 10% of the report, with around half a page devoted to each unified board area.

The 2003/04 financial overview report (Audit Scotland, 2004b) marks a further shift in the function of the overview reports from a summary of the findings of the audits of individual NHS bodies to an overall assessment of the financial performance of the NHS as a whole by Audit Scotland. The overview report no longer provides detailed accounts of the financial position of individual Boards, but introduces specific case studies to illustrate general points.

“This report is in a different format from previous financial overview reports, where we included a section on NHS bodies causing greatest concern. This report features case studies on NHS bodies which are used to demonstrate emerging issues.”

(Audit Scotland, 2004b:5)

As the scope of the overview report expands to an integrated financial and operational performance overview report in 2003/04, there is a reduction in the coverage of financial issues. For example, the 2004/05 overview devotes just 11 pages to the financial performance of the NHS, but continues to report the performance of all NHS bodies against formal financial targets (Audit Scotland, 2005:45-6); the section on financial performance in the 2006/07 overview is restricted to just six pages (Audit Scotland, 2007:26-31) plus an appendix reporting the outturn of each NHS body against formal financial targets (Audit Scotland, 2007:37-8).

With the overall financial health of the NHS in Scotland considered to be good in 2006/07, the overview report has little to say about the achievement of financial targets. The report highlights that only one Board failed to meet all of its financial targets and that auditors did not issue any qualified opinions on the financial statements of NHS bodies (Audit Scotland, 2007:27).

#### *SEHD overspend*

The SEHD recorded an overall overspend of £32 million against its budget allocation in 2004/05, representing 0.4% of its budget.

“This [overspend] is a breach of regulations and has resulted in a qualified regularity opinion on the Scottish Executive’s accounts. The overspend was a result of failing to budget accurately for single system working.”

(Audit Scotland, 2005:27)

In contrast to the pages of analysis on overspending Trusts and NHS Boards in previous and future overview reports, the SEHD overspend elicits limited analysis and Audit Scotland does not offer any insights into the future outlook for the aggregate financial position of NHSScotland. The report uses objective language to report the volatility in the reported position following year end, but concludes the discussion with a judgement that there are “weaknesses in budget monitoring”.

“The SEHD’s overspend was not identified until August 2005, when the consolidated health accounts were prepared. The forecast for revenue expenditure fluctuated significantly between February and August 2005. This varied from an overspend position of £36.2 million to underspends of £90 million and £67.2 million in March and June, and back to an overspend

of £35 million in August (the revenue overspend is offset by a £3 million capital underspend). This indicates weaknesses in budget monitoring.”

(Audit Scotland, 2005:36)

This shows how the auditor presents an apparently neutral account of the outcome of financial management processes and highlights deficiencies without directly criticising the audited organisation. A factual account is presented, but the auditor does not offer direct advice on how to strengthen these processes or indeed make specific recommendations on improvements which the auditee should make in the coming year.

The 2005/06 financial overview report (Audit Scotland, 2006) provides an update on actions taken by the SEHD to address the weaknesses in process which were manifest in the failure to meet statutory financial targets in the previous year.

“The auditor has reported that the SEHD completed an internal review of financial management and budgetary control during 2005/06 and is now in the process of restructuring its finance function. The SEHD has asked its auditor to do a joint review with internal audit of the new arrangements during 2006/07.”

(Audit Scotland, 2006:10)

In contrast to the neutral position taken in the overview report for the year in which overspend against budget arose, the national audit body again presents itself as a key actor in the network which will improve financial management. This supports the proposition that the auditor uses the overview report as a vehicle to demonstrate that it is a key actor in the financial management network in NHS Scotland. The neutral presentation of events reinforces an appearance of authority and supports the development of an identity for the national audit body as a trusted source of expertise on financial management.

This case also shows how the auditor highlights its role in remedying weaknesses in financial management, even though the audit process did not itself identify the original weakness. This is obscured to the lay reader by the lack of scrutiny of audit processes (Power, 2000a; 2003a).

### 6.6.2 Redefining financial performance

As the overview reports evolve, the definition of financial performance used by Audit Scotland widens from statutory financial targets to incorporate broader measures, including the sustainability of a breakeven position.

The 2002/03 overview report reaches “general conclusions” which, for the first time in the overview reports, convey Audit Scotland’s overall assessment of the financial health of the NHS (Audit Scotland, 2003b). While this assessment is essentially positive, it highlights that NHS organisations rely on non-recurring funding to support recurrent expenditure. This overview report also links financial performance with wider NHS performance and outcomes. Audit Scotland purports that transparency should be maintained in financial management:

“not only to support sound and open accountability, but also to enable a clear view of the healthcare benefits resulting from the major additional resources being placed at the disposal of the NHS in Scotland.”

(Audit Scotland, 2003b:7)

This is the beginning of a process which introduces a broader definition of financial performance.

#### *Recurring vs non-recurring*

A growing interest in the more general financial health of NHS bodies is evident in the increasing coverage of reliance placed by health bodies upon ‘non-recurring’ funding sources to support ‘recurring’ costs. As this language becomes embedded in the financial performance dialogue of NHS Scotland, a new measure of financial performance emerges. This measure can be traced back to audit interest and co-exists with statutory financial targets. Thus, the auditor has redefined NHS financial performance.

Audit Scotland reports in the 2006/07 overview that reliance on non-recurring income to support recurring costs “does not represent a large financial risk for most boards” (Audit Scotland, 2007:26). However, the only recommendation included in the section of the report on financial performance is that “NHS Boards should aim to

be in recurring financial balance and minimise the use of non-recurring income on day-to-day expenditure” (Audit Scotland, 2007:31).

By the 2008/09 overview report, the underlying position of territorial NHS boards has improved slightly. The national audit body nevertheless continues to highlight the risks associated with this financial position and encourage boards to reduce reliance on non-recurring funding. “The tightening financial situation” across the UK public sector is used as leverage to legitimate the recommendation (Audit Scotland, 2009b:19).

The overview report presents the actual underlying position of each NHS body in 2006-07 and the forecast position for 2007/08 (Audit Scotland, 2007: 28). The source of the data is quoted as “*unaudited* returns from the NHS bodies” (emphasis added)<sup>55</sup>. The overview reports continue to give prominent coverage to the reliance which NHS boards place upon non-recurring funding sources and report measures of underlying financial performance, but these measures reported by NHS boards have not been independently verified by appointed auditors or at national level by Audit Scotland.

This is a significant development: Audit Scotland has promoted a new measure of financial performance, which considers how financial targets have been achieved by NHS boards, but has not expanded its audit work to bring this measure within the scope of audit testing.

This supports the existing literature that audit is influential in constructing an auditable environment (Power, 1994a; 1996; 1999) and that performance audit reviews lead the auditor to construct a definition of performance which can be subjected to audit (Day and Klein, 1987; Everett, 2003; Lindeberg, 2007).

It also marks a departure in that, having made a new measure of performance auditable, the national audit body does not apply audit procedures to reports of performance against that measure. The purpose of promoting the new measure

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<sup>55</sup> The 2008/09 overview report also includes a table showing the actual and forecast underlying position of each NHS Board in 2008/09 and 2009/10 respectively (Audit Scotland, 2009b:20). A similar table is presented in the 2009/10 overview report (Audit Scotland, 2010c:8). The source of the data quoted in both reports is “unaudited returns from NHS bodies” (ibid.).

appears not to be to broaden the application of traditional audit tests but to provide an evidence base for the developing commentary which the national audit body provides on the financial performance of NHSScotland. This supports the view that Audit Scotland's identity in the performance network has evolved from traditional external auditor to commentator on NHS financial performance.

### *Efficiency savings*

The overview reports adopt a cautious position in relation to the achievement of efficiency targets by NHS bodies: "Efficient Government savings targets were *reported* to be met" (Audit Scotland, 2007:31, emphasis added). The audit report quotes savings figures from a Scottish Executive report on its efficiency programme, but does not provide evidence that it has independently verified these savings (ibid.).

The efficiency savings achieved by individual NHS bodies are reported for the first time in the 2008/09 overview, although the source of these figures is "unaudited returns from NHS bodies" which "do not necessarily correspond with Efficient Government programme returns to SGHD" (Audit Scotland, 2009b:12).

The treatment of efficiency savings in the overview reports illustrates two emerging themes: the national audit body primarily reports on NHS performance without providing assurance over systems or controls, while further expanding the definition of financial performance beyond statutory targets. This begins to establish the role of the national audit body as a commentator, not an assurance-giver; this role will be explored further at Section 6.8 below.

### 6.6.3 Critiquing financial targets

The Auditor General begins to question the official financial governance and performance framework in the 2002/03 overview report in a short section headed 'validity of targets'.

"While the revised financial framework is intended to enhance the transparency of NHS financial performance, a number of auditors commented on the usefulness of the Revenue Resource Limit as a financial target. SEHD's initial notification of the RRL to each NHS board and special health board is subject to change throughout the financial year...

“Auditors reported that the RRL of a number of NHS boards and trusts was only finalised after the year-end... Setting the RRL after the year-end does not accord with the primary reason for setting a target in the first place, i.e. to provide a challenging, yet achievable, target for operational management to aim for. Agreeing a target once the final outturn position is known reduces the likelihood that the target is real or effective.”

(Audit Scotland, 2003b:36)

This is a departure from the traditional role of the auditor to independently evaluate reported performance against the financial accounting framework and specific financial targets linked to budgetary control. The additional commentary is an early indicator of the changing role of Audit Scotland.

In the next year’s financial overview report, Audit Scotland directly asks “how useful are the financial targets?” (Audit Scotland, 2004b:10). The answer rehearses the points made in the 2002/03 overview report quoted above, but the national audit body ultimately suggests that the financial performance framework should be reformed.

“The SEHD should consider reviewing the current financial targets set for NHS bodies.”

(Audit Scotland, 2004b:11)

The national audit body is expanding the scope of its interest in NHS financial management from ensuring that performance against financial targets is accurately reported, to commenting on the effectiveness of the financial targets themselves.

The position taken by the Auditor General on financial performance has progressed from factual reporting of performance against financial targets through commenting on how those results were achieved to undermining the targets themselves. The prevailing identity of the auditor has shifted from an agent of accountability to an agent of change (Bowerman et al., 2000; Gendron et al., 2001; Skaerbaek, 2009).

## **6.7 Operational performance**

The previous section demonstrated how Audit Scotland’s approach to reporting on financial performance evolved over the period of analysis. This section traces the emergence and development of an interest in broader operational performance.

### 6.7.1 Relationship between financial and operational performance

Early overview reports give no sense of the broader performance of the NHS; their scope is limited to presenting actual performance against statutory financial targets.

The 2002/03 overview is the first report to specifically consider NHS performance management, as part of a discussion of corporate governance (Audit Scotland 2003b). It reproduces a case study of how Lothian NHS Board uses the Performance Assessment Framework (PAF) to manage its performance (Audit Scotland, 2003b:27), which was originally reported in the external auditor's 2002/03 report. This case study reveals that the board established a steering group to coordinate and implement action required to ensure that the board performed well against the PAF. Actions are assigned to individual service areas. The board assigns responsibility for monitoring progress against action plans to the assistant director of finance, despite the fact that financial performance is only one dimension of performance measured by the PAF.

This case study establishes a practical relationship between financial and operational performance through the role of the assistant director of finance and the implication that the director of finance is the executive director with responsibility for operational, as well as financial performance. The normative framework and organisational framework of financial performance is applied to operational performance, and by extension the operational framework becomes auditable. The imposition of financial management norms onto operational performance lays the ground for auditors to transfer their skills into the domain of operational performance (Power, 1999:6).

As noted above at Section 6.2.2, Audit Scotland produced an overview of operational NHS performance in 2003/04 (Audit Scotland, 2004a), as well as the regular financial overview report (Audit Scotland, 2004b). The former report was hailed by the national audit body as the first comprehensive report on the performance of NHSScotland following devolution.

The 2003/04 reports make an explicit link between financial performance and operational performance within the NHS.

“NHS financial performance cannot be considered in isolation from overall performance and service delivery, so this report should be considered alongside our overview report on the performance of the NHS which was published in August 2004.”

(Audit Scotland, 2004b:5)

This link is reaffirmed in later reports, as readers are invited to read the biannual financial overview report alongside the previous year’s broader performance overview report (Audit Scotland, 2008:3). This is perhaps unsurprising in light of the publication of the performance overview report but makes clear that the auditor considers it necessary to take an integrated approach to assessing the overall performance of NHSScotland.

The integrated performance reports are presented as sitting alongside policy documents prepared by the Scottish Executive.

“The Scottish Executive has recently published *Fair to All, Personal to Each* and *Building a Health Service Fit for the Future...* This integrated overview report *complements* these publications by providing an independent view of where progress is being made and identifying emerging issues which need to be addressed.”

(Audit Scotland, 2006:2, emphasis added)

Audit Scotland attempts to create a space for itself in the wider policy and performance network of NHSScotland, presenting the overview report as a key companion to policy documents.

By producing integrated overview reports, Audit Scotland begins to establish itself as a key actor in a multidimensional definition of NHS performance, not just in the realms of financial performance.

### 6.7.2 Redefining operational performance

Auditors traditionally provide a view on reports which organisations produce of their performance in a certain area or over a given period. The technical norms of the audit process are challenged when organisations do not produce their own performance reports.

Although NHSScotland introduced a formal PAF in 2001<sup>56</sup> it did not produce a comprehensive report detailing how individual organisations or the NHS as a whole performed against the PAF.

“The SEHD has detailed arrangements in place to hold NHS boards to account for their performance. But at present it does not publish a single source of information in a user-friendly format for the public to show how NHSScotland is performing against its key targets.”

(Audit Scotland, 2004a:6)

Audit Scotland filled this space in the performance assessment network by producing an overview of operational performance (Audit Scotland, 2004a). In doing so, Audit Scotland made the performance of NHSScotland auditable. This resonates with other studies of performance audit which show that audit bodies actively construct the definition of ‘performance’ in order to support the audit process (Day and Klein, 1987).

The first performance overview report explains how Audit Scotland went about defining ‘NHS performance’, drawing data from a number of published sources and acting as arbiter of the elements of performance which are most important to patients and the public. Significantly, this definition is broader than the formal performance management system, which is “taken account of” but is not the primary source of information. This lessens the profile of the PAF in the NHSScotland performance network, with the audit definition of performance placed in competition with the NHS’ own definition.

“In planning this report we have taken account of those areas of performance that we think are important to patients and to the public in general. We have also taken account of NHSScotland’s performance management system.”

(Audit Scotland, 2004a:3)

The auditor narrates the story of performance in NHSScotland. However, this is not a systematic re-telling or even a comprehensive account; Audit Scotland has selected the dimensions of performance covered in the overview.

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<sup>56</sup> See Section 5.3 above

The 2004/05 overview report (Audit Scotland, 2005) continues to focus more on national-level targets, than on organisation-level targets set by the PAF. The report highlights mis-matches between formal performance targets and data collection systems to measure progress towards achieving the target (e.g. reducing smoking in young people, Audit Scotland, 2005:6; healthy eating targets, Audit Scotland, 2005:8; cervical cancer screening, Audit Scotland, 2005:11).

These factors combine to present a picture of an NHS performance system lacking in purpose and focus. But more significantly, they show how the national audit body has produced its own composite definition of NHS performance which is independent of the formal performance assessment framework.

### 6.7.3 Primary source of performance information

The overview report is established as a key source of multidimensional performance information on the Scottish NHS.

As the early overview reports purported to be an authoritative source of information on NHS reforms including changes to the financial governance framework<sup>57</sup>, so too do the later performance overview reports communicate imminent changes to the performance management system in NHSScotland, as well as information on how the new HEAT system works in practice (Audit Scotland, 2005:39; Audit Scotland, 2007:13).

These are factual accounts; Audit Scotland does not offer any views on the proposed changes, reinforcing the role of the national audit body as a trusted source of reference information on changes to the NHS.

A full list of current HEAT targets is published as an appendix to the 2006/07 overview (Audit Scotland, 2007), together with details of whether and where performance data is published and an indication of the most recent reported performance at national level. The variety of sources of published data for performance against HEAT targets implicitly communicates the lack of coherent public reporting of overall performance of the NHS.

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<sup>57</sup> See Section 6.4.6

NHSScotland has established its own comprehensive performance reports (see below) by publication of the 2008/09 overview report. Nevertheless, the audit report includes an assessment of whether each HEAT target has been achieved at national level. It highlights in the main body of the text that two targets were not met and that a further target was replaced (Audit Scotland, 2009b:21). Audit Scotland continues to have a prominent role in reporting operational performance, even after the Scottish Government launches a national performance report.

The 2008/09 overview report explores the role of performance information in discharging local, as well as national, accountability to the public.

“The HEAT targets are intended to improve the performance and accountability of the NHS in Scotland, but it is not easy for the public and patients to easily get a comprehensive picture of how the NHS is performing at board level. There is an annual review of each NHS body by the Cabinet Secretary, which is held in public, and the Chief Executive of the NHS in Scotland’s annual report comments on performance at a national level. However, there is currently no single publication or website which pulls together how every NHS body is performing against these targets.”

(Audit Scotland, 2009b:22)

The national audit body calls for publication of organisation-specific performance data to facilitate comprehensive assessment of individual NHS bodies and to improve the transparency of organisational performance. This is a departure from the established performance assessment principle in NHSScotland that local organisations contribute to the performance of a nationally integrated system.

#### *NHSScotland annual report*

Having produced its own performance overview reports since the 2003/04 financial year, Audit Scotland makes an explicit recommendation in the 2006/07 overview report that the SGHD should publish an annual report on its performance.

“The Scottish Government should ensure that information on the performance of the NHS is publicly reported and brings together data on costs, outcomes, targets, productivity, patient satisfaction and experience. It should assess performance against all these elements together to better inform decision-making.”

(Audit Scotland, 2007:18)

The first annual report of NHSScotland since devolution was duly published in November 2008, covering the 2007/08 financial year (Scottish Government, 2008a). The accompanying press release issued by the Scottish Government opens thus:

“Today sees the publication of the NHSScotland annual report.

“This is in response to Audit Scotland's request, in its last Overview Report of Scotland's health and NHS performance, that the Scottish Government should improve its public performance reporting.”

(Scottish Government, 2008b)

Audit Scotland reinforces this link: the 2007/08 overview notes that the decision by the SGHD to publish an annual report was a direct consequence of the recommendation in the 2006/07 overview report (Audit Scotland, 2008:3).

This case demonstrates the extent of the national audit body's influence in the performance network of NHSScotland by 2008; a recommendation in the overview report led to the introduction of a new comprehensive performance report by the Scottish Government. Furthermore, the Scottish Government explicitly linked the introduction of the report to a recommendation made by Audit Scotland.

This suggests that there is now a self-referential legitimacy relationship between Audit Scotland and the Scottish Government; the Scottish Government uses the audit recommendation to legitimate the publication of its own performance report, while Audit Scotland draws on the action taken by the Scottish Government in response to its recommendation to legitimate its earlier findings and reports. A mutually beneficial legitimacy relationship has been established by the audit process, with both auditor and auditee deriving legitimacy from the implementation of audit recommendations (Free, Salterio and Shearer, 2009).

#### 6.7.4 Critiquing performance assessment

As well as providing a source of information on NHS performance, the overview reports include comments and recommendations on the prevailing performance assessment network. These comments can raise questions about the substantive independence of the national audit body from NHS management and from the

government and about the dividing line between commenting on process and commenting on policy.

The overview reports comment on the performance assessment framework in relation to established 'good practice'.

“...at present not all the measures are relevant to the target they are supposed to be measuring...”

(Audit Scotland, 2007:17)

“The National Performance Framework includes the adoption of [Single Outcome Agreements] between the Scottish Government and councils and the abolition of ring-fenced funding for local government. This could present a risk to boards in that they may be accountable for meeting targets for which they do not have financial control. For example, delayed discharge funding will be allocated directly to councils and will no longer be ring-fenced.”

(Audit Scotland, 2008:26)

Although the scope of the overview report has been expanded, the auditors still make recommendations which relate to essentially process, rather than policy, issues. This does not dispel the potential threat to the auditor's independence, however, as Audit Scotland promotes the prevailing accepted performance assessment practice “as if it was the one-best way” (Gendron et al, 2001:304) and so potentially excludes competing knowledge systems.

There is evidence in the overview reports that the national audit body favours a quantitative definition of performance. When discussing targets for health improvement, Audit Scotland offers the following advice to the Scottish Executive.

“In setting targets the SEHD should consider how *measurable* these targets are and how it will collect and report progress on a regular basis.”

(Audit Scotland, 2004a:10, emphasis added)

The national audit body also notes concerns about the ability of a new body to “monitor” progress in the absence of quantitative measures of performance.

“In 2005 the Scottish Health Council was established to promote improvement in the quality and extent of patient focus and public involvement in health services. It will monitor NHS boards' progress in this area and support the development of PPFs (Public Partnership Forums).

However, it is difficult to say how progress in patient and public involvement will be measured.”

(Audit Scotland, 2005:41)

In providing a summary assessment of the PAF as applicable in 2003/04, Audit Scotland concludes that:

“Further work is needed to clarify targets where they are open to different interpretation, and *improve those that are not measurable* or provide an incomplete picture of performance... All targets should be reviewed and refined on a regular basis so that they can contribute to continuous improvement in services. In particular the targets relating to health improvement and mental health services need attention.”

(Audit Scotland, 2004a:5)

This apparent predisposition for quantitative measures of performance resonates with the view in the literature that measurability is a precondition for auditability (Power, 1996:299). It allows a link to be made between Audit Scotland’s interest in operational performance and the trend for auditors to construct performance in terms of its own technical norms (Power, 1994a; 1996; 1999).

The previous quote from the 2003/04 performance overview report sees the auditor criticise specific performance targets for not being effective in improving services. The level of potential controversy attached to this statement depends upon whether targets are considered to be instruments of policy or managerial tools. If the former, it is questionable in constitutional terms whether the auditor should offer a view.

Regardless, it demonstrates that the interest of the auditor extends beyond the verification of performance data to the underlying purpose of the performance assessment framework. Indeed, it is questionable whether the national audit body has any interest in verifying performance data; this proposition will be considered in more detail below at Section 6.8.1.

The auditor also questions the appropriateness of the threshold level of performance attached to a target. For example, the Scottish Executive set a target that 80% of eligible women should be regularly screened for cervical cancer, but actual performance showed that on average 87% of eligible women came forward for screening.

“This is good news, but it raises the question of whether the target is challenging enough.”

(Audit Scotland, 2004a:38)

This shows an interest in the substance of the performance assessment framework, as well as its control framework.

Criticism of performance targets continues in the discussion in the 2003/04 performance overview report (Audit Scotland, 2004a:19) of commitments given by the Scottish Executive to increase NHS staffing over a four year period. These commitments were set out by the Executive in the partnership agreement document<sup>58</sup> produced by the Labour / Liberal Democrat coalition administration following elections to the Scottish Parliament in May 2003. This agreement summarised the joint policy priorities of the coalition, setting out specific priorities for the NHS. These are not, therefore, managerial performance targets set by central government officials to direct the operations and outcomes of public bodies under their control, but the high level political policies of the ruling administration.

Audit Scotland has interpreted political commitments as performance targets and offers criticism of these as if they were specific targets on organisations; political promises have been transformed into auditable performance targets.

The commitments or targets relate to increasing the size of three NHS staff groups: 600 extra consultants, 12,000 more nurses and midwives and 1,500 more allied health professionals. Audit Scotland (2004a:19) highlights that no unit of measurement has been allocated to these subjects, that there is no consideration as to which specialties the new posts should be created in or to how these extra professionals should be distributed around the country. While these would be valid comments for an auditor to make about managerial performance targets, it is questionable whether they remain appropriate when directed at high level political commitments. They could be interpreted as a further attempt to reduce political governance of the health service to auditable performance targets (Gendron et al, 2001; Power, 1996, 1999).

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<sup>58</sup> *A Partnership for a Better Scotland* (Scottish Executive, 2003) available at <http://www.scotland.gov.uk/Publications/2003/05/17150/21952> (accessed on 1 September 2011)

Audit Scotland also uses the overview reports to express the views of NHS stakeholders on the performance assessment framework, which enables the communication of judgement on the current system without the national audit body threatening its independence by commenting directly on the effectiveness of the system.

“Auditors report that most NHS boards have found the PAF indicators to be helpful in reviewing and assessing their performance. One NHS body found that the indicators provide more robust measures of performance than previous performance measurement systems, although another considered there was a balance to be struck in achieving high performance against a particular PAF indicator and the cost of achieving that high performance.”

(Audit Scotland, 2003b:26)

The 2006/07 overview report highlights the inherent paradox in presenting HEAT as a tool for NHSScotland to discharge accountability for its performance to the public.

“The HEAT targets are intended to improve the performance and accountability of the NHS in Scotland, but there is no publicly available information on performance against the following [three] targets...”

(Audit Scotland, 2007:17)

The national audit body is thus interested in the purpose, as well as the content of, the performance assessment framework.

There is evidence throughout the overview reports that the national audit body holds opinions on, and seeks to influence, the process of performance assessment and that it favours a measurable concept of performance. This interest broadens into how performance assessment is used to drive improvement and also to discharge public accountability. The national audit body thus seeks to influence not only process, but also content and use of performance assessment technologies.

#### 6.7.5 Considering outcomes

In the 2006/07 overview report, Audit Scotland articulates the expansion of the remit of the performance overview beyond operational performance management. The scope of the report is expanded beyond the process of NHS performance management to the outcomes which the performance management system is intended to support.

“This report provides an *overview of the health* of people living in Scotland and the performance and financial management of the NHS in Scotland.”

(Audit Scotland, 2007:3, emphasis added)

In reality, this analysis corresponds to presenting statistical data on health outcomes but in a way more akin to the annual report produced by Directors of Public Health than to reports on operational performance. It represents a shift away from the traditional professional domain of a national audit body into a clinical domain.

This interest had been hinted at in previous overview reports. In the 2003/04 performance overview (Audit Scotland, 2004a), Audit Scotland discusses how NHSScotland is performing against the three clinical priorities identified by the Scottish Executive<sup>59</sup>. The auditor comments on improvements made to health outcomes and offers an assessment of whether long term improvement targets are likely to be achieved.

Nevertheless, the auditor is now commenting upon the state of the nation’s health; national audit bodies are traditionally considered experts on public financial management, financial control and increasingly public management more generally (Gendron et al., 2007) and so would not normally be considered authorities on health outcomes.

This section has shown how Audit Scotland developed its interest in performance from collating performance data and commenting on the process of performance assessment through to commenting on the substance of NHS performance. The next section explores the emerging role of the national audit body as commentator.

## **6.8 Auditor as commentator**

This section presents evidence of the evolution of the national audit body to authoritative commentator on NHSScotland performance. There are three particular sources of evidence: offering opinions on activities and systems which have not been subject to audit procedures; an increasing focus on future performance; and a new focus on the wider fiscal environment.

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<sup>59</sup> These are cancer, coronary heart disease and stroke, and mental health.

### 6.8.1 Opinions which are not supported by audit work

In evaluating the role of the national audit body in relation to the operational performance of the NHS, it is important to consider the presence or absence of traditional audit functions, as well as the material presented in the overview reports. In the course of analysing performance and cost data published by the NHS, Audit Scotland identifies weaknesses in current systems for data collection.

“The Scottish Health Service Costs Book... publishes costs for the NHS each year... based on figures provided by NHS bodies but there are questions about their reliability...”

“This is an issue that NHSScotland needs to address. It is difficult to demonstrate value for money without accurate costs.”

(Audit Scotland, 2004a:30)

It is not clear that the auditor is taking any action to provide assurance over this key performance data. If financial statement production were to be taken as an analogous situation, you would expect the auditor to independently verify the data produced by performance measurement systems, either by substantively verifying that data or reviewing the systems used to collect and record that data. In this instance the audit body presents itself as a commentator on reported substantive performance, rather than a conduit for assuring the accuracy or validity of the underlying performance data.

There is no evidence in the overview reports that external auditors undertook any form of controls testing or other audit-based review of the arrangements implemented by Trusts and Boards to measure performance and report on performance against PAF or HEAT indicators.

There are further examples earlier in this analysis of the national audit body considering specific issues in the overview reports which have not been subject to audit testing or other means of verification, including the introduction of recurring

financial position as a key component of financial performance<sup>60</sup>, reporting of efficiency savings<sup>61</sup>, and reporting of operational performance measures<sup>62</sup>.

The national audit body has made the domain of operational performance subject to audit interest, but not in a traditional sense as the principles of audit have not been applied. Instead, the auditor has rendered itself interested in operational performance, but at the same time has redefined its own role in the performance network. Rather than verifying performance data or the systems that generate reported performance data, the auditor has chosen to establish itself as a commentator on, and often critic of, NHS performance.

### 6.8.2 Future financial outlook

Even the early NHS overview reports make some reference to future financial performance, including assessments of the risks underlying delivery of organisational financial plans<sup>63</sup> and an overall judgement on the financial outlook for NHSScotland. For example, following the injection of additional funding by the Scottish Executive, the Auditor General warns that “the additional funding will not necessarily solve the financial problems faced by the NHS” (Audit Scotland, 2003a:45).

The 2003/04 financial overview report (Audit Scotland, 2004b) includes a separate section on emerging factors that may affect future financial performance. This is the longest section in the 2003/04 financial overview<sup>64</sup>, suggesting that Audit Scotland is

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<sup>60</sup> See Section 6.6.2

<sup>61</sup> Ibid.

<sup>62</sup> See Section 6.7

<sup>63</sup> See Section 6.4.3

<sup>64</sup> The table below shows the number of pages devoted to the four main sections of the 2003/04 financial overview report.

Part 1. Setting the scene	4 pages
Part 2. Financial performance in 2003/04	7 pages
Part 3. Emerging factors that may affect future financial performance	9 pages
Part 4. Financial stewardship and corporate governance	3 pages

promoting its role in relation to assessing future financial performance above its role in providing retrospective assurance on historic financial performance.

### 6.8.3 Commenting on the fiscal environment

The 2008/09 operational performance overview report “examines the implications for the NHS of the current economic climate and how the NHS is placed to respond to the challenges ahead” (Audit Scotland, 2009b:3). This marks an expansion of audit interest from financial and operational performance to the fiscal environment. The role of Audit Scotland in relation to financial performance has advanced again, from expert on financial management to key commentator on the readiness of the NHS to respond to the financial challenges associated with the overall fiscal climate.

The NHS overview report recognises and highlights the new focus.

“In previous years, the annual NHS overview report has described the finances and performance of the NHS in relation to the ongoing cost pressures it faces. We comment in this report not just on cost pressures within the NHS but also on the operational challenges for the NHS.”

(Audit Scotland, 2009b:5)

The publication of the 2008/09 NHS overview report came shortly after publication of *Scotland's public finances: preparing for the future* (Audit Scotland, 2009a) which broadened the scope of Audit Scotland performance audit studies to include a macro-level analysis of the wider fiscal environment and the impact which it has on the delivery of public finances.

“*Scotland's public finances: preparing for the future* contains an overview of the financial environment in Scotland and the pressures and challenges facing the public sector... It suggests some key questions for the Scottish Government, the Parliament and the wider public sector to consider when planning the delivery of public services in a time of severe resource constraints... The aim of this report is to *help inform the debate* on the future of public finances in Scotland.”

(Audit Scotland, 2009a:5, emphasis added)

The evolution of the role of Audit Scotland in relation to the performance of the NHS is located within a wider development of the identity of the national body, which is repositioning its work across the whole of the Scottish public sector.

As the focus of the 2008/09 performance overview shifts to the sustainability of the NHS in a time of fiscal constraint, there is a step-change in the discussion of financial performance. Achievement of financial targets in the previous year becomes secondary to a wider-ranging discussion of financial challenges facing the NHS. Likewise, the discussion of wider operational performance issues is located very much in the context of the financial environment.

The 2008/09 overview report (Audit Scotland, 2009b) arguably severs the last links between the overview report and the external audits of NHS bodies: there is no discussion within the report of either external auditors' opinions on NHS financial statements or the achievement of statutory financial targets by NHS bodies.

The 2009/10 overview report continues to consider macro-level financial issues. It presents a comprehensive picture of the demographic and cost pressures facing NHSScotland, drawing on data from Scottish Government and other statistical publications (Audit Scotland, 2010:13-5).

The auditor also voices concerns on the impact of financial decision-making on frontline services.

“This [efficiency target for 2009/10] presents a significant challenge for many NHS bodies, and their auditors have stated that it will be difficult for some to achieve the required level of savings without any negative impact on the services they provide.”

(Audit Scotland, 2009b:11)

While not necessarily highlighting that this is in direct opposition to the official position of the Scottish Government, it nonetheless positions the auditor as a competing authority as Ministers had repeatedly promised that frontline services would not be adversely impacted by efficiency savings targets.

Another example of this implicit disagreement with policy decisions is staffing policy.

“The Auditor General for Scotland commented in his report on Scotland's public finances [Audit Scotland, 2009a] that without the flexibility to redeploy or reduce staffing levels or rationalise the assets used to deliver

services, public bodies have limited discretion to reduce their costs while maintaining the levels of front-line services they provide.”

(Audit Scotland, 2009b:11,13)

The Cabinet Secretary for Health and Wellbeing would later provide an unqualified guarantee to all NHS staff that there would be no compulsory redundancies over the life of the Parliament. There is now a very public disagreement between the Scottish Government and the Auditor General on financial strategy for the NHS.

The 2009/10 financial overview report calls into question the Scottish Government budget policy of ‘ring-fencing’ the health budget, drawing on evidence provided to the Scottish Parliament Finance Committee<sup>65</sup> by the Auditor General for Scotland and external sources.

“... The Auditor General invited MSPs to ‘consider the longer-term implications of ring-fencing NHS funding’. In response to questions about whether any spending area should be protected from real terms cuts, the Auditor General advised: ‘that excluding any specific sector from the requirement to deliver services more efficiently represented a missed opportunity and that the public sector needs to ensure it has a priority-based approach to budgeting and spending’.”

(Audit Scotland, 2010c:15)

To provide support for this position, the overview report includes direct quotations from the Independent Budget Review set up by the Scottish Government to inform the budget-setting process for 2010/11 (Audit Scotland, 2010c:15-6).

The Auditor General is commenting upon the merits of macro fiscal policy decisions, not the value for money of decisions taken by specific public sector organisations or the financial control and governance frameworks. He is inviting MSPs to support his own view, which is in direct competition to the official view of the Scottish Government.

In doing so, the Auditor General establishes his position as an authoritative commentator on macro-level financial policy, not just value for money, regularity and control at organisational level. Rather than focusing upon the impact which the

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<sup>65</sup> Submission from Audit Scotland to the Finance Committee’s Inquiry into Efficient Public Services, Tuesday 20 April 2010

relative protection of the Health budget will have upon NHSScotland, the overview report questions the merit of this policy decision.

This is a new type of conflict; it relates to current financial strategy and is essentially subjective and judgement-based.

The national audit body is now established as an authoritative commentator, having re-defined itself as an influential outside commentator pronouncing judgement on public services, from the role of outside expert imposing its own norms on to NHSScotland performance. Is this evidence of a post-‘audit society’ approach taken by national audit bodies, who have evolved beyond the role of modernising agents imposing NPM philosophies and techniques (Gendron et al, 2001; Skaerbaek, 2009) to assume an elevated position as ultimate critic of NHS performance?

The capacity for the national audit body to become an authoritative commentator on NHS performance and financial strategy is still to be fully explored in the academic literature.

## **6.9 Reflections and concluding remarks**

### 6.9.1 Key findings and reflections

This chapter traces the transformation of the identity of the national audit body in relation to the performance of NHSScotland over the first 10 years of the Scottish Parliament.

The national audit body was transformed from an independent body holding the government and public services to account for financial results (Hollingsworth et al, 1998), through a period as an agent of change in NHSScotland (Gendron et al, 2007; Skaerbaek, 2009), to an authoritative commentator on the financial and operational performance of the NHS.

This transformation is evidenced through changes in the form and content of the NHS overview reports. The early overview reports are first person accounts of the collective findings of NHS audit activity, presented to Parliament and the public by the Auditor General of Scotland. The narrative style of the reports shifted with the

introduction of third person narration as the overall style of reporting became more corporate, in keeping with the role of the audit body as an agent of change, close to a management consultant (Gendron et al, 2007; Skaerbaek, 2009). The overview reports ultimately became a platform for communicating judgements on the performance of the NHS, which were not necessarily based on the findings of conventional audit activity.

The content of the overview reports underwent a parallel transformation: the initial reports are recognisable as “traditional” audit reports, discussing the appropriateness of accounting judgements, financial reporting decisions and weaknesses in systems and controls identified through routine audit testing. Over time, the interest of these reports broadened to include the reported financial performance of NHS bodies, how the reported performance had been achieved and the fiscal and environmental factors which influenced financial performance.

The previous chapter found that Audit Scotland was not given a formal role in the performance assessment network of NHSScotland. This chapter has shown that Audit Scotland created its own role in that network by reporting on operational, as well as financial, performance, and by introducing its own definition of operational performance. The national audit body was thus able to exert a greater influence on the operational performance of NHS bodies than envisaged by the official policy narrative.

### 6.9.2 Implications for the *Audit Society*

This study highlights three important developments in the *Audit Society*: the way in which a national audit body creates its own space in the performance network by rendering operational performance “auditable”; the propensity of the national audit body to make assertions which are not supported by conventional audit testing; and the previously undocumented role for the national audit body as commentator on the performance of public services.

Audit Scotland adopted a proactive role in reporting in the financial and operational performance of the NHS in Scotland and in so doing became the primary source of published information on NHS performance following the introduction of the

biannual performance overview report. The NHS did not produce its own overview report at that time and so Audit Scotland made that performance auditable (Power, 1996; 1999). Audit Scotland rejected the prevailing official performance assessment framework and created its own broader definition of performance, thus influencing how external parties conceived the performance of NHSScotland.

The national audit body not only drew on existing concepts of NHS performance, but began to introduce its own measures. For example, it reported on the underlying financial health of NHS organisations based on a measurement of the organisations' recurring financial position. Significantly, Audit Scotland did not "audit" these measures, but rather made judgements based on unaudited reports provided by NHS organisations.

This has implications for society's relationship with audit and the reliance placed on audit as a source of verification of reported performance, be it in the form of financial statements or operational performance measures. The transparency which audit is designed to uphold can become obscured when auditors begin to make public statements which are not supported by conventional audit procedures. While it is not new for performance auditing to define performance (Day and Klein, 1987; Everett, 2003; Lindeberg, 2007), the propensity for auditors to make pronouncements which are not supported by testing is and needs to be better publicly understood if audit is to maintain its credibility as a provider of independent assurance and accountability.

Audit Scotland thus establishes itself as a trusted commentator on the financial and operational performance of individual NHS organisations and on the wider public finances. This is a departure from the existing literature which has generally focused on the capacity of audit bodies to promote the introduction of managerial reforms through a role akin to a management consultant.

While the evolution of the national audit body to commentator is not necessarily damaging to public accountability, it does have significant implications for the constitutional role of public audit and creates a distance between public audit practices and accepted technical definitions of audit as embodied in professional standards. This is arguably a new form of auditing which draws on a body of

professional expertise and experience. It could herald a natural evolution of an audit society which prioritises the assurance provided by the auditor above all other sources and thus represent the ultimate assertion of the value of the programmatic dimension of audit over the technical (Power, 1999:6-8).

The role of national audit body as commentator deserves to be explored further in other institutional and political contexts to determine whether it is a product of the Scottish system or symptomatic of an emerging international trend.

### 6.9.3 Further issues to be explored

The present study has traced how Audit Scotland's role in the NHSScotland performance network evolved over time. While it was beyond the scope of this study to consider why the national audit body evolved in this way, there is clearly scope for future research to explore why Audit Scotland has defined its role in a different way from other UK audit bodies and from other international audit institutions.

In particular, the precise source of Audit Scotland's influence on the Scottish public sector, including the NHS, is under-researched. There is room to consider, for example, whether this influence is related to the relatively small and intimate parliamentary and governmental networks in Scotland and the extent to which it is driven by the personal leadership of a particular Auditor General.

It was also beyond the scope of the present study to explore the relationship between Audit Scotland and the Scottish Parliament in discharging and upholding democratic accountability for the financial and operational performance of public services. Future research could build on these findings by studying the use which the Scottish Parliament makes of Audit Scotland findings and how they are used to hold the executive arm of government to account.

The next chapter presents a case study of a recent performance crisis in NHSScotland, which explores the role of audit and the national audit body in diagnosing and remedying performance failures, alongside other key actors in the NHS performance network.



## **Chapter 7**

# **Audit in times of performance crisis – NHS Lothian waiting time management**



## 7.1 Introduction

This chapter explores the official response to a recent performance crisis in the Scottish NHS. In the face of increasing evidence that NHS Lothian, a large NHS board, had deployed gaming tactics in order to report compliance with national waiting time targets, the Scottish Government looked to audit to both diagnose and provide solutions to the problem. Earlier chapters have shown that there is no formal role for audit in the NHSScotland performance framework and the relationship between the executive and NHS bodies in the first three terms of the Scottish Parliament could be characterised as ‘high trust’. But nevertheless, audit proved to be the first line policy response when a performance crisis arose.

This case study analyses documents which trace the official response to the crisis, including:

- media reports from October 2011, when the story broke in *The Sunday Times* newspaper,<sup>66</sup> to May 2012, when Audit Scotland announced its intention to undertake a national review of waiting time management in NHSScotland;
- written parliamentary questions tabled by Members of the Scottish Parliament and answers provided by Scottish Ministers;
- the ‘official record’ of ministerial statements and debates on this issue in the Scottish Parliament;
- audit and management reports, including an independent review carried out at NHS Lothian; and
- NHS Lothian board papers and minutes of public board meetings at which the waiting time management issue was considered.

The research design and strategy are influenced by Latour’s (1987, 2005) account of ANT; the aim is to reassemble the key associations between actors in order to present a rich account of both the performance crisis and the official response.

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<sup>66</sup> *The Sunday Times*, “Waiting lists fudged”, Sunday 23 October 2011, Scotland edition; *The Sunday Times*, “NHS Lothian accused of targets scam; Patients offered treatment 200 miles away to cut waiting time lists, writes Mark Macaskill”, Sunday 23 October 2011, Scotland edition.

This study is not concerned with the performance crisis *per se*; gaming of performance targets by NHS managers has received extensive coverage in the literature (e.g. Bevan and Hood, 2006). Rather, the primary focus of the present study is on the use of audit technologies, otherwise conspicuous by their absence in the standing performance assessment framework, as the main policy response to a performance crisis.

## **7.2 Background**

### 7.2.1 'New Ways' of managing patient waiting times in NHSScotland

In 2004, the then Scottish Executive announced its intention to introduce a new methodology for defining, recording and measuring patient waiting times (Scottish Executive, 2004). The 'New Ways' methodology was introduced with effect from 1 January 2008 to improve the transparency, consistency and fairness of waiting time management (NHS National Services Scotland, 2007) in light of concerns NHS boards were making inappropriate use of 'availability status codes' to take some patients outside waiting times guarantees.

These codes could be exploited by NHS boards to ensure that they could report delivery of national performance targets. Such behaviour could render the waiting time guarantee meaningless for the individual, while NHS bodies could report achievement of national targets. Opposition politicians argued that widespread use of availability status codes had led to the creation of 'hidden waiting lists', which undermined the veracity of reported waiting time statistics.

The Scottish Executive summarised the principles of the new methodology in *Fair to All, Personal to Each*.

“By the end of 2007, the NHS in Scotland will calculate patients’ waiting times on a different basis that will be fairer, more open to scrutiny, more understandable, and which will help put patients at the centre of their care. Waiting times will be calculated from the date a patient is placed on the waiting list to the date of an outpatient appointment or hospital admission for treatment. Availability status codes – which at present mean that some patients waiting for highly specialised or low priority treatment have to wait longer than the guaranteed maximum times – will be abolished. Patients who are waiting for such treatments will be admitted within the same maximum waiting times period as all other patients. Patients will have any periods of unavailability for medical, social or personal reasons subtracted from the calculated waiting time. Periods of unavailability will be reviewed regularly, so that no-one will remain unavailable for treatment for more than 3 months without a check on their status.”

(Scottish Executive, 2004: 9)

As well as ending the use of availability status codes, ‘New Ways’ introduced another three key changes to waiting time management (NHS National Services Scotland, 2007):

- Introduction of a consistent ‘reasonable offer’ of appointment or admission, subject to national definition and guidance on interpretation.
- Introduction of national guidance on how to deal with patients who could not or did not attend their appointment once they had accepted a ‘reasonable offer’ of appointment or admission.
- National guidance on dealing with patients who are unavailable for treatment for medical or social reasons but have yet to be assigned a date for their appointment or admission. Periods of unavailability can be subtracted from the patient’s reported waiting time.

The ‘New Ways’ waiting times methodology was proposed and conceived by the Labour / Liberal Democrat coalition administration in the second session of the Scottish Parliament (2003-07), but was implemented by the Scottish National Party (SNP) minority administration in the third session of the Parliament (2007-11).

### 7.2.2 Introduction of 18 week referral to treatment target

The SNP administration quickly introduced more demanding waiting time standards after taking office in May 2007. Within weeks, Nicola Sturgeon, the new Cabinet Secretary for Health and Wellbeing, announced the introduction of a “new and ambitious target for NHS waiting times: a new whole journey waiting time target of 18 weeks from general practitioner referral to treatment... It will drive the transformation of NHS services and will put NHS Scotland at the forefront of international best practice. The action plan will set out how we intend to meet the target by December 2011.”<sup>67</sup>

This was a significant shift from previous policy where separate waiting time targets were in place for the period from GP referral to outpatient appointment and then from outpatient appointment to admission for treatment. At the time of the June 2007 announcement, each stage carried a maximum waiting time of 18 weeks, effectively allowing for a 36 week patient journey from GP referral to admission.

The Scottish Government (2008c) subsequently published detailed guidance which explained the practical application of the new methodology and created a national programme board and associated operational infrastructure to ensure delivery of the 18 week standard across Scotland by 2011.

### 7.2.3 National audit activity

Audit Scotland (2010a) undertook a performance audit of waiting list management in NHS Scotland, which focused upon NHS Boards’ compliance with the ‘New Ways’ guidance. The study found that the ‘New Ways’ methodology had been successful in stopping patients waiting indefinitely for treatment and that the NHS had “done well to implement and support the new arrangements” (ibid, p. 13).

However, the national audit body found evidence of variation in the interpretation of national guidance at local level, particularly where patients did not or could not attend their appointment, as well as evidence of gaps in the recording of some

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<sup>67</sup> Official Report of the Scottish Parliament, 28 June 2007, Column 1226

information required to demonstrate full compliance with the ‘New Ways’ guidance, i.e. there was an incomplete audit trail.

The report identified five key recommendations for NHS boards, including:

“[NHS boards should] record all New Ways data, including information on patient reviews and transfers, to ensure that all patients are being managed in line with the guidance and that this is demonstrated in a clear way.”

(Audit Scotland, 2010a:5)

The review methodology included analysis of national data, a survey of all NHS boards, review of a sample of patient information, conducting a patient survey and focus groups, and interviewing staff at a sample of four NHS Boards, including NHS Lothian.

Alongside the main report, Audit Scotland published a supplement for non-executive Board members to provide them with a list of issues and questions they may wish to satisfy themselves were being adequately addressed locally (Audit Scotland, 2010b).

Audit Scotland published a “twelve-month summary impact report” as a follow up to the 2010 performance audit on NHS waiting list management (Audit Scotland, 2011b). This impact report summarised the findings of the original review, analysed media and parliamentary reaction to the report, discussed the impact which the report had upon national policy and what further actions were required to fully address concerns which it had raised in the 2010 report.

The impact report noted the number of instances of media coverage and report downloads from the Audit Scotland website three and twelve months after publication of the original report. The report noted that “the amount of media coverage is slightly less than (sic) what was expected given the report topic. In the twelve months since publication there were 34 media items; this compares to an average of 47 media items from other similar Audit Scotland reports” (Audit Scotland, 2011b:3). This implies a relatively benign media response to the original performance audit.

The impact report returned to the 2010 finding regarding “gaps in recording data about reviews of patients who are unavailable [for treatment]... This made it

difficult to demonstrate that boards are managing all patients in the right way” (Audit Scotland, 2011b:1). The review of parliamentary scrutiny of the 2010 report indicates that politicians did not consider this finding in detail, but focused instead on findings relating to the recording of, and provision of information to, patients with additional needs, and measures which could be introduced to reduce the number of patients who do not attend their scheduled appointments.

The impact report highlights that eight NHS boards discussed the report at a board meeting, with the remaining six boards noting publication of the report for information only. The original report included a self-assessment checklist for boards to improve waiting list management. The impact report found that only five NHS boards completed the checklist, of which three developed an action plan as a result.

The overall tone of the impact report suggests that the performance audit had less of an impact than anticipated by Audit Scotland, both in the media and within NHS boards. Having conducted a full performance audit in 2010 and a follow up impact report in 2011, the national audit body did not hold any significant concerns about waiting time management practices in NHS Scotland as of June 2011. The impact report concludes that “there should not be any need to conduct a follow up study in the foreseeable future” (Audit Scotland, 2011b:6).

### **7.3 Allegations of inappropriate waiting time management practices**

#### **7.3.1 Newspaper reports**

On 23 October 2011, the front page of the Scottish edition of *The Sunday Times* newspaper<sup>68</sup> carried the headline “Waiting lists fudged”. The story revealed that:

“Officials at NHS Lothian, one of Scotland’s largest health boards, admitted that dozens of patients have been offered surgery in Harrogate, in North Yorkshire, in recent months... All of them declined, allowing the board to exclude them from a list of patients not treated within a government target of 18 weeks.”

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<sup>68</sup> See footnote 66 above.

The reports<sup>69</sup> alleged that patients were offered treatment in English hospitals in the knowledge that it was unlikely that patients would accept the offer; patients could then be marked as “unavailable for treatment” and would not be included in reported performance against national targets. Such practices allowed managers to avoid breaches of national waiting time standards. NHS Lothian defended the practice, indicating that such offers were only made in a small number of cases and that the Board had “an excellent track record in meeting our waiting times targets. The practice is about providing fast and effective care for our patients, and not about geographical boundaries”.

Opposition politicians inferred from the story that NHS Lothian had engaged in gaming of waiting time targets, as illustrated by quotes attributed to them in the report.

“It is deeply worrying that hard-working NHS staff are being forced, either by the SNP government or by health boards, to *fiddle* waiting-time figures like this.”

Jackie Baillie MSP, Scottish Labour, Shadow Cabinet Secretary for Health, Wellbeing and Cities Strategy (emphasis added)

“These cases are deeply concerning and show a lack of respect towards NHS patients. By offering appointments in locations that are too far to travel to they are not providing any real choice and some patients will be forced to decline them... To *doctor* the statistics in this way is totally unacceptable and it must be stamped out.”

Murdo Fraser MSP, then Deputy Leader of the Scottish Conservatives and spokesperson for Health and Wellbeing (emphasis added)

An unnamed medical consultant employed by NHS Lothian regarded the practice as a way of ‘massaging’ reported figures.

“Patients are being offered appointments they simply will not accept.

“They don’t realise that, for health board purposes, their refusal is marked down as a declined appointment. It’s a very effective way of *massaging* the waiting times figures.”<sup>70</sup>

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<sup>69</sup> A more detailed report was included at page 7 under the headline “NHS Lothian accused of targets scam; Patients offered treatment 200 miles away to cut waiting time lists”.

<sup>70</sup> Emphasis added

A spokesperson for the Scottish branch of the British Medical Association stops short of characterising the practice as gaming of waiting time targets, instead taking the opportunity to attack the underlying targets: “this type of activity would appear to demonstrate the efforts that boards feel they have to go to in order to comply with inflexible targets”.

Opposition politicians call upon the Scottish Government to launch an investigation into the practice, demanding to know if other NHS Boards engage in similar practices. But the Scottish Government does not concede that the actions taken by NHS Lothian constituted the manipulation of waiting time figures, either knowingly or unintentionally. A spokesperson is thus quoted:

“Patients in Scotland are benefiting from the lowest ever waiting times in years. Those offered treatment further from home, but who choose to be treated locally, remain on the waiting list and are treated within NHS guidelines.”

*The Sunday Times* story was recycled in the local newspaper<sup>71</sup> the following day but there was no further coverage of the initial story elsewhere in the national press.

### 7.3.2 Newspaper report taken to Parliament

The issue at NHS Lothian is brought into the political spotlight a few days later when Richard Simpson, a Labour MSP and former general medical practitioner and consultant psychiatrist, asked the First Minister at First Minister’s Questions on Thursday 27 October 2011<sup>72</sup> whether the Scottish Government would investigate the claims made in *The Sunday Times* article.

The First Minister admits to the Parliament that initial findings from an internal investigation underway at NHS Lothian suggested that the offer of treatment in England did not constitute a ‘reasonable offer’ in accordance with the New Ways guidance. He informed the Parliament that the Chief Executive of NHS Lothian had

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<sup>71</sup> “NHS Lothian chiefs deny ‘doctoring’ waiting lists”, *Evening News (Edinburgh)*, Monday 24 October 2011, 1<sup>st</sup> edition, p. 6, Sue Gyford and Laura Cummings

<sup>72</sup> Question lodged by Dr Richard Simpson MSP: “To ask the First Minister whether the Scottish Government will investigate claims that patients are being offered unrealistic surgery appointments in England in order to circumvent waiting times targets.” S4F-00205

ordered a full investigation and that a copy of the final report would be submitted to the Cabinet Secretary for Health, Wellbeing and Cities Strategy.

The supplementary (follow up) question posed by Dr Simpson asked whether the Scottish Government would “undertake a review of the new ways waiting times initiative to ensure that no gaming is taking place in other areas of Scotland.” The First Minister responded that “there is now transparency, so the Cabinet Secretary [for Health, Wellbeing and Cities Strategy] does that as a matter of course”<sup>73</sup>.

This exchange highlights two contrasting views on the need for independent scrutiny of waiting time management as a result of the failure of one organisation to fully comply with national guidance. The ruling government maintains that this is an isolated case and that existing governance arrangements prevent the gaming of targets, thus there is no need for a further review. However, opposition politicians make the case for a wider investigation to provide robust evidence that the practice deployed by NHS Lothian is, in fact, an isolated case and the integrity of national waiting time performance is not under threat. In the very early days, the government does not accept that any external scrutiny or audit is required, in line with the prevailing policy theme in Scotland that NHS organisations can be trusted to accurately report performance without the need for third party assurance.

The ensuing national media coverage focuses on demands for an independent review: *The Herald* newspaper reports the aforementioned exchange at First Minister’s Questions under the headline “Demand for waiting list inquiry”<sup>74</sup> carrying a quote from Dr Richard Simpson MSP that “we need a full Scotland-wide investigation into the SNP’s hidden waiting-list scandal”.

The focus of the review shifts within a couple of days. *The Sunday Times* follows up its initial report a week later by reporting on plans by NHS Lothian to refer a large number of patients to private hospitals in order to comply with national waiting time

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<sup>73</sup> Official Report of the Scottish Parliament, Thursday 27 October 2011, at Column 2847

<sup>74</sup> “Demand for waiting list inquiry”, *The Herald*, Friday 28 October 2011, 1<sup>st</sup> edition, p. 6

targets. The Scottish Labour Party again calls for “a full, independent, Scotland-wide investigation”<sup>75</sup>.

That report does not carry any official statement from the Scottish Government but does state that the practice of offering patients surgery in England “was described last week as ‘unreasonable’ by Alex Salmond, the first minister, in a statement to the Scottish Parliament”.

Detailed review of the Official Report of the exchange in the Scottish Parliament between the First Minister and Dr Simpson<sup>76</sup> reveals that the First Minister referred to initial findings from the internal investigation at NHS Lothian that the Board “did not make its patients a *reasonable offer*” (emphasis added). This is a technical term defined in the New Ways guidance. The First Minister did not pass judgement on either the practice or NHS Lothian in the parliamentary chamber. The newspaper report transforms a factual statement on compliance with official guidance into a value judgement by the most senior politician in devolved Scotland. The newspaper report has the potential to influence wider opinions and actions by inferring direct criticism of the Board’s practices by the ruling government.

A further report in the same edition of *The Sunday Times* considers the internal inquiry launched by NHS Lothian “after *The Sunday Times* raised concern that figures for waiting times were being fiddled by staff”<sup>77</sup>. A newspaper report, a seemingly inanimate object, has triggered a series of actions. A single page of newsprint has given rise to an organisational investigation by one of the largest public bodies in Scotland which is to be reported to government ministers, and discussion in the Scottish Parliament, including pronouncements by the most senior politician in devolved Scotland.

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<sup>75</sup> “MSPs call for probe into NHS loophole”, *The Sunday Times*, Scotland edition, Sunday 30 October 2011, 1<sup>st</sup> edition, p. 1, Mark Macaskill

<sup>76</sup> Official Report of the Scottish Parliament, Thursday 27 October 2011, at Columns 2847-8

<sup>77</sup> “Inquiry into NHS waiting list ‘fiddle’”, *The Sunday Times*, Scotland edition, Sunday 30 October 2011, p 4, Mark Macaskill

## 7.4 Initial official response by NHS Lothian

### 7.4.1 Response by Lothian NHS Board

Lothian NHS Board met on Wednesday 23 November 2011, the first public meeting of the board since the story on waiting time management broke.

Board meetings are held in public with minutes and papers made available on the Board's website<sup>78</sup>. At the time the initial allegations were reported, 'delivering waiting times' was a standing item on the agenda of board meetings. Management presented board members with a short report under this item.

The 'delivering waiting times' reports were co-produced by the business manager and associate director of strategic planning, and presented to board members by the interim director of strategic planning who is the executive lead in this area. The executive lead has responsibility, *inter alia*, for performance reporting across the organisation, but not for delivery of the underlying services which are the subject of the performance measures.

The reports produced for the September and November 2011 meetings were reviewed in detail in order to understand whether the newspaper reports and internal inquiry had brought about any change in board reporting practices.

Both reports summarise targets and latest performance statistics for each waiting time target, of which elective procedures covered by the 18 weeks referral to treatment (RTT) standard is just one. An 'assessment' is included in the report to show whether the Board is meeting the milestone set for each target.

The reports show that reported performance against the 18 week RTT standard improved marginally between September and November 2011, from 90.3% to 90.6% (against milestone targets of 83.3% and 85% respectively).

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<sup>78</sup> All NHS Lothian Board papers and Committee minutes referred to in this chapter were accessed on the NHS Lothian website via the following link <http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx> (accessed on 15 June 2013)

Neither report provides any detailed data on how targets are met, or indeed the number of patients who are currently coded as ‘unavailable’ for medical or social reasons.

The report for the November meeting makes an implicit reference to the issues raised by *The Sunday Times* reports:

“As from October 2011 patients are no longer being offered treatment in England. The Medical Director is currently leading a review group to ensure future practice is strictly in line with Scottish Government guidance on New Ways.

The Board’s Chief Operating Officer is reviewing capacity locally to ensure that this is maximised. As well as this, contact has been made with other surrounding NHS boards to source any additional capacity that they may have available.”

This is the only written reference in the public Board papers to recent media and parliamentary attention on the organisation’s waiting time management practices.

The published minutes of the discussions held under the ‘delivering waiting times’ items at the September and November board meetings are both essentially summaries of the written report presented to the meeting. There is no written record of substantive comment or challenge by non-executive board members on performance against the 18 week RTT standard, or any other waiting time target, at either meeting. The minute of the discussion at each meeting runs to five paragraphs and, in both cases, is shorter than the discussion of other ‘performance reports’ included on the agenda (see table 7.1 below).

*Table 7.1: Numbers of paragraphs included in minutes of Lothian NHS Board meetings held on 28 September 2011 and 23 November 2011 in respect of the four standing items included on the agenda under ‘performance management’*

	September	November	Total
Financial position	17	7	24
Delivering waiting times	5	5	10
Tackling delayed discharge	6	10	16
Healthcare Associated Infection	8	9	17
Total	36	31	67

Source: Minutes of Lothian NHS Board meetings held on 28 September 2011 and 23 November 2011, accessed via [www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

The tone and content of the concluding paragraph of the minute, summarising the Board's collective position, shifts slightly between September and November:

September:

“The Board noted the positive performance in respect of waiting time targets.”<sup>79</sup>

November:

“The Board noted the progress being made by NHS Lothian in delivering waiting times targets.”<sup>80</sup>

It may be inferred that the organisation has become more guarded in its judgement on waiting times: a value-based “positive” judgement gives way to a factual statement.

There are few traces in the public record of the November board meeting of consideration of either the concerns raised in the media reports or the follow up action initiated by the Chief Executive.

#### 7.4.2 Parliamentary interest

There was also little trace of parliamentary interest in the waiting time issue following the exchange at First Minister's Questions in late October 2011, save for one written question regarding Scottish patients receiving treatment in England and Wales<sup>81</sup> and one oral question which was not taken in the parliamentary chamber and a written answer was subsequently issued<sup>82</sup>. Both questions were lodged by Scottish Labour MSPs with a constituency interest in NHS Lothian.

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<sup>79</sup> Minute of Lothian NHS Board meeting held on Wednesday 28 September 2011, at paragraph 67.5

<sup>80</sup> Minute of Lothian NHS Board meeting held on Wednesday 22 November 2011, at paragraph 89.5

<sup>81</sup> Kezia Dugdale MSP, Scottish Labour regional member for Lothian, lodged the following written question on 27 October 2011: “To ask the Scottish Executive whether it plans to amend the guidance for NHS boards to ensure that appointments in England and Wales offered to patients from Scotland that are not taken up do not count toward the 18-week guarantee on waiting times” [S4W-03656]. Nicola Sturgeon answered the question on 7 November 2011 – see written answer report published online at [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20111107.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20111107.pdf) (accessed on 17 July 2012).

<sup>82</sup> S4O-00416 “To ask the Scottish Executive what progress is being made on the investigation of allegations of so-called hidden waiting lists in NHS Lothian”. Nicola Sturgeon answered the question on 24 November 2011 – see written answer report published online at

## 7.5 Publication of the internal investigation report

Sarah Boyack MSP subsequently lodged a written question, asking the Cabinet Secretary to specify the further information which she had requested from NHS Lothian following receipt of the initial review report. An answer was provided on 11 January 2012<sup>83</sup>, although by this time the report was in the public domain. The Cabinet Secretary sent a copy to the convener of the Parliament's Health and Sport Committee and to the Scottish Parliament Information Centre two days prior to publication of the answer.

The covering letter sent to the Health and Sport Committee convener<sup>84</sup> introduces 'audit' into the official response to the performance concerns

“While Lothian Health have promised that there will be no reoccurrence of this practice we will be asking the Board's internal audit function to specifically audit the application of waiting time practices and management within Lothian in the Spring to provide further reassurance on this matter.”

This statement marks a shift in the relationship between Scottish Government Ministers and NHS Lothian: the Board is no longer trusted to report on local practices and a secondary source of assurance is now required to validate the board's own reports. This contrasts with the position taken by the First Minister in the Parliament in October 2011 when he resisted requests from opposition politicians to launch a separate investigation into the claims.

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[http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20111124.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20111124.pdf) (accessed on 20 August 2013).

<sup>83</sup> S4W-04642 “To ask the Scottish Executive further to the answer to question S4O-00416 by Nicola Sturgeon on 24 November 2011, what further information was requested by the Cabinet Secretary for Health, Wellbeing and Cities Strategy following receipt of the initial report”. Nicola Sturgeon answered the question on 16 January 2012 – see written answer report published online at [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20120111.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20120111.pdf) (accessed on 17 July 2012).

<sup>84</sup> Letter from Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy, to Duncan McNeil MSP, convener of the Health and Sport Committee, 9 January 2012 – published online by the Health and Sport Committee at [http://www.scottish.parliament.uk/S4\\_HealthandSportCommittee/General%20Documents/2012.01.09\\_to\\_DM\\_-\\_report\\_from\\_NHS\\_Lothian\\_on\\_waiting\\_times\\_management.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/General%20Documents/2012.01.09_to_DM_-_report_from_NHS_Lothian_on_waiting_times_management.pdf) (accessed on 17 July 2012).

The Lothian review concluded that the offer of treatment in England was not intended to manipulate waiting time performance, yet the minister still requests that an internal audit review be carried out.

The letter also makes clear that the request for the internal audit has been made directly by the Scottish Government; Ministers did not ask NHS Lothian to commission an internal audit review. The Government is claiming ownership of the internal audit review.

The letter goes on to consider the implications for other NHS Boards.

“All NHS Boards have assured us that they are following the guidance in relation to making offers to patients that can be considered fair and reasonable. I am aware that this guidance was drawn up some years ago and we will wish to take the opportunity in the early part of this year to refresh this guidance such that there is no possibility of misinterpretation.”<sup>85</sup>

The Minister makes no suggestion that the practice employed by NHS Lothian is symptomatic of practices elsewhere in Scotland. At this point, the assurances offered by other Boards are sufficient for Ministers to conclude that no further action is required to assure the national position. It appears that a high-trust relationship is maintained with all NHS organisations, other than Lothian, and the Minister has no need to seek independent verification of their assurances.

The primary response in relation to other organisations is a commitment to ensure that official guidance is as clear as it could be, rather than to test compliance with existing guidance. This response implicitly gives the Scottish Government responsibility for addressing any potential for ambiguity which could be exploited or misinterpreted by NHS boards.

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<sup>85</sup> Ibid.

## 7.6 NHS Lothian Waiting Time Management Group report

The report of the NHS Lothian Waiting Time Management Group (NHS Lothian, 2012) runs to 16 pages, with the main body of the report confined to five pages. Two of these five pages comprise context and background material.

The review was chaired by the medical director, supported by a group of five senior members of staff including the employee director and director of HR and organisational development. The Group was given a specific remit by the Chief Executive:

“To investigate claims that patients in NHS Lothian are being offered unrealistic surgery appointments in England to circumvent guidance, and to review the organisational management of waiting lists, including administration, capacity planning and training to ensure it is strictly in compliance with New Ways guidance.”

(NHS Lothian, 2012a:2)

The review was based on a 20-question survey issued to 10 ‘key’ inpatient services and interviews with 13 members of staff<sup>86</sup> responsible for waiting time management. The survey, which is reproduced as an appendix to the main report, asks general questions about waiting time management processes and procedures; it does not review specific cases. The report indicates that interviewees were “drawn from all levels of the organisation” (NHS Lothian, 2012a:4) but review of the list of interviewees indicates a bias towards senior management with 7 of the 11 interviewees listed in the appendix employed at assistant director level or above.

The overall position taken by the authors of the report can be characterised as defensive. The ‘context’ section congratulates the Board on “remarkable achievements” (NHS Lothian, 2012a:2) in coping with significant increases in demand for elective procedures in recent years and emphasises that a significant proportion of Lothian patients who receive treatment in hospitals in England are referred for highly specialist care.

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<sup>86</sup> Only 11 interviewees are listed at Appendix 1 to the report so it is not clear if all 13 staff were interviewed.

The Group interprets the findings of the survey in such a way as to allow it to conclude that “overall the key ‘New Ways’ guidance was being adhered to” (NHS Lothian, 2012a:4). This is a bold conclusion to infer from answers to survey questions on high level policies, and without testing actual practice. There is no evidence in the report of serious reflection on the inappropriate practices highlighted by the media. Indeed, the specific practice highlighted in *The Sunday Times* report in October 2011 is defended:

“In areas where treatment might be offered at a different Lothian site, an alternative site in Scotland or elsewhere, this was made clear to patients at the outset and the consequences of declining such offers in terms of the effect on waiting times was also explained. The specific offer of treatment being made available in Northumbria was confined to the specialties of General Surgery, Urology and Orthopaedics.”

(NHS Lothian, 2012a:4)

The report highlights deficiencies in the national New Ways guidance, as well as the limitations posed by the patient management IT system. It emphasises areas of ambiguity in the national guidance, creating an impression that NHS Lothian staff were making offers to patients in accordance with the guidance. This contrasts with the position taken by the First Minister in October that the Lothian practices did not comply with the New Ways guidance discussed above.

The report concludes that there was no intentional breach of the New Ways guidance by NHS Lothian. This reinforces the impression that the Board’s initial response is to hold the national guidance responsible for any unintentional dysfunctional behaviour, rather than the organisation or individual members of staff. Indeed, the official response almost sanctifies the actions taken by staff by praising them for “trying hard” to provide patients with timely treatment.

“We believe that staff with responsibility for managing waiting times according to the ‘New Ways’ guidance have been trying hard to ensure patients have surgery as soon as possible. The additional capacity that was offered in surgery, urology and orthopaedics in Northumbria we believe was a genuine attempt to provide an additional option for patients with routine clinical needs.”

(NHS Lothian, 2012a:6)

It thus shifts blame from the organisation on to the Scottish Government, which was responsible for the overall policy and production of the associated operational guidance.

Four improvement actions are identified for implementation by the organisation over a three-month period.

The report does not suggest at any point that the action taken by NHS Lothian was unacceptable or not permitted under the New Ways guidance.

### **7.7 Parliamentary and media reaction to the report of the NHS Lothian Waiting Time Management Group**

Publication of the NHS Lothian report re-ignited political interest in the issue and the Cabinet Secretary faced two oral questions from opposition MSPs in the Scottish Parliament during Health, Wellbeing and Cities Strategy questions on Thursday 12 January 2012.

The first question<sup>87</sup>, asked in the chamber as a supplementary question and not lodged in advance, challenged the report prepared by NHS Lothian on three grounds: (i) there was no patient representation on the NHS Lothian Waiting Time Management Group; (ii) the report did not consider any of the individual cases where patients had refused an offer of treatment in England; and (iii) no information was available on the reasons underlying a significant proportion of suspensions from the waiting list.

The Cabinet Secretary replies with a strongly negative judgement on the practices employed by NHS Lothian:

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<sup>87</sup> Question asked by Dr Richard Simpson MSP, as reported in the Official Report of the Scottish Parliament, 12 January 2012, Col. 5263

“The investigation shows that there was no intention on the part of NHS Lothian to manipulate waiting times. However, I am clear that it was *not acceptable* for the health board to offer patients treatment in England at short notice... I *will not tolerate* any attempts to get round the waiting times target. It is vital that patients are treated as quickly as possible.”<sup>88</sup>

The Cabinet Secretary’s position is clear: she considers that NHS Lothian behaved inappropriately in making offers of treatment in England at short notice, regardless of the stated conclusion of the review that there was no intention to circumvent New Ways guidance on waiting time management.

The second question<sup>89</sup>, lodged prior to publication of the NHS Lothian report earlier that week, asked when the Scottish Government would publish its response to the NHS Lothian investigation. The Cabinet Secretary refers the questioner to the letter sent to the Health and Sport Committee<sup>90</sup>, but she neither explains that response, nor makes reference to the internal audit examination which she requested. The supplementary question focuses on the apparent pressures on NHS Lothian’s capacity and resources over recent years following significant increases in demand for elective procedures, which were highlighted in the NHS Lothian report.

The NHS Lothian report has diverted political attention away from the specific practices employed by the NHS board in order to report that waiting time targets have been met, to the adequacy of resources which the Scottish Government provides to NHS Lothian. And again the Scottish Government, not NHS Lothian, is held responsible for the practices highlighted in *The Sunday Times*.

Initial media coverage of the report’s publication was limited to one local<sup>91</sup> and one national<sup>92</sup> story. The focus of both news reports is the criticism which the Cabinet

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<sup>88</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), quoted in the Official Report of the Scottish Parliament, Thursday 12 January 2012 at Column 5263, emphasis added

<sup>89</sup> S4O-00561 lodged by Sarah Boyack MSP, Scottish Labour

<sup>90</sup> Reported in the Official Report of the Scottish Parliament, Thursday 12 January 2012 at Columns 5268-9

<sup>91</sup> “Sturgeon slams NHS chiefs over English surgery offer”, *Evening News* (Edinburgh), Saturday 14 January 2012, p. 7, 1<sup>st</sup> edition, Sue Gyford

Secretary directed towards NHS Lothian in the Scottish Parliament, carrying the headlines “Sturgeon slams NHS chiefs over English surgery offer” and “Lothian in waiting list rebuke” respectively.

The tone of the response from NHS Lothian shifts slightly in the wake of the Cabinet Secretary’s remarks; both newspaper reports carry a quote from its Chief Operating Officer which suggests that the Board accepted greater responsibility for the waiting list management practices than the initial review report implied.

“We have learned many lessons from this experience. One of those is that we should have been aware earlier that we were making offers to patients which they couldn’t accept.”

The report in the local newspaper is accompanied by an editorial<sup>93</sup> which, rather than focus upon the unacceptable practices employed by NHS Lothian, again directs blame towards the Scottish Government for apparent under-funding of the health board which has restricted its ability to develop capacity to accommodate increasing demands for elective treatment. This mirrors the parliamentary scrutiny from opposition politicians and demonstrates the success of the NHS Lothian report in transferring responsibility for any questionable practices back to the Scottish Government.

The national article<sup>19</sup> carries a reference to the internal audit requested by the Scottish Government in response to NHS Lothian’s own review report.

Political interest in waiting time management then temporarily subsided. Only one written parliamentary question was lodged in response to publication of the NHS Lothian report. This question<sup>94</sup> from Alison McInnes MSP, Liberal Democrat spokesperson for Health and Justice, returned to the issue of how the Scottish

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<sup>92</sup> “Lothian in waiting list rebuke”, *The Sunday Times*, Scottish edition, Sunday 22 January 2012, p. 14, 1<sup>st</sup> edition, Mark Macaskill

<sup>93</sup> “Leader: The underlying problem remains”, *Evening News* (Edinburgh), Saturday 14 January 2012, p. 11, 1<sup>st</sup> edition

<sup>94</sup> S4W-05042 “To ask the Scottish Executive, in light of the investigatory group on waiting times in NHS Lothian, how it will ensure that NHS boards will not offer patients short-notice surgery appointments in England”. Nicola Sturgeon answered the question on 25 January 2012 – see written answer report published online at [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20120125.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20120125.pdf) (accessed on 17 July 2012).

Government would ensure that other NHS Boards did not also offer patients short-notice surgery appointments in England. The Cabinet Secretary reaffirms her earlier response: NHS boards have provided assurances that they do not engage in this practice and no further action is required. The high-trust relationship with other NHS organisations is reinforced.

Up until this point, concerns regarding potential ‘gaming’ of targets were restricted to the practice of making short-notice offers of treatment in England to patients awaiting elective procedures.

## **7.8 Intervention in the internal audit review**

Lothian NHS Board met again on Wednesday 25 January 2012 and considered the recent waiting time management issues under the standing agenda item ‘delivering waiting times’. There are some presentational changes in the accompanying report, compared to the equivalent reports submitted to the September and November 2011 meetings reviewed above. The report was now produced in the name of the executive lead, rather than executive management, as well as presented by him. This indicates that the organisation has recognised the significance of the waiting time issues by assigning responsibility for reporting on the issue further up the management hierarchy.

The report outlines changes that NHS Lothian made to waiting list management practice in October and November 2011 “to ensure *strict* compliance with the Scottish Government New Ways Guidance” (emphasis added). The board papers make repeated references to “strict compliance” with New Ways guidance. It appears that senior management is not willing to concede that NHS Lothian had previously failed to comply with the guidance, merely that a more liberal interpretation of potentially ambiguous guidance had been adopted.

The changes made to waiting time management practices resulted in a high number of “breaches” of treatment targets, meaning that patients were waiting longer for treatment than the national standard prescribed. These breaches were driven by a

significant reduction in the number of patients coded as ‘unavailable’ for treatment. The total number of reported breaches increased by c. 2,100 (c. 250%) between October and November. The report explains that action is being taken to source additional capacity but that short-term shortages have necessitated the use of private hospitals to treat the backlog of patients. This course of action has been “discussed and agreed with the Scottish Government Health Directorates”. This is a further example of NHS Lothian using the Scottish Government as a buffer against potential criticism of organisational action.

This report to the board is the first public intimation of the scale of the inappropriate practices employed by NHS Lothian and their impact on patient waiting times. Furthermore, the scale of reported breaches far exceeds the number of breaches highlighted in the addendum to the internal review by the Waiting Time Management Group which reported that 100 patients who declined an offer of treatment in England were still awaiting treatment.

Although the length of the minute of the associated discussion at the Board meeting is comparable to the minutes of earlier meetings (see table 7.1 above), there is greater evidence of challenge from non-executive board members to the position reported by executive management. The minute indicates that it was the Chief Operating Officer who answered questions from non-executive board members, and not the acting director for strategic planning who is named as executive lead for the paper. This highlights a disconnect between operational responsibility and reporting responsibility for waiting time management within the board, which may be symptomatic of the decoupling behaviour which can arise in the audit society (Power, 1994a:28-9; Power, 1999:96; Arnaboldi and Lapsley, 2008).

The ‘delivering waiting times’ report to the January board meeting was the subject of a front-page story in the local paper two days later: “Probe into NHS ‘hidden’ waiting list”<sup>95</sup>. The newspaper article quotes the number of patients who have had to wait longer for treatment than the target, as reported to the board. Unlike articles in the same newspaper two weeks earlier which focused attention on under-resourcing

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<sup>95</sup> “Probe into NHS ‘hidden’ waiting list”, *Evening News* (Edinburgh), Friday 27 January 2012, p. 1, 1<sup>st</sup> edition, Rory Reynolds

of NHS Lothian, this article returns the focus to the health board. It carries a statement from the Chief Operating Officer outlining the actions being taken to address the backlog of waiting time ‘breaches’.

There are no comments in the article from the Scottish Government, although the Chief Executive “welcome[s] the support from the Scottish Government in terms of additional funding and the expertise they are giving us in recognition of our particular circumstances”<sup>96</sup>. This is a change from the previous reports which attempted to move responsibility for the criticised actions towards NHS Lothian.

This newspaper report is also significant as it is the first public trace that the *internal* audit review requested by the Cabinet Secretary has become an *external* review:

“The *Evening News* can also reveal that external auditors have been brought in to probe the health board’s official figures on hitting Scottish Government waiting time targets...”<sup>22</sup>

On the same day that the *Evening News* report was published, Dr Richard Simpson MSP lodged a series of four written questions<sup>97</sup> on the conduct and findings of the internal review of waiting time management conducted by NHS Lothian. In answering one of the questions on 9 February 2012<sup>98</sup>, almost a week after publication of the newspaper report, the Cabinet Secretary indicates that: “an external audit of the NHS Lothian’s waiting time management is currently underway” (sic.). This is the first public trace whereby the Cabinet Secretary acknowledges that the terms of her initial request, as outlined in her letter to the Health and Sport Committee on 9 January 2012, have changed.

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<sup>96</sup> Ibid.

<sup>97</sup> References S4W-04960 to S4W-04962 and S4W-04964, all lodged on 27 January 2012 (see Business Bulletin for Monday 30 January 2012 published online at <http://www.scottish.parliament.uk/parliamentarybusiness/BusinessBulletin/46422.aspx>)

Questions S4W-04961 and S4W-04962 were answered on 6 February 2012 – see Written Answer Report published online at [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20120206.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20120206.pdf)

Questions S4W-04960 and S4W-04964 were answered on 9 February 2012 – see Written Answer Report published online at [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20120209.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20120209.pdf)

All online links accessed on 17 July 2012.

<sup>98</sup> S4W-04960 – see reference to published answer at previous footnote.

Meanwhile, the NHS Lothian Finance and Performance Review Committee met on 8 February 2012. While papers of board committee meetings are not made public, the minutes of meetings are routinely included in the publicly available papers for the next meeting of the full board. The minute of the Committee meeting held on 8 February 2012, included in the papers for the Lothian NHS Board meeting held on 28 March 2012, indicates that the Chief Operating Officer provided both written and verbal updates on waiting time management to the meeting.

The minute of that discussion runs to 17 paragraphs, indicating either that a longer and more involved discussion on waiting time management took place at the committee meeting than at the full board meeting held three weeks earlier, or that the committee members were more anxious to leave a formal trace of the discussion.

The minute clarifies some points raised in the internal review report.

The internal review report found that:

“Staff also mentioned a common operational ‘work around’ that results in high levels of in-month fluctuations in volumes of waiting times suspensions. The TRAK [patient management] system, as currently configured, does not permit staff to book patients for admission outwith their guarantee date. In order to book patients beyond their guarantee date it was necessary to apply a period of unavailability to the patient’s waiting time.”

(NHS Lothian, 2012a:5)

However, the minute of the meeting of the Finance and Performance Review Committee held on 8 February 2012 indicates that:

“Mrs Sansbury emphasised that the review undertaken by the Medical Director had revealed that in some areas some administrative staff had diverged from the expected practice of consulting a supervisor who was able to book outwith in the standard timeframe...”<sup>99</sup> (sic)

This clarification fundamentally changes the meaning of the original finding; it has been transformed from a system limitation to a personnel failure to adhere to standard operating procedures.

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<sup>99</sup> Minute of the meeting of the NHS Lothian Finance and Performance Review Committee held on 8 February 2012, at paragraph 68.4

The minute also reveals instances of board members pre-judging the outcome of the external review which was now being conducted by Big 4 professional services firm PricewaterhouseCoopers (PwC) under the direction of NHS Lothian.

“Mr Egan [employee director] advised the Committee that he had been part of the review and could *categorically reassure* the Committee and the Board that there had been no misconduct at Executive Director level. He confirmed that Executive Directors had been as unaware of the problem as Non-Executive Board members...

“Mr Egan was therefore confident that the PricewaterhouseCoopers audit was likely to find that Executive Management Team colleagues had done nothing wrong in their handling of the situation.”<sup>100</sup>

This is the most emphatic offer of assurance made by NHS Lothian during the period of study. It also indicates complacency at the highest level of the organisation: the primary focus is on absolving executive management of blame, rather than showing leadership and being held to account for the performance failings. The essential point is arguably that senior management and board members should have been able to identify and remedy the weaknesses in waiting time management practices earlier.

Meanwhile, the NHS Lothian Audit Committee met on 28 February 2012. Like the Finance and Performance Review Committee, Audit Committee meetings are not held in public, but the minutes of such meetings become public through inclusion in the papers of the subsequent board meeting, the papers for which are published on the NHS Lothian website.

It is apparent from the minute that the Audit Committee also met on 31 January 2012 and 21 February 2012. However, formal minutes of these meetings are not tabled on 28 February 2012, and are not included in the public board papers. The only minutes tabled relate to the last scheduled meeting of the Committee which took place in October 2011. Instead, the Committee chair provides a verbal update on the intervening meetings. This suggests that the Committee did not wish to leave a public trace of these interactions.

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<sup>100</sup> Minute of the meeting of the NHS Lothian Finance and Performance Review Committee held on 8 February 2012, at paragraphs 68.11-12, emphasis added

The minute of this meeting provides a summary of recent events in relation to the waiting time issue. Table 2 below presents this summary as a timeline from the date of the first non-minuted meeting up to the date of the present meeting.

*Table 7.2: Timeline of Audit Committee involvement in waiting list management response, 31 January 2012 to 28 February 2012*

Date	Event(s)
31 January 2012	Audit Committee meeting – minutes not formally tabled
6 February 2012	Audit Committee, on behalf of the board, commissions PricewaterhouseCoopers (PwC) to undertake audit of waiting list management
17 February 2012	PwC provides verbal report on interim findings to NHS Lothian Waiting time management group
20 February 2012	Board receives letter from the Scottish Government, indicating that “the audit should be carried out by the Scottish Government (as distinct from Lothian NHS Board)”
21 February 2012	Audit Committee meets to consider Scottish Government letter
22 February 2012	Board agrees to terminate contract between NHS Lothian and PwC
28 February 2012	Audit Committee meeting

*Source: Minutes of NHS Lothian Audit Committee meeting held on Tuesday 28 February 2012, as included in published papers for the Lothian NHS Board meeting held on 28 March 2012*

One short paragraph in the public minute of the Audit Committee meeting provides a public trace of the intervention made by the Scottish Government to assume the contractual relationship with the external firm originally commissioned by NHS Lothian to undertake the audit review requested by the Scottish Government in January. It evidences that an internal audit to be conducted by the Board became a review by a third party under the direction of the Scottish Government.

There is significant erosion of trust in the relationship between the Scottish Government and NHS Lothian in the period following publication of the original newspaper report:

- NHS Lothian was initially asked to conduct an internal investigation of claims made by *The Sunday Times* newspaper that NHS Lothian was

deploying gaming tactics in order to report achievement of waiting time targets.

- Having received the report of the internal investigation, the Scottish Government asks the Board's internal audit function to carry out its own review of waiting list management to "provide further reassurance".
- The Board commissions an external independent firm to carry out this review. Once that external firm discusses interim findings with NHS Lothian, the Scottish Government intervenes and assumes contractual responsibility for the review so that findings are reported directly to them. This implies that NHS Lothian could no longer even be trusted to faithfully report the findings of an independent review.

The minutes of the Audit Committee meeting leave a trace of the Board's position in relation to the ongoing review:

"The Chair highlighted the strong sense of commitment from the Board to maintain the internal efforts towards achieving waiting times targets. He highlighted that management actions originally identified as a consequence of Dr Farquharson's report were progressing in order to ensure waiting times systems in NHS Lothian were fit for purpose."<sup>101</sup>

"The Chair commented that this issue had been handled with diligence, transparency and rigour."<sup>102</sup>

The minutes also indicate further defensive moves to protect both executive and non-executive board members from the allegations, following the 'categorical reassurances' provided by the employee director to the Finance and Performance Review Committee on 8 February:

"[The employee director] referred to the work of the Special Review Group of the Board and reported that an internal investigation was being taken forward to provide assurance that internal reporting to the Board was consistent."

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<sup>101</sup> Minute of the meeting of the NHS Lothian Audit Committee held on 28 February 2012, at paragraph 20.2.1

<sup>102</sup> Minute of the meeting of the NHS Lothian Audit Committee held on 28 February 2012, at paragraph 20.4

“[The Chief Executive] added that the reporting of waiting times data has been consistent across governance committees, with executive directors reporting figures as presented to them and understood by them. The Committee acknowledged this position.”<sup>103</sup>

Although the minutes of the aforementioned Finance and Performance Review and Audit Committee meetings were not officially published by NHS Lothian until late March, news of the Scottish Government’s intervention in the audit was already in the public domain. Neil Findlay MSP, of the Scottish Labour Party, lodged a series of six written parliamentary questions on 27 February 2012<sup>104</sup> regarding the Scottish Government’s intervention in the independent audit of waiting times practices commissioned by NHS Lothian. These were answered on 9 March 2012, but not before the intervention had been reported by the local newspaper.

The newspaper report which appeared on Thursday 1 March 2012<sup>105</sup>, the day after the Audit Committee meeting and Neil Findlay’s written questions were published in the Scottish Parliament Business Bulletin, summarises recent events. It also makes public the growing discord between NHS Lothian and the Scottish Government by publishing extracts from a letter sent by the chair of NHS Lothian to the Cabinet Secretary and carrying further statements which the chair made directly to the newspaper.

Quoting from the letter:

“Board members have asked me to relay to you their disappointment at the suggestion in your letter that their independent external audit lacked the ‘appropriate corporate governance’... Board members particularly wished me to communicate to you that they believe they were appointed by you in the expectation that they would act with integrity at all times”.

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<sup>103</sup> Minute of the meeting of the NHS Lothian Audit Committee held on 28 February 2012, at paragraph 20.2.3

<sup>104</sup> Written question references S4W-05946 to S4W-05951, inclusive, published in the Scottish Parliament Business Bulletin on Tuesday 28 February 2012 (see <http://www.scottish.parliament.uk/parliamentarybusiness/BusinessBulletin/47816.aspx> accessed on 18 July 2012)

<sup>105</sup> “Emergency surgery for NHS audit”, *Evening News* (Edinburgh), Thursday 1 March 2012, p. 11, 1<sup>st</sup> edition, Sue Gyford

The report also carries a quote from a Scottish Government spokesperson:

“In the interests of appropriate corporate governance, the Scottish Government will take over the management of the external audit report. This will preserve the independent status of the audit function.”

It is clear from the above quotes that the board members view the intervention as a direct, and personal, attack on their professionalism. Furthermore, an adversarial relationship is developing between the Scottish Government and NHS Lothian where there was previously a high trust relationship.

The official Scottish Government statement also raises questions over generally accepted auditing practice: in the private, voluntary and parts of the public sector, organisations appoint their own external auditors. It is not clear which fundamental principle of corporate governance is under threat. However, the symbolic importance of the reference point is perhaps greater than its technical significance. The public do not necessarily need to understand the technical point, but rather to accept the signpost that the government is upholding objective good practice in dealing with the performance crisis.

The editorial which appears in the same edition of the local newspaper<sup>106</sup> expresses some exasperation at developments in the review but returns the focus to one group who had been missing from more recent reports on the unfolding issues with waiting list management: the patients.

“The latest twist in the NHS Lothian waiting-list saga has descended into farce...

“‘Appropriate corporate governance’ is the problem, apparently. What taxpayers are left with is presumably a bigger bill and delay.

“Quite why this is necessary is anyone’s guess but at best it has been a monumental breakdown in communication and at worst demonstrates a worrying nosedive in the relationship between NHS Lothian and Holyrood...

“None of this, however, matters to patients. All they care about is being seen by a medical professional as swiftly and as efficiently as possible.

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<sup>106</sup> “Leader: NHS Lothian audit: Why end one report just to start another?” *Evening News* (Edinburgh), Thursday 1 March 2012, p. 16, 1<sup>st</sup> edition

“If the fact the Scottish Government is now instructing the audit helps to ensure that and get to the root of any problems which PwC wouldn’t have done otherwise then it has to be a good thing. But we must ask why this wasn’t just done from the very beginning?”<sup>107</sup>

“Those waiting for an end to this saga may be waiting some time.”<sup>107</sup>

To the public, the Scottish Government intervention in the PwC review appears to be nothing more than a distraction from fixing the underlying problem and ensuring that patients are treated as quickly as possible in line with national waiting time commitments. These concerns override any interest in the ‘corporate governance’ surrounding the review. It may be that audit technologies are being used to serve a political, rather than public, interest, allowing the Scottish Government to exert greater control over the investigation and over NHS Lothian.

The Cabinet Secretary provided an official update on progress with the review to the Scottish Parliament on Thursday 8 March 2012 in response to a question from the late David McLetchie, an MSP from the Conservative party, during Question Time<sup>108</sup>. The Cabinet Secretary confirmed that Scottish Government officials had taken over the commissioning of the audit “in the interests of appropriate corporate governance”. In response to a supplementary question which both queries the basis of the turnaround on conduct of the audit and suggests that ambiguities in the official guidance on waiting list management are the true source of the problem, the Cabinet Secretary states that:

“The carrying out of an audit that complies with strict standards of corporate governance and *is seen to be completely independent* of NHS Lothian should be welcomed...

“I want to ensure that people have confidence in Lothian and in every part of Scotland. Patients expect and deserve that the rules that we set out to ensure speedy access to treatment should be complied with.”<sup>109</sup>

Again, it is not clear what ‘standards of corporate governance’ are being adhered to. The Cabinet Secretary dismisses claims that the guidance is ambiguous and turns

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<sup>107</sup> Ibid.

<sup>108</sup> Question S4O-00767 answered in the Chamber on 8 March 2012 as reported in the Scottish Parliament Official Report at Column 7059.

<sup>109</sup> Ibid. Emphasis added.

attention back to patients and the public. The statement implies that the public cannot have any confidence in NHS Lothian's waiting time performance without an independent audit; the minister calls on the public to place their trust in the audit function, not in the providers of frontline NHS services (Power, 1999).

The following day, the Cabinet Secretary answers six written questions lodged by Neil Findlay MSP in late February<sup>110</sup>. These questions focus on the Scottish Government decision to intervene in the audit process and, in particular, the specific failings in corporate governance which prompted the Cabinet Secretary's intervention in the management of the audit.

The phrase "the interests of appropriate corporate governance" recurs in the letter sent to NHS Lothian asking the board to terminate its relationship with PwC, official lines provided to newspapers, and answers to both oral and written parliamentary questions. It appears time and again in official dialogue but its meaning remains unclear. The government appears to be using managerial terminology to provide a buffer against its decision to intervene in the audit process and to deflect further questions from the media and opposition politicians.

The Cabinet Secretary makes clear that the intervention "will ensure not only that the governance arrangements for this piece of work are independent and transparent but that they are seen to be so". The appearance of independence is important to politicians, who see it as another way to create distance between the allegations of improper practice and the Scottish Government.

## **7.9 Publication of the PwC report – from local issue to national crisis**

### **7.9.1 The report**

The PwC report was issued to the Scottish Government on 19 March 2012 and placed in the Scottish Parliament Information Centre on 21 March 2012.

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<sup>110</sup> Answers to questions S4W-05946 to S4W-05951 (see footnote 104 above) published in the Written Answer Report on 9 March 2012 – see [http://www.scottish.parliament.uk/S4\\_ChamberDesk/WA20120309.pdf](http://www.scottish.parliament.uk/S4_ChamberDesk/WA20120309.pdf) (accessed on 18 July 2012).

The PwC report (PwC, 2012) runs to 29 pages and is entitled “Review of aspects of waiting time management at NHS Lothian”. While Ministers and NHS Lothian had regularly referred to this review as an audit in preceding correspondence and public statements, nowhere does PwC describe this piece of work as an ‘audit’. In fact, the background and scope section of the report is at pains to emphasise that the review did not constitute an ‘audit’ in a technical sense.

“This review, initially commissioned by the NHS Lothian Board, and subsequently transferred to the Scottish Government, *has not constituted an external audit* under generally accepted auditing principles, nor has it constituted a formal forensic investigation into waiting times within NHS Lothian.

“Similarly, our work and deliverables were *not designed or intended to comply with* the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000.

“Our work has been performed in accordance with terms and conditions outlined in our engagement letter... As a result our work has been undertaken in a similar manner to a subject specific internal audit review in the NHS in Scotland, comprising of meetings with staff and management, review of relevant documentation and sample testing of process and transactions.”

(PwC, 2012:4, emphasis added)

The term ‘audit’ clearly has a different meaning for NHS Lothian, the Scottish Government and Members of the Scottish Parliament than it does for the firm which conducted the independent review. Audit has a technical meaning, with clearly defined professional and legal implications, for the firm. However, politicians have a wider, non-technical understanding of ‘audit’. It appears that the use of ‘audit’ holds a ritual or symbolic appeal for politicians and public services which is quite distinct from its technical or professional definition. This supports Power’s thesis that ‘audit’ has both technological and programmatic dimensions (Power, 1999:6-8).

PwC deployed a similar methodology to the earlier internal review commissioned by NHS Lothian, including interviews with members of staff and managers and a review of policy and procedure documents. Crucially the PwC review also included sample testing of patient records and interrogation of data held in the patient management system, a more typical ‘audit’ procedure.

The review was initially focused upon the application of periods of patient unavailability by NHS Lothian staff, investigating allegations made in *The Sunday Times* newspaper that patients were offered treatment at hospitals in the north of England at short notice. However, this practice “was only one example of the problematic issues with NHS Lothian’s waiting time management” (PwC, 2012:4) uncovered by the PwC review (see Table 7.3 below for a summary of the main findings of the review).

The review report concludes that:

“In considering the multiple evidence sources, it is apparent that the management and processes for waiting times at NHS Lothian have been sub optimal.”

(PwC, 2012:7)

Despite the evidence led in the report of apparent gaming and manipulation of performance data, the review report is very careful not to express an opinion in these terms. The under-stated language compares starkly with that adopted by ministers and Members of the Scottish Parliament in debating the report’s findings, which will be discussed below.

Indeed, the language adopted throughout the report is highly caveated and careful not to directly attribute views to the report’s authors or assume responsibility for absolute factual accuracy. For example, there is frequent use of phrases such as “it would appear”, “what appears to be”, “is questionable” and “we have been advised”. ‘Facts’ are quoted, based on the results of specific tests undertaken (“on 30 May 2011 (just before breach reporting) between 10am and 11am, a member of staff made 124 amendments to periods of unavailability, retrospectively” (PwC, 2012:6)).

*Table 7.3: Main findings of the PwC review of waiting time management at NHS Lothian*

<p>Use of periods of unavailability</p> <ul style="list-style-type: none"> <li>• Data interrogation highlighted “excessive and inappropriate use (and apparent misuse) of periods of patient unavailability”, including retrospective changes made to patient records to reduce the number of reported breaches of targets.</li> <li>• Most recorded periods of unavailability were classified as ‘other’ despite a wide range of possible reasons being available for selection within the system.</li> </ul> <p>Reporting</p> <ul style="list-style-type: none"> <li>• Review of internal reports found that consistent data was reported to the executive and board committees as well as to the main board itself. However, some senior managers who sat on executive committees had access to more detailed information which was not formally reported to these committees.</li> <li>• However, the formal reports to executive and board committees did not contain sufficiently detailed information to enable committee members to exercise appropriate scrutiny over waiting time performance.</li> <li>• There was evidence of some manual interference with figures extracted from the patient management system before they were reported to more senior managers.</li> <li>• Testing indicates large numbers of retrospective adjustments to patient records (i.e. applying periods of unavailability) just prior to reporting dates.</li> </ul> <p>Culture and governance</p> <ul style="list-style-type: none"> <li>• Interviews revealed that clerical, supervisory and management level staff were placed under significant pressure to find workarounds to waiting list issues rather than allow them to be escalated to management and board committees for action.</li> </ul> <p>System controls</p> <ul style="list-style-type: none"> <li>• Flexible input controls allowed some users to input periods of patient unavailability which would not normally be considered reasonable and there was little oversight or reporting of activity in the patient record system.</li> </ul> <p>Working practices and guidelines</p> <ul style="list-style-type: none"> <li>• NHS Lothian never formally finalised revisions to its Waiting List Management Policies and Procedures following introduction of the national New Ways guidance in 2008.</li> </ul>
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*Source: PwC (2012:4-7)*

Similar to the Audit Scotland overview reports reviewed in the previous chapter, the PwC report rarely gives a direct opinion on practices, findings or the appropriateness of actions taken by NHS Lothian but instead presents information in a style which makes the risks associated with a course of action clear to the reader.

“We have been advised that NHS Lothian has recently taken additional steps to address the waiting list challenge. This should be considered against a backdrop of challenges around increased demand and patients exercising choice between hospital sites for treatment.”

(PwC, 2012:7)

There is a strong implication that the author believes that there is a significant risk that the additional steps will not deliver the anticipated results, but this is not explicitly stated.

The report highlights the potential disconnect between a reporting process and the substance of what is reported. The PwC review analysed minutes of meetings of each committee which had a role in the governance and reporting structure for waiting time performance, as well as papers presented to those meetings. The review found that waiting time issues were considered at all levels of the organisational structure so at face value there appeared to be sufficient scrutiny over waiting time performance. However, on closer inspection, the reviewers found that the data presented to more senior committees “was not sufficient... to highlight the serious issues that NHS Lothian needed to address, specifically the complete size of the waiting list in terms of breachers or the level and use of periods of unavailability” (PwC, 2012:16).

Furthermore, the documentary representations of performance created by the organisation were often disconnected from operational reality.

“Our interviews with relevant staff indicate that minutes and action plans for the WTMG [Waiting time management Group] held before August 2011 are not a true reflection of the discussion held during these meetings...”

(PwC, 2012:17)

The minutes of meetings provided a trace or representation of organisational ‘facts’ which were divorced from the underlying reality. They created a sanitised fictional account of performance which became accepted as fact as the information was cascaded up to more senior layers in the governance structure. The documentary representations created a new organisational reality and show how official records and processes were decoupled from substantive activities (Power, 1999:96).

Without documentary or other manifestations of organisational life, it is not possible for actions to be retrospectively reviewed or verified. The PwC review team could find no evidence of the operation of a process whereby clinical specialties reviewed performance data downloaded from the patient management system and requested manual adjustments which were then applied in the final performance management reports shared with management and governance committees (PwC, 2012:18). It was therefore not possible to ‘test’ the operation of the process as there was no visible trace of the actions taken. Management, and practices, can only be rendered auditable if they leave a trace.

The report considered ‘softer’ issues, such as management culture, as well as ‘hard’ auditable facts. Although beyond the scope of the present study, it is interesting to note that the review finding that an oppressive and bullying culture put pressure on staff to report achievement of targets is similar to the findings of organisational research conducted to understand the impact of the star ratings system on hospital staff (Mannion et al., 2005).

#### 7.9.2 Statement to Parliament

The Cabinet Secretary for Health, Wellbeing and Cities Strategy made a statement on the PwC review to the Scottish Parliament on Wednesday 21 March 2012<sup>111</sup>, hours after the report was made public.<sup>112</sup> The statement was approximately nine minutes long and was followed by approximately 30 minutes of questions from Members of the Scottish Parliament. The following analysis is based on an in-depth review of the transcript of the Ministerial Statement and ensuing questions from Members of the Scottish Parliament, and review of the video footage of the parliamentary session<sup>113</sup>.

The language adopted by the Cabinet Secretary is passionate and, in contrast to the passive language adopted in the PwC report, directly critical of NHS Lothian. The

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<sup>111</sup> “Ministerial Statement: NHS Lothian Waiting Times” as recorded in the Official Report of the Scottish Parliament for Wednesday 21 March 2012, at columns 7456 to 7469.

<sup>112</sup> The report was placed in the Scottish Parliament Information Centre (SPICe) on 21 March 2012

<sup>113</sup> Video footage of the Ministerial Statement viewed on the BBC website at [http://news.bbc.co.uk/democracylive/hi/scotland/newsid\\_9707000/9707377.stm](http://news.bbc.co.uk/democracylive/hi/scotland/newsid_9707000/9707377.stm) (accessed on 18 July 2012)

minister's displeasure with NHS Lothian is tangible. The neutral tone of the original review report is transformed into a subjective judgement of the organisation by the Cabinet Secretary.

The statement provides an insight into why the Scottish Government considered an audit necessary to supplement the internal review led by the NHS Lothian Medical Director.

“However, the report also made reference to administrative practices in the management of waiting times that I considered needed further investigation. On 6 January, my officials, on my behalf, asked that the board carry out an audit of its waiting times practices and management. In response, the chair of NHS Lothian decided to commission an external audit and, on 31 January, appointed PWC (sic) to conduct it.”<sup>114</sup>

Thus, the internal review report raised further questions and doubts about waiting time management practices. Having failed to receive the necessary assurances directly from the board, the Cabinet Secretary initiated an additional review. An ‘audit’ would provide the Scottish Government with definitive answers to those outstanding questions.

The decision to require an ‘audit’ in addition to the internal review is arguably vindicated by the seriousness of the findings of the PwC review. The review provides objective evidence that adjustments were made to patient records in order to improve reported compliance with waiting time standards, and mask poor substantive performance. Furthermore, the scope of the independent review was broader than the internal investigation.

The Cabinet Secretary later explains her true concerns underlying the intervention in the PwC review in an answer to questions posed by the late David McLetchie MSP:

“When the concerns about NHS Lothian began to surface, they were potentially so serious and I lacked so much knowledge about where things were known and about what the chain might have been that I felt that the review had to be taken out of the hands of NHS Lothian and instructed by my officials. At that time, I did not know that the practices at NHS Lothian about

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<sup>114</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Columns 7456-7

which I was beginning to hear were not known by the board, the chair or senior management. I needed an independent piece of work to answer the question in my mind whether I still had confidence in the chair and the board.”<sup>115</sup>

A picture emerges of audit as a bearer of independent assurance when trust is threatened or breaks down between principal and agent (Power, 1999:16-17), in this case between government and an organisation responsible for the delivery of public services. Audit took the review out of the hands of those who may have been responsible for the practices which the audit was intended to uncover. The true reason for the intervention appears not to be a theoretical interest in “appropriate corporate governance”<sup>116</sup> but a practical concern that the findings of the audit could be covered up if senior management or non-executives were found to be at fault. Audit became a substitute for trust.

The Cabinet Secretary’s statement demonstrates how the external review highlighted deficiencies in the oversight and scrutiny provided by the board. Although the review confirmed that the “board was not presented with a sufficiently comprehensive picture of waiting times to have identified that an issue existed”<sup>117</sup>, neither the review nor the statement explores the extent to which the board *should* have challenged the sufficiency of the information provided or asked more searching questions of executive management.

It appears that the board accepted the information provided by management at face value, with review of board meeting minutes preceding the initial allegations (see 7.4.1 above) showing scant evidence of debate or discussion of the paper summarising waiting time performance. The Cabinet Secretary asks the NHS Lothian chair to ensure an improved standard of performance reporting to the board. This finding raises questions about the role of non-executives in holding an

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<sup>115</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7462

<sup>116</sup> See above – letter from Scottish Government to NHS Lothian published in “Emergency surgery for NHS audit”, *Evening News* (Edinburgh), Thursday 1 March 2012, p. 11, 1<sup>st</sup> edition, Sue Gyford

<sup>117</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament on 21 March 2012, at Column 7458

organisation to account for performance and their ability to fulfil this role if they do not understand the particular operational risks or potential for gaming of reported figures.

The Cabinet Secretary is as outraged by the PwC findings relating to management culture at NHS Lothian as those exposing inappropriate waiting time management practices. Detailed consideration of these issues is beyond the scope of the present study. However, the finding that “staff were under pressure to find tactical solutions to waiting times rather than to tackle the root causes of the delays”<sup>118</sup> provides evidence of the dysfunctional consequences which can occur when the reporting of performance becomes more important to an organisation than underlying substantive performance (Power: 1999, 2005:335; Strathern, 2000); when being seen to comply with performance targets or standards becomes more important than the provision of the underlying service, in this case the timely treatment of patients.

The Cabinet Secretary orders a further investigation into management culture. This review is to be led by the chair of NHS Lothian, whereas the PwC review was ultimately managed by the Scottish Government.

“I needed an independent piece of work to answer the question in my mind whether I still had confidence in the chair and the board. This piece of work has answered that question and I retain confidence in the chair.

“It is now appropriate to allow the chair to carry out the investigation...”<sup>119</sup>

The PwC review went some way to restoring the Cabinet Secretary’s trust in the chair of the organisation. The need for independently commissioned reviews has subsided. So audit-style mechanisms can play a role in restoring trust, as well as undermining it (Lapsley and Lonsdale, 2010:91-2).

The Cabinet Secretary’s statement also returns the focus of the political debate to the patients who are the intended beneficiaries of performance targets and standards on

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<sup>118</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7458

<sup>119</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7462

waiting times. She expresses a desire that affected patients should be treated as quickly as possible<sup>120</sup>; she does not call for an improvement in the reported performance of NHS Lothian. This is a subtle but key distinction: individual patients are prioritised over the achievement of performance targets.

Later in the session, the Cabinet Secretary makes clear that NHS Lothian's behaviour represents "a betrayal of its own patients" which also "undermines the reputation of thousands of NHS staff members across the country who have worked hard to reduce waiting times"<sup>121</sup>. This could be interpreted as an attempt to restore the true objectives and ethos of the NHS in Scotland, which were displaced in at least one organisation by the imperative to report compliance with performance targets.

The closing section of the Cabinet Secretary's statement considers the implications of the NHS Lothian issue for other NHS organisations in Scotland which are required to comply with the New Ways waiting time guidance and the national waiting time targets. Although the Cabinet Secretary has received assurances from the Chief Executives of these other organisations that they comply in full with the guidance (and thus that their reported performance accords with their substantive performance), she requires further evidence of this.

“...as an added assurance, I have asked for the rigour of a specific and detailed audit of local waiting time management and processes, as part of each board's internal audit programme over 2012-13. The results of that process will be made public in each board's meeting papers.”<sup>122</sup>

Assurance from the Chief Executive, the statutory accountable officer<sup>123</sup>, is no longer sufficient in the wake of the NHS Lothian scandal. The breakdown of trust between

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<sup>120</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7459

<sup>121</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7464

<sup>122</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7459

<sup>123</sup> Chief Executives of NHS boards in Scotland are appointed as the “accountable officer” of that board under section 15 of the Public Finance and Accountability (Scotland) Act 2000. This section also confers statutory duties on the accountable officer, including a responsibility to ensure the

the minister and one NHS organisation has contaminated the trust which until recently underpinned the relationship between the minister and other NHS organisations. The “rigour” of an audit must also be applied in these other organisations for the Cabinet Secretary to have absolute confidence in them. The findings of each audit will be made public, indicating that the audits have a function in discharging accountability to the wider public, as well as to ministers. NHS internal audit reports are not routinely published in board papers; they are primarily treated as internal management documents rather than conduits for the discharge of public accountability.

During the question and answer session which follows the Ministerial statement, opposition MSPs express their dissatisfaction with the promised series of internal audits and call upon the Cabinet Secretary to order a national review by the national audit body.

“I am sure that the Cabinet Secretary will agree that the people of Scotland should be able to trust the Scottish Government statistics on waiting times... rather than allowing health boards to undertake internal audits, I ask the Cabinet Secretary to request that Audit Scotland undertakes a full and thorough review of each and every territorial health board in Scotland to restore confidence in the system.”<sup>124</sup>

“A Lothian internal report did not unmask the manipulation that we now see laid bare by the PWC (sic) report. Will the Cabinet Secretary invite Audit Scotland to carry out a further review of the new ways waiting time system, particularly all aspects of the removal of patients from waiting lists...?”<sup>125</sup>

The Cabinet Secretary rejects the notion that it is her place to direct Audit Scotland to conduct a national audit<sup>126</sup>. However, the requests themselves serve to further undermine public trust in NHS organisations – these MSPs imply that the internal

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propriety and regularity of the finances of the organisation and a responsibility to ensure that the organisation’s resources are used economically, efficiently and effectively.

<sup>124</sup> Jackie Baillie MSP (Scottish Labour), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7460

<sup>125</sup> Dr Richard Simpson MSP (Scottish Labour), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7463

<sup>126</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Columns 7461 and 7464

audits conducted by NHS boards will not secure the necessary transparency in Scotland-wide practices and the involvement of an independent body is necessary before the people of Scotland can again have faith in reported waiting times performance. Opposition politicians are causing further damage to the trust which the public places in the NHS by casting doubt on these organisations' integrity to report internal audit findings (Justesen and Skaerbaek, 2005).

The ritual appeal of 'audit' is evident in the number of references made to either 'audit' or 'Audit Scotland' in the 40 minute parliamentary session on the PwC report. As discussed above, the PwC review does not identify itself as an 'audit' and even explicitly states that it is not an 'audit' in any technical sense. Nevertheless, politicians continue to make reference to the PwC 'audit' and make demands for further 'audits' in other parts of the system. In all, there are 20 references to 'audit' during the session (see Table 7.4 below).

*Table 7.4: Count of references to "audit" and "Audit Scotland" during Ministerial statement and questions on Waiting Times (NHS Lothian) in the Scottish Parliament, 21 March 2012*

Word / phrase	Ministerial statement	Questions	Answers to questions	Total
"audit"	5	5	3	13
"Audit Scotland"	-	2	5	7
Total	5	7	8	20

*Source: Official Report of the Scottish Parliament, 21 March 2012, at Columns 7456-7469*

'Audit' has a programmatic value for politicians, which appears to be distinct from its technical definition (Power, 1999, 2000a; Free, Salterio and Shearer, 2009:137; Malsch and Gendron, 2009). The popular ambiguity of "audit" strengthened its appeal to politicians who could derive legitimacy from commissioning an 'audit' without a need to consider the technical definition of the underlying work.

### *NHS Lothian response*

NHS Lothian released a formal statement following publication of the PwC review<sup>127</sup>. In the statement (NHS Lothian, 2012b), the board intimated that it “fully accepted” the findings of the review and noted that action had already been taken to address many of the issues highlighted in the report.

The statement suggests that the internal review team fully investigated the issue of patients being marked as unavailable for treatment after refusing an offer of treatment and that review concluded that “practice and conduct of some individuals needed to be further investigated” (NHS Lothian, 2012b). This contrasts with the written conclusions of the Waiting Time Management group (NHS Lothian, 2012a) which did not note specific concerns over individual behaviour.

Two of the members of the Waiting Time Management group highlight in the statement that the earlier internal review raised a number of cultural issues which the board was beginning to address. No concerns regarding organisational culture were expressed in the final report. The statement attempts to re-write the conclusions of the original internal report, but at the same time suggests that the public written representation of the review may have differed from the findings as understood by members of the initial review group.

The statement carries direct quotes from five senior figures associated with NHS Lothian: the Chair, Chief Executive, Director of Human Resources and Organisational Development, Employee Director and Chief Operating Officer. While the chair “apologise[s] unreservedly” for the practices employed by the board, the other quotes focus on the actions being taken to address the issues raised in the report.

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<sup>127</sup> This statement refers to the ‘external review’ performed by PwC; it does not contain any references to ‘audit’.

### 7.9.3 Media coverage

Jackie Baillie MSP insinuates that the timing of the ministerial statement to the Scottish Parliament was strategically selected to minimise media attention<sup>128</sup>. She points out that the UK government made its annual budget statement to the House of Commons earlier that day, an event that can be expected to dominate the British media in the following days. The Cabinet Secretary rebuts this suggestion; she indicates that she had received the report the previous day and wished to share its findings with the Scottish Parliament at the earliest opportunity.

Nevertheless, publication of the PwC report and the Cabinet Secretary's statement to Parliament receives wide coverage in the newspaper media over the next 24 hours, including online and print formats, as shown in Table 7.5. The performance crisis was elevated from a local story to a matter of national interest. Eleven articles appeared in nine different publications with a total word count of 3,457 words.

The role of the media also shifted at this point, relative to earlier reports on the emerging crisis. The newspapers are now reporting on information already in the public domain whereas they previously drove the story, bringing new information to a wider audience. Journalists started to report reactively to political events, and no longer directed the narrative.

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<sup>128</sup> Jackie Baillie MSP (Scottish Labour), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Columns 7459

Table 7.5: Summary of newspaper headlines following Ministerial Statement and Questions on Waiting Times (NHS Lothian) on 21 March 2012

Publication	Headline	Page number	Word count
The Telegraph (Scotland)	“Health board manipulated waiting lists Sturgeon admits”	12	412
The Times (Scotland)	“Hospital wait time ‘masked’”	17	113
Scottish Star	“Lothian probe”	2	93
The Sun (Scotland)	“Nic’s fury at op wait ‘fiddlers’”	2	138
<i>The Scotsman</i>	“Furious Sturgeon orders inquiry into false waiting times”	15	557 <sup>129</sup>
<i>The Herald</i>	“Sturgeon to probe waiting times tactics”	5	244
Metro (Scotland)	“Health board is probed”	44	78
Edinburgh <i>Evening News</i>	“Betrayed: Thousands face treatment delays after being dumped from waiting lists”	1	90
Edinburgh <i>Evening News</i>	“Thousands of patients forced off waiting lists”	6	1,302
Edinburgh <i>Evening News</i>	“Leader: NHS must now move swiftly to rebuild trust”	18	384
Evening Times	“Patients betrayal probe”	2	46
Total		11	3,457

While the newspaper reports largely regurgitate the ministerial statement, the associated parliamentary discussion and the NHS Lothian statement, some offer additional insight into actions not previously in the public domain.

“...Ms Sturgeon hauled NHS Lothian Chief Executive James Barbour and chairman Charles Winstanley into her office yesterday and ordered them to put their house in order.”<sup>130</sup>

<sup>129</sup> Different versions of the same article appeared in the 1<sup>st</sup> and 2<sup>nd</sup> editions of *The Scotsman* on 22 March 2012 of 538 and 557 words in length respectively. Both versions appeared at page 15 of the newspaper.

<sup>130</sup> “Thousands of patients forced off waiting lists”, *Evening News* (Edinburgh), Thursday 22 March 2012, p. 6, 1<sup>st</sup> edition, Sue Gyford

The same article carries a direct statement from the Cabinet Secretary.

“[The Cabinet Secretary] told the *Evening News*: “I am furious at this. We attach a huge amount of importance to waiting times, patients really value quick access to treatment and people across the health service have worked really hard over the past number of years to get waiting times down.

“So when I get a report that says a health board has been manipulating the figures to try and mask breaches of the waiting time guarantee, I feel angry on behalf of the patients. I saw both the chair and the Chief Executive separately and left them in no doubt how I feel.”

This statement is significant as it is a direct address by the minister to the public. More members of the public are likely to read the newspaper report than to directly follow the exchange in Parliament. She again expresses strong feelings about the conduct of NHS Lothian.

These newspaper reports frequently quote the following phrases used by the Cabinet Secretary in the Scottish Parliament the day before:

- “My reaction to this report is one of disappointment and considerable anger”
- “I will not tolerate the manipulation of them”
- “What angers me about NHS Lothian’s behaviour is not just that it’s a betrayal of their own patients...”
- “serious misconduct”

These phrases are likely to remain in the public consciousness as they encapsulate the strength of political feeling on this issue, and also because the newspaper coverage edits the events of the previous day for their consumption, selecting for the public the key messages from the Parliamentary exchanges. The media becomes a powerful actor in selecting the messages to report, wielding significant influence over the development and sustainability of trust between the public and organisations and professionals who are subject to audit (Justesen and Skaerbaek, 2005:340-1)

## 7.10 Unfolding reaction

The First Minister receives a question on the wider implications of the PwC report, focusing on management culture, governance and practices, at First Minister's Questions the day after the report's publication and the Cabinet Secretary's statement to parliament<sup>131</sup>. The First Minister is not drawn on the issue, reiterating the statement which the Cabinet Secretary made to Parliament the previous day. This reinforces the Cabinet Secretary's statement as the definitive government statement on the issue, and also implicitly reinforces the First Minister's support for his health minister.

Media coverage of the issue in the following days focused on the suspension of two members of NHS Lothian staff in the wake of the report's publication<sup>132</sup>, which was announced in a press release (NHS Lothian, 2012b).

*The Sunday Times* newspaper attempted to broaden the story to implicate other NHS bodies with a front-page story on Sunday 25 March 2012 carrying the headline "Scandal of doctored NHS waiting lists deepens"<sup>133</sup>. The story alleged that "the Scottish government's (sic) Information Services Division (ISD), which collates health statistics, has 'regularly' challenged health boards over the accuracy of their data on waiting times". Specific allegations were made against one NHS Board<sup>134</sup>. The revelations provide a further opportunity for opposition politicians to repeat calls for an independent national investigation led by Audit Scotland.

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<sup>131</sup> Question raised by Neil Findlay MSP, Scottish Labour, at First Minister's Questions on Thursday 22 March 2012 as reported in the Official Report of the Scottish Parliament at Column 7637.

<sup>132</sup> "Two suspended as waiting times figures are probed", *Metro*, Friday 23 March 2012, p. 4; "First Minister forced to say sorry to Trozeri pensioners", *The Daily Telegraph* (Scotland), Friday 23 March 2012, p. 1, Simon Johnson; "NHS pair suspended", *Daily Record*, Friday 23 March 2012, p. 22; "Health staff in work ban", *Evening Times* (Glasgow), Friday 23 March 2012, p. 2; "More staff facing suspension over waiting times fix", *Evening News* (Edinburgh), Friday 23 March 2012, p. 7, Sue Gyford; "Staff face probe into doctored waiting times list", *The Herald*, Friday 23 March 2012, p. 11.

<sup>133</sup> "Scandal of doctored NHS waiting lists deepens", *The Sunday Times* (Scotland), Sunday 25 March 2012, pp. 1&3, Mark Macaskill

<sup>134</sup> NHS Grampian

Indeed, it is reported by *The Sun* newspaper on Sunday 25 March 2012<sup>135</sup> that the Scottish Labour party has written to the Auditor General for Scotland, calling for Audit Scotland to conduct such a national review of waiting times. This intimates that Scottish Labour politicians have taken positive action to support their words in the Scottish Parliament, when the Cabinet Secretary rejected their calls for a national audit review.

Lothian NHS Board met again on Wednesday 28 March 2012. There is little public trace of discussion on the waiting list management issue besides its financial consequences, although “delivering waiting times” was again included as a standing item on the agenda. The accompanying public board paper did not follow the standard format used for the papers on the same topic presented to meetings in September 2011, November 2011 and January 2012 and analysed earlier in this chapter. The short paper referred only to outpatient and inpatient waiting times covered by the 18 week referral to treatment standard and did not provide information on any of the other waiting time targets to which the Board is subject and which are usually reported under this standing agenda item.

The report provided high level information on the number of patients suspended from waiting lists for the first time, including a graphical trend analysis covering the period from April 2011 to February 2012. As well as providing the latest suspension data for the board in absolute and percentage terms, the report also provides national comparative performance information. It states that the provisional suspension rate for February 2012 is the lowest reported by any board in Scotland.

The report also provides an update on actions being taken to provide additional capacity and address the backlog of patients requiring treatment in light of the changed suspension practice.

For the first time, the report is produced in the name of the Chief Operating Officer and the director of finance, who are also named as joint executive leads. Earlier reports were prepared in the name of managers and directors with responsibility for performance reporting and strategy. It appears that responsibility has shifted from

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<sup>135</sup> “NHS list row”, *The Sun* (Scotland), Sunday 25 March 2012, p. 2, 1<sup>st</sup> edition

those who report on performance to those charged with service delivery. This could intimate that focus is shifting from public reporting back to the underlying substantive service, potentially reversing the displacement of organisational objectives which could be inferred from the PwC review (cf. Power, 1999; 2005).

The public minute of the discussion runs to only three paragraphs and provides evidence that the chair and vice chair asked management one question each. It can be surmised that there would have been private board discussions on the PwC report around this time, but there are few public traces of board scrutiny or detailed consideration of the report's findings. The press release (NHS Lothian, 2012b) is the primary public response to the review; there is a dearth of public evidence of official consideration through the usual governance channels.

The Cabinet Secretary again faces questions on the issue and opposition calls for a national independent investigation into waiting list management at Question Time on Thursday 29 March 2012<sup>136</sup>. In responding to the latter calls, she highlights recent Audit Scotland national studies on compliance with New Ways waiting time guidance.

“In 2010, Audit Scotland carried out a review of new ways. It updated that review in the middle of last year<sup>137</sup> and said that it did not consider that any further investigation was required. However, as I said last week, I have asked all boards to carry out an internal audit. We will seek Audit Scotland's advice on the terms of that audit, because it is important that we ask boards to audit the right things.”<sup>138</sup>

The Cabinet Secretary is mobilising previous studies conducted by Audit Scotland to legitimate her judgement that a further national investigation is not essential. It brings the recent national audit activity back into public focus and could raise

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<sup>136</sup> Initial question raised by Neil Findlay MSP (Scottish Labour) (S4O-00859) – asked and answered in the chamber on Thursday 29 March 2012. Supplementary questions were asked by Marco Biagi MSP (Scottish National Party) and Dr Richard Simpson MSP (Scottish Labour). A transcript of the exchange is contained within the Official Report of the Scottish Parliament for 29 March 2012 at Columns 7953 to 7956.

<sup>137</sup> Audit Scotland (2011b)

<sup>138</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 29 March 2012, at Columns 7955-6

questions regarding the purpose and usefulness of that review although those questions are not publicly asked by any of the politicians.

By intimating that the government will obtain advice on the terms of the internal audit, the Cabinet Secretary is harnessing the respected and recognised professional expertise of the national audit body to legitimate the exercise (Funnell, 1994; Malsch and Gendron, 2009).

An article in *The Sunday Times* newspaper<sup>139</sup> makes public the reply to the Scottish Labour letter from the Auditor General for Scotland. The article quotes the letter thus:

“We [at Audit Scotland] share the widespread concern that there is evidence pointing to an inappropriate use of this [social unavailability] code... we also wish to understand the nature of the problem in more depth and are arranging to meet the Information and Statistics Division (sic) to discuss trends in the use of this code.”<sup>140</sup>

The article continues:

“The body adds that after the meeting, it will consider if it can “add value” by carrying out a full review.”<sup>141</sup>

This article is also significant in introducing the views of the Scottish Patients Association, the most high profile pressure group in Scotland representing patients’ interests. The chair of the Association adds support to the calls for a further independent review.

“It would be prudent to hold an independent investigation. We suspect there’s more to this than meets the eye.”<sup>142</sup>

This quote builds an impression that an independent review would be in the interests of patients and so the opposition parties are on the side of patients, unlike the government. However, the basis for this course of action is suspicion and conjecture;

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<sup>139</sup> “Audit Scotland concern over waiting lists”, *The Sunday Times* (Scotland), Sunday 1 April 2012, p. 7, 1<sup>st</sup> edition, Mark Macaskill

<sup>140</sup> Ibid.

<sup>141</sup> Ibid.

<sup>142</sup> Ibid.

the Association no longer trusts NHS bodies which, as highlighted above, have been contaminated by the exposure of significant gaming of waiting time targets by NHS Lothian.

The NHS Lothian Audit Committee met again on Thursday 5 April 2012. There is little public evidence of direct consideration by the Committee of the waiting time management issue. However, the minute of the Committee's consideration of the external audit plan for 2011-12 highlights a potential tension between recent issues and the audit process.

“[The Chief Executive] observed that given the extensive coverage of recent incidents the Committee should reflect on the statements detailed in the report... highlighting that the external auditors consider the Board's performance management systems and corporate governance and control arrangements to be sound and operating satisfactorily. It is important to recognise that any system of control can be compromised by rogue behaviour. [The external auditor] advised the Committee that Audit Scotland [in their capacity as statutory external auditor of NHS Lothian] remained content to rely on these systems to inform the audit of the financial statements.”<sup>143</sup>

The position taken by Audit Scotland and the Chief Executive could be interpreted in two ways. It could suggest that the Chief Executive is using the satisfactory judgement of the external auditors to make clear that the waiting times case was an isolated issue within the board and organisational controls are otherwise operating as they should, thus seeking to use the auditors to confer legitimacy on organisational systems and controls (Free, Salterio and Shearer, 2009). The statement could also highlight the limitations of the assurance which the external audit process provides over organisation-wide controls.

The Cabinet Secretary continued to receive written parliamentary questions on technical aspects of the waiting time system and reporting practices, including the role of Information Services Division.<sup>144</sup>

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<sup>143</sup> Minute of Lothian Audit Committee meeting held on Thursday 5 April 2012, at paragraph 6.1.2

<sup>144</sup> Written questions lodged by Dr Richard Simpson MSP on 23 March 2012 and answered on 17 April 2012 (references S4W-06379, S4W-06380, S4W-06381 and S4W-06385), by Dr Richard Simpson MSP on 23 March 2012 and answered on 18 April 2012 (S4W-06382), and by Jackie Baillie MSP on 27 March 2012 and answered on 17 April 2012 (S4W-06483).

The Cabinet Secretary faced further questions on the review into management culture at NHS Lothian during Question Time on Thursday 19 April 2012<sup>145</sup>, including a supplementary question from Dr Richard Simpson MSP.

“Will [the Cabinet Secretary] tell the Parliament what steps she took after Audit Scotland’s warning – in its 2010 report – about variation in the use of social unavailability codes in relation to the new ways waiting times programme?... Will she now undertake an inquiry – similar to the Lothian inquiry – in each health board in which there is either high use of the codes or variation from month to month in the use of the retrospective correction mechanism...?”<sup>146</sup>

While the response does not directly answer the question, it turns responsibility back onto the national audit body; the latter’s decision that no further work was required in 2011 validates the government’s actions or in this case apparent lack of action.

“...I have asked that this issue be included in the audit arrangements of all health boards. As I said in the chamber before the recess, we will consult Audit Scotland on the terms of the exercise.

As for the 2010 report, we pay close attention to and act accordingly on all Audit Scotland’s comments and recommendations. Richard Simpson will know that Audit Scotland conducted and published a follow-up report in 2011, and said that there was no need for any further work.”<sup>147</sup>

Thus, the national audit body provides a buffer for the government against claims that it should have taken action earlier to address variation in the use of social unavailability codes. The audit body publicly declared that “this audit provided assurance that the new arrangements are generally working well... There should not be any need to conduct a follow up study in the foreseeable future” (Audit Scotland, 2011). The government placed assurance on this expert opinion and in so doing gained a defence against accusations that it could have taken action sooner to identify and address the practices adopted by NHS Lothian.

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<sup>145</sup> Initial question raised by the late David McLetchie MSP (S4O-0084) – asked and answered in the chamber on Thursday 19 April 2012. A supplementary question was also raised by Dr Richard Simpson MSP. A transcript of the exchange is contained within the Official Report of the Scottish Parliament for 19 April 2012 at columns 8226 and 8227.

<sup>146</sup> Dr Richard Simpson MSP, as quoted in the Official Report of the Scottish Parliament, 19 April 2012, at Columns 8226-7

<sup>147</sup> Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon), as quoted in the Official Report of the Scottish Parliament, 19 April 2012, at Column 8227

This is the same body which the questioner is calling upon to conduct an independent national investigation to provide assurance that the practices adopted by NHS Lothian are not replicated within other organisations. It does not serve the interests of the questioner to apply too much scrutiny to the earlier Audit Scotland reports. The symbolic importance of the review appears to exceed the value of its substantive content (Power, 1999:125).

## **7.11 Audit Scotland national review**

### 7.11.1 Announcement of national review

Meanwhile, both the media and opposition politicians continued their attempts to demonstrate that the practices observed at NHS Lothian were replicated in other parts of Scotland and that only a full independent investigation would provide assurance that this was not the case.<sup>148</sup>

“...We need full transparency to get to the bottom of this once and for all... Anything short of a full, independent investigation carried out by Audit Scotland... simply isn't good enough.”

Jackie Baillie, Health spokesperson for Scottish Labour, quoted by *The Sunday Times* newspaper<sup>50</sup>

A Scottish Government press release issued in early May confirms both that Audit Scotland have agreed the terms of the internal audit review which the Cabinet Secretary has asked all boards to undertake and that the national audit body will perform a separate national review (Scottish Government, 2012).

The press release states that these measures “aim to provide confirmation that waiting times practices are completely transparent right across the country” (ibid.). The Cabinet Secretary requires these reviews “to show that recording of waiting times data is accurate and transparent” despite there being “absolutely no evidence that these practices are widespread” (ibid.). Independent assurance is considered

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<sup>148</sup> “NHS waiting times scandal spreads”, *The Sunday Times* (Scotland), Sunday 29 April 2012, pp. 1-2, 1<sup>st</sup> edition, Mark Macaskill; “Second board in waiting times query: NHS Tayside challenged over ‘substantial’ data revisions just as Sturgeon was reassuring the public, writes Mark Macaskill”, *The Sunday Times* (Scotland), Sunday 29 April 2012, p. 9, 1<sup>st</sup> edition, Mark Macaskill

necessary to secure public confidence in the system and that assurance will be provided by multiple audit reviews.

Audit Scotland does not formally announce the national review at this time; instead, the Scottish Government breaks the news by including it as a secondary announcement within a press release, noting that Audit Scotland “have also agreed to undertake a separate review themselves” (ibid.).

The phraseology adopted in the latter statement is at odds with the Cabinet Secretary’s earlier proclamation in the Scottish Parliament that “it is not for [her] to tell Audit Scotland what to do”<sup>149</sup>.

The Scottish Government press release created the impression that the Scottish Government is in control of the process; it has assumed ownership of the Audit Scotland review and by extension the actions taken to secure transparency. The Scottish Government becomes the primary actor driving the national review by formally announcing it to the public, and in so doing displaces the role which opposition politicians have publicly played in calling on Audit Scotland to conduct such a review.

The press release links the forthcoming review by Audit Scotland to the earlier national studies which the Cabinet Secretary also referred to previously in the Scottish Parliament.

“The audit body will also conduct a separate report on waiting times to build on their March 2010 review. This found the system to be fair for patients and was followed up by an impact report in June 2011.”

(Scottish Government, 2012)

The earlier statements of assurance from Audit Scotland are again mobilised by the government as a defence mechanism against potential criticism that improper practices should have been identified earlier. There is still no attempt to address the inherent tension between seeking absolute assurance over waiting time management from a body which previously reported that the system was operating effectively.

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<sup>149</sup> Quoted in the Official Report of the Scottish Parliament, 21 March 2012, at column 7461.

However, the announcement sparks further criticism of the government's position. Newspaper reports make public a letter sent by Audit Scotland to Jackie Baillie in response to her earlier written request for the body to launch a national review of waiting time management.

“The Auditor General has now asked Audit Scotland to review the management of NHS waiting times, recognising the importance of this for patients and the public and the need for independent assurance in this area.

“We will examine how social unavailability codes have been used by NHS boards and will focus our attention around the period when discrepancies came to light in NHS Lothian.”<sup>150</sup>

Political opponents round on the Cabinet Secretary's apparent change in position and also seek to extend the negative management culture under investigation at NHS Lothian to behaviour by Scottish Government ministers and officials. In particular, opposition politicians present the announcement as victory for them following their calls for a full independent investigation of the national position.

“This is a hugely positive development, and comes in sharp contrast to Nicola Sturgeon's attempts at Holyrood to block an inquiry into the SNP's hidden waiting times scandal. I will be writing to the Auditor General urging him to also examine the culture that has led to waiting times being manipulated to determine whether undue pressure was put on health board staff to fiddle waiting times by SNP ministers.”<sup>151</sup>

“Scottish Labour has been pressing the Government to hold a full, independent, Scotland-wide investigation for months now.

“But at every turn the SNP seemed desperate to brush our concerns under the carpet.

“Patients and the public deserve to have complete confidence and I am delighted that the Auditor General has instructed this inquiry.”<sup>152</sup>

These quotes illustrate how opposition politicians suggest that the Cabinet Secretary was against accountability because she did not immediately ask Audit Scotland to

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<sup>150</sup> Quoted in “Scots health boards face waiting times investigation”, *The Herald*, Friday 4 May 2012, p. 9, 1<sup>st</sup> edition, Brian Currie

<sup>151</sup> “Pressure on Sturgeon builds as NHS faces waiting times inquiry”, *The Daily Telegraph*, Scotland edition, Friday 4 May 2012, p. 17, 1<sup>st</sup> edition, Simon Johnson

<sup>152</sup> “Scots health boards face waiting times investigation”, *The Herald*, Friday 4 May 2012, p. 9, 1<sup>st</sup> edition, Brian Currie

conduct a national review. She considered that a series of internal audits would be sufficient to provide the necessary transparency and assurance over practices adopted by other NHS boards. The Cabinet Secretary's assertion that it was not her role to demand a review from a national audit body is transformed by opposition politicians to attempts to "block" an inquiry. To not be publicly supportive of a national audit is presented as tantamount to denying the need for openness and accountability.<sup>153</sup>

#### 7.11.2 Parliamentary discussion of the national response

The Scottish Labour party called a debate on NHS waiting times in the Scottish Parliament on Thursday 17 May 2012.<sup>154</sup> The scope of this debate covered both the gaming of waiting time targets and the management culture review at NHS Lothian.

The following analysis is based on review of the transcript of the debate<sup>155</sup> and video footage<sup>156</sup>.

The opening statement by Jackie Baillie MSP provides the most direct signal to date that trust has been displaced from NHS organisations to the national audit body and that there has been a fundamental shift in the attitude in relation to the role of audit in Scottish public services.

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<sup>153</sup> Maltby (2008) levels similar accusations at Michael Power's work, implying that the *Audit Society* is opposed to making public services accountable.

<sup>154</sup> Motion S4M-02905 lodged by Jackie Baillie MSP. Full transcript of proceedings in the Official Report for 17 May 2012 at columns 9065 to 9089.

<sup>155</sup> Official Report of the Scottish Parliament, Thursday 17 May 2012, Columns 9065 to 9090.

<sup>156</sup> Video footage of the Ministerial Statement viewed on the BBC website at [http://news.bbc.co.uk/democracylive/hi/scotland/newsid\\_9720000/9720682.stm](http://news.bbc.co.uk/democracylive/hi/scotland/newsid_9720000/9720682.stm) (accessed on 20 July 2012)

“Frankly, it is not good enough for health boards to inspect themselves, which is the option that the Cabinet Secretary favours. I believe that the people of Scotland deserve much greater openness and transparency, so I was delighted that Audit Scotland responded positively to [Scottish Labour’s] request for a Scotland-wide independent review.”<sup>157</sup>

NHS organisations had been trusted to faithfully and truthfully report upon their performance ever since the devolution of responsibility for health services to the Scottish Parliament in 1999; under coalition administrations led by the Scottish Labour Party as well as two terms of the Scottish National Party in government. But some 13 years later, demands are made for more extensive external verification of performance data to support the performance assessment framework.

Ms Baillie’s claims are refuted by the Cabinet Secretary.

“What happened in NHS Lothian was completely unacceptable, and it is of paramount importance that there is trust in, and transparency around, waiting times...

“To imply, without evidence, that the massive achievement of staff, under this and previous Administrations, is somehow not real, is to do a massive disservice not to me or the Government but to every member of NHS staff whose hard work has delivered record low waiting times.”<sup>158</sup>

The Cabinet Secretary is more reserved in her use of the term ‘audit’ than in her statement of 21 March 2012 but makes a link between the need for public confidence and the assurance provided by the series of internal audits which she announced in that statement.

“We have a transparent system, but we must always ensure that it operates as it should and that the public have confidence in it. That is why I have asked all boards to conduct a detailed internal review into their waiting time management. Audit Scotland has approved the remit...

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<sup>157</sup> Jackie Baillie MSP speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9068.

<sup>158</sup> Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy, speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9071.

“I welcome Audit Scotland’s announcement that it is carrying out a separate, further audit”<sup>159</sup>

In fact, there are fewer references to ‘audit’ in this debate than in the exchanges surrounding the Cabinet Secretary’s statement to parliament on 21 March 2012 in the wake of publication of the PwC review of waiting list management at NHS Lothian (see Table 7.6 below).

*Table 7.6: Count of references to “audit” and “Audit Scotland” during Ministerial statement and questions on Waiting Times (NHS Lothian) in the Scottish Parliament, 17 May 2012*

Word / phrase	Ministers	SNP MSPs	Opposition MSPs	Total
“audit”	1	3	-	4
“Audit Scotland”	4	1	7	12
Total	5	4	7	16

*Source: Official Report of the Scottish Parliament, 17 May 2012, at Columns 9065 to 9090*

The statement from the Conservative party health spokesperson offers an alternative, if factually incorrect, account of the Audit Scotland national study.

“I therefore welcome what the Cabinet Secretary has done in giving Audit Scotland a remit to look at other boards.”<sup>160</sup>

Some MSPs show unstinting faith in the power of audit and make bold statements about the overall assurance offered by the series of internal audits to be carried out by NHS bodies and the Audit Scotland national study.

“Those audits will give the public unprecedented confidence in the waiting times system, which is currently delivering the shortest waiting times on record.”<sup>161</sup>

Audit is now being presented as the solution to the crisis: only audit can restore public confidence in the NHS (Lapsley and Lonsdale, 2010:91-2).

<sup>159</sup> Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy, speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9072.

<sup>160</sup> Jackson Carlaw MSP, speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9074.

<sup>161</sup> Richard Lyle MSP, Scottish National Party, speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9080.

### 7.11.3 Audit Scotland project brief

Audit Scotland published a project brief for its national review of management of NHS waiting lists in June 2012, in line with usual practice for performance audits. The brief provides details on the background to the review, the scope, aims and objective of the project, methodology used and the timetable for completion. It also sets out how the review will “add value”.

Audit Scotland considers that the national review is required on the grounds of trust.

“The public needs to be able to trust how public services are managing [waiting time] information and be assured that patients are not being impacted negatively. Audit Scotland is uniquely placed to provide independent public assurance on the management of waiting lists across the NHS in Scotland.”

(Audit Scotland, 2012:3)

Audit Scotland holds itself out as a key intermediary in restoring public trust in the reporting of waiting time targets and in the provision of treatment in accordance with national target times. It also sets out a “unique” position for itself, supporting the findings of the earlier chapter that Audit Scotland carved out a position for itself as an expert on the financial and operational management of the NHS in Scotland.

Although the title of the review is broad, the scope is very narrow. The review will consider the use of unavailability codes, including any retrospective adjustments. The latter are a recurring theme of opposition parties’ interest in waiting time management in light of the issues at NHS Lothian. Similar to the PwC review, it reviews only nine months of activity, from April to December 2011 and so will provide *retrospective* assurance only.

The project brief clarifies the differences between the national review and the series of individual internal audits requested by the Scottish Government. The internal audits are broader in scope, considering both compliance with national guidance on waiting list management and how waiting time performance is reported within the organisation.

One other key difference is evident in the aims of the Audit Scotland study which will “examine how the Scottish Government monitors NHS boards’ management of waiting times” (Audit Scotland, 2012:4) as well as practices within NHS boards. This brings direct scrutiny to bear on the overall performance management approach to waiting time guarantees, as well as operational practice.

Audit Scotland also publishes a “flyer” to accompany the project brief for some reviews, including the waiting list management review. This is a short document, running to 2 pages with half of the first page taken up with the title of the review and a graphic. Although the purpose and audience for this flyer are not explicitly stated, this would appear to be an abbreviated project brief aimed at the general public.

Unlike the project brief, it provides background information on what NHS waiting lists are and the national requirements. Rather than stating “how Audit Scotland will add value” (Audit Scotland, 2012:3), the flyer asks “why is this audit important?” The answer is the same in both cases; so that the public can trust that public services are managing waiting list information appropriately and patients are not negatively impacted by inappropriate management practices. This reinforces an impression that Audit Scotland is the gatekeeper of trust in public service delivery.

The flyer also asks “what do we want to happen as a result of our audit?” Audit Scotland provides the following answer:

“The length of time you have to wait for treatment is very important to patients. The audit will evaluate whether data recording practices at NHS boards are valid and seek to provide assurances that patients are not waiting longer than necessary due to inappropriate management of waiting lists. Should we identify any irregularities, we will make recommendations for NHS boards and the Scottish Government to help them improve the way they manage their waiting lists.”

This answer tells the public what is important to them. It also continues the theme of holding Audit Scotland out as an expert on the subject area through reference to recommendations to help the providers of public services improve their operational practices.

## **7.12 Reflections and concluding remarks**

### 7.12.1 Key findings and reflections

This chapter has provided a rich account of a performance system in crisis and traced how audit came to be mobilised as political response to the most significant shock to the reported performance of NHSScotland following devolution. The selection of audit as the first-line response is rendered more significant by the preceding studies which found that successive official performance assessment frameworks did not create a role for audit so the national audit body created its own space in the performance network.

A single newspaper report in October 2011 set in motion a series of reviews which progressively unravelled performance reports and exposed them as false representations of substantive performance. The investigation into an allegation that a small number of patients were being offered treatment in distant hospitals at very short notice uncovered more systemic gaming which undermined the reliability of performance reports produced by one of Scotland's largest health boards and ultimately undermined confidence in reports of national progress in reducing patient waiting times.

Government Ministers and opposition politicians alike relied upon audit to uncover the truth, but this reliance appeared to be based on the ritualistic appeal of audit rather than an understanding of the technical capacity of audit.

The seriousness of the findings at NHS Lothian contaminated other NHS organisations, and contributed to a breakdown of trust across a performance management system which had previously allowed organisations to report on their own performance without recourse to external verification. Auditors were established as the most trustworthy actors, who were called upon to restore trust in NHS organisations despite a national performance audit study having failed to identify the existence of gaming in the system only months earlier. The national audit body eventually undertook a national review, which opposition politicians presented as the only means by which public trust in NHS organisations could be restored.

### 7.12.2 Implications for the *Audit Society*

The voluntary recourse to audit as the primary response to this performance crisis, despite there being no formal role for audit in the NHSScotland performance assessment framework, supports the findings of earlier studies that a voluntary independent audit can bestow legitimacy on a process (Free, Salterio and Shearer, 2009), particularly a system which has been threatened by a scandal (Andon and Free, 2012).

The legitimacy of audit appeared to be more important to politicians than its technical capacity: although the PwC report on waiting times management was explicit that it was not an “audit” report, MSPs made more than 20 references to “audit” in a 40 minute session to discuss the report. The popular ambiguity of audit appeared to strengthen its appeal to politicians. This supports the proposition that the ambiguity of audit is a key source of its influence (Power, 2000a:116) and refutes claims by other that the audit society cannot exist without an accepted definition of “audit” (Humphrey and Owen, 2000; Lindeberg, 2007).

The programmatic appeal of audit is a recurring motif in this study: politicians often take symbolic actions to restore or create an impression of independent assurance, such as the decision to intervene in the relationship between PwC and NHS Lothian. This action received much attention but in substance changed nothing more than the counterparty to a contractual relationship with PwC. Although the government proclaimed that it had taken over management of the review in the interests of “appropriate corporate governance”, it later transpired that this was a smokescreen for a loss of trust in senior management and non-executive board members.

The significance of the recourse to audit to restore confidence in the performance system is greater than the voluntary nature of that recourse. The national audit body had conducted a national study of waiting time management a year earlier, when the gaming practices were being deployed by NHS Lothian. However, there is no evidence of any media or parliamentary scrutiny of Audit Scotland's previous study and the national audit body was not "sacrificed" in the manner of private sector auditors in the wake of a corporate crisis before it became part of the solution (Guenin-Paracini and Gendron, 2010). Instead, both government Ministers and opposition politicians relied upon the legitimacy bestowed by audit to support their own actions and so it was not in the interests of either party to apply too much scrutiny to the work of Audit Scotland. This connection could tentatively be regarded as an enabler of the near-universal acceptance of the national audit body and supports claims of uncritical trust in audit practices (Power, 1999:136-7).

#### 7.12.3 Further issues to be explored

The present study has focused upon the emergence of the performance crisis and the immediate response. It has not considered the long-term effectiveness of that response in securing improvements in both substantive performance and the quality of performance reports. A future study could thus explore what happened next, including the findings of the Audit Scotland national study and the responses of key actors including NHS boards, the Scottish Parliament and internal auditors.

There is evidence in both this case study and in the preceding study of Audit Scotland annual audit reports that audit institutions have succeeded in shielding themselves from external criticism. It is beyond the scope of this thesis to consider how Audit Scotland and other audit institutions build such immunity, but future studies could explore this in greater detail.

There is also scope for study of the impact which this crisis, and similar crises which undermine the veracity of performance reports, have upon public trust in the organisations in light of the increasing reliance which the public places in abstract ranking systems (Jeacle and Carter, 2011). The official account of this crisis is saturated with the views of politicians and senior managers, with little attention given to the impact which this gaming had upon patients.

The next chapter presents the findings of an observation-based case study within a Scottish NHS Board. It will consider how audit mechanisms are manifest at organisational level and what effect they have on organisational governance and processes, as well as individual managers.

## **Chapter 8**

# **Observing performance, audit and organisational life in NHSScotland**



## 8.1 Introduction

This chapter presents the results of an observational case study set in a large Scottish NHS board. It explores the impact which audit technologies and concepts have on organisational life through observing interactions between senior managers, general managers, auditors and non-executive board members in three committee settings.

The case provides direct insight into how audit manifests itself in relationships and interactions in an NHS organisation which operates in a national policy framework which does not prioritise audit and which is subject to a national performance assessment framework which has no formal role for audit. It shows how audit can still permeate organisational life in such an environment, both in terms of formal audit processes and requirements and in terms of the ideology of audit, including characteristics of Power's audit society.

### 8.1.1 Case study setting

This case study was conducted in a large Scottish NHS Board. The confidentiality of the NHS board will be maintained and the Board is not identified in the following analysis. Table 8.1 below summarises some key facts about the NHS board, which demonstrate the scale of the Board's operations.

*Table 8.1: Case study setting – key facts*

- |  |
|--|
| <ul style="list-style-type: none"><li>• Resident population &gt; 400,000</li><li>• Workforce &gt; 10,000 WTEs</li><li>• Baseline funding &gt; £500m</li><li>• 4 major acute hospitals</li><li>• 17 other hospital sites, including community hospitals</li></ul> |
|--|

*Source: review of key organisational documents; all criteria correct at time of fieldwork*

The governance of the Board follows the national requirements for NHSScotland organisations, as outlined in *Chapter 2: Research context*. The Board's external auditor is appointed by the Auditor General for Scotland; Audit Scotland was the appointed external auditor at the time of fieldwork. Internal audit services are provided by an in-house team.

### 8.1.3 Method

The Board granted access to meetings of three Committees: the Audit Committee; the Operational Audit Sub-Committee; and the Executive Management Team. These Committees are at the heart of the organisation's response to formal audit and performance systems and their respective roles and remits are considered further below.

The researcher observed four meetings of three different committees between September and November 2011, as summarised at Table 8.2 below.

*Table 8.2: Meetings observed during case study*

Committee Name	Date(s) of meetings attended	Length of meeting(s)
Operational Audit Sub-Committee	26 September 2011	2 hours, 45 minutes
	28 November 2011	2 hours
Audit Committee	11 October 2011	3 hours
Executive Management Team	5 October 2011	3 hours, 30 minutes

*Source: Fieldwork notes*

Detailed notes were taken during each meeting to capture the key issues discussed and note which actors participated in which discussions. The discussion was not transcribed. In order to preserve the anonymity of committee members, verbatim quotes are used sparingly in the text but are included where the precise wording is considered significant to the analysis. The substance of other discussion points is reflected in the text.

Observational research was supported by detailed review of Committee documents, including meeting papers, minutes of meetings and terms of reference.

The research design and strategy underpinning this case are influenced by Latour's account of ANT (Latour, 1987, 2005); the aim is to reassemble the key associations between actors in order to present a rich account of their interactions in Committee settings.

The methods employed in this case study are considered in further detail in *Chapter 4: Research design and methods*.

#### 8.1.4 Findings

This chapter is structured by Committee, with observations from each meeting presented in a separate section. In order to present a vivid account of how each meeting unfolded, observations are presented in chronological order. Agenda items which were not relevant to audit or performance have been excluded from the analysis.

## **8.2 Operational Audit Sub-Committee**

### 8.2.1 Background

The Operational Audit Sub-Committee (OASC) is a formally constituted sub-committee of the Audit Committee, which is itself a formally constituted statutory committee of the NHS Board. The role and remit of the Audit Committee are considered further below at Section 8.3.1.

The OASC is “responsible for seeking assurance on the adequacy and effectiveness of [the] Board’s systems of corporate governance and internal control. The material it receives will be all external and internal audit reports relevant to the Board’s system of internal control, any other reports pertinent to systems of control which affect Board income and expenditure, national performance audit reports, and any additional material from management on internal control. The OASC will present minutes of its meetings to the Audit Committee, and will refer any exceptional items to the Committee...”<sup>162</sup>

It can thus be considered as a forum for more in-depth review of audit activity than is permitted at the statutory Audit Committee and a physical forum in which managers

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<sup>162</sup> Terms of reference of the Operational Audit Sub-Committee, provided to the researcher by the case study organisation.

responsible for services or functions which have been under audit scrutiny can be held to account for their actions.

The OASC brings together a diverse range of individuals from across the NHS Board. It is chaired by a non-executive Board member, and the remaining OASC members are also non-executive Board members. The OASC Chair is also Chair of the Audit Committee, although this was not required by the terms of reference of either committee. The non-executive members are outnumbered at each meeting by attendees from operational management and both internal and external audit.

There was no seating plan at the observed meetings, with the non-executive members sitting amongst the operational managers. This gave the meeting a collegiate atmosphere and the physical configuration of the room did not create an appearance that managers had been summoned to give account to a panel of scrutineers.

Table 8.3 below shows who was present at each meeting of the OASC observed by the researcher.

Table 8.3: Attendees at observed meetings of the OASC

26 September 2011	28 November 2011
<p><u>Committee members</u></p> <ul style="list-style-type: none"> <li>• Chair (non-executive member of NHS Board)</li> <li>• 2 non-executive members of NHS Board</li> </ul> <p><u>In attendance</u></p> <ul style="list-style-type: none"> <li>• Chief Internal Auditor</li> <li>• Deputy Chief Internal Auditor</li> <li>• External audit senior manager (outgoing and ingoing audit teams)</li> <li>• Deputy Director of Finance, Acute Operating Division</li> <li>• Deputy Director of Finance, Primary Care</li> <li>• Director of Strategic Planning</li> <li>• 9 senior operational managers</li> <li>• Corporate governance and value for money manager</li> <li>• Committee secretariat</li> </ul>	<p><u>Committee members</u></p> <ul style="list-style-type: none"> <li>• Chair (non-executive member of NHS Board)</li> <li>• 4 non-executive members of NHS Board</li> </ul> <p><u>In attendance</u></p> <ul style="list-style-type: none"> <li>• Chief Internal Auditor</li> <li>• Deputy Chief Internal Auditor</li> <li>• External audit senior manager</li> <li>• Deputy Director of Finance, Acute Operating Division</li> <li>• Deputy Director of Finance, Primary Care</li> <li>• Director of Strategic Planning*</li> <li>• Director of eHealth*</li> <li>• Divisional Nurse Director, Acute Operating Division</li> <li>• 5 senior operational managers</li> <li>• Corporate governance and value for money manager</li> <li>• Committee secretariat</li> </ul>

Source: Fieldwork notes

\* Attended part of meeting only

The meeting papers were used as a reference point throughout both meetings observed, but it was not always clear that OASC members had used the papers to identify in advance any points or issues which they wished to raise at each meeting – there were infrequent references to precise sections or paragraphs of reports.

Meeting agendas followed a standard format, as summarised in Table 8.4 below, including four substantive categories of business: primary care reports, internal audit reports, Counter Fraud Services<sup>163</sup> and general corporate governance. Multiple papers could be tabled under each heading.

*Table 8.4: Pro forma agenda for Operational Audit Sub-Committee meetings*

1. Welcome and introduction from chair
2. Minutes for approval
3. Running action note
4. Primary care reports
5. Internal audit reports
6. Counter Fraud Services
7. General corporate governance
8. Any other competent business
9. Future meeting dates and locations

*Source: OASC meeting agendas, September and November 2011*

The management of risk is a pervading theme of OASC meetings. Not only does the template for committee papers include a mandatory “risk register” heading, prompting the author to consider whether there is a need to reflect issues raised in the paper in the corporate risk register, but the discussion of operational issues often referred to the need to update the organisation’s risk register.

There is little evidence in the observed committee meetings that performance audit is conducted locally and the internal audit workplan for the financial year focuses on systems and controls, influenced by risk assessments. Organisational performance

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<sup>163</sup> Counter Fraud Services is the specialist function providing fraud deterrence, detection and investigation services to NHSScotland. It is an operating division of NHS National Services Scotland.

targets were only mentioned once in the September OASC meeting<sup>164</sup>. Management of operational performance appears to be organisationally separate from the formal audit mechanisms within the Board, or at least the traditional audit functions reporting to the Audit Committee.

Although two external audit representatives were present at the September meeting of the OASC, they were not active participants in the meeting. They spoke only once, in response to a direct question from the committee Chair, about an Audit Scotland performance audit report tabled at the meeting by management. Were it not for this intervention by the Chair, they would likely have remained silent throughout the meeting. One might speculate that they attend the meeting for intelligence-gathering purposes, to enhance their knowledge of the internal control framework; their attendance may be ritualistic rather than participative; or that external audit is not a powerful influence within the organisation at the level of operational control.

The level of participation of OASC members appeared directly linked to their own professional interests. For example, the OASC member who is a general medical practitioner actively participated in the discussion of primary care agenda items, but did not comment on the remainder of OASC business.

The two observation sessions demonstrated that the OASC focuses on identification of risks facing the organisation and the implementation of controls which can manage those risks. Non-executive OASC members attempted to link these back to corporate or strategic issues facing the organisation but most of their interest was in micro-level organisational systems.

### 8.2.2 Observations: September meeting of the OASC

This was the first in the series of meetings observed in the case study.

Three of the five OASC members were present at the meeting, including the chair (see Table 8.3 above).

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<sup>164</sup> OASC meeting observed on 26 September 2011, agenda item 5.5

*Primary care reports – payment verification in primary care 2010-11*

The substantive business began with consideration of a report on payment verification in primary care. The report sought to provide the committee with assurance that the national organisation responsible for making payments to family health service practitioners<sup>165</sup> deployed a payment verification system over these payments to ensure they complied with official regulations, to review the local process followed within the board and to further provide assurance to the committee that there is no risk to the board arising from these payments. It provided the results of the payment verification activity for the most recent quarter for which data was available.

Although not detailed in the paper, payments made by the national organisation on behalf of the board comprised around 20% of the board's gross expenditure in the 2010-11 financial year.

The report provides a summary of the results of the payment verification activity carried out for each contractor group, while a short appendix provides information on the nature of the checks carried out. The paper is written in technical language which it is unlikely lay OASC members would fully understand without recourse to more detailed guidance.

The paper was presented to the OASC by the responsible general manager who prefaced his update with a general overview of payment verification and explained that the report is intended to provide the OASC with high level assurance. He noted that a greater level of detail was provided for higher-value payment streams.

The paper boldly states that there is no risk for the organisation in terms of these payments, despite the payment verification process identifying areas where recoveries were due from contractors who claimed payments in breach of regulations. The OASC chair nevertheless seeks confirmation from the general manager that, while the risks were not significant enough to appear in the corporate risk register, they were recorded in the local register.

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<sup>165</sup> Being general medical practitioners, general dental practitioners, community pharmacists and optometrists.

There is a short discussion on the paper, with questions asked by one OASC member and by internal audit. In an interesting role reversal, one of the OASC members, who is a general medical practitioner, provides an answer to the question raised by the deputy chief internal auditor in support of the initial response provided by the general manager.

*Primary care reports – Quality & Outcomes Framework 2010/11 minutes of QOF payment verification group*

The next item of business asks the OASC to note the minutes of the Quality and Outcomes Framework<sup>166</sup> (QOF) payment verification group meeting to review the achievement of general medical practices against the QOF in the preceding financial year and approve achievement payments to practices. The OASC is effectively being asked to provide a higher level of assurance by approving the findings of a management assurance process, providing an example of increasing layers of audit and control (Power, 2000a).

The primary care general manager presents the report to the OASC and specifically highlights that internal audit used to be active in the QOF prepayment verification process but, now that the process has been operating effectively for a number of years, the chief internal auditor no longer attends the meeting and receives instead a copy of the minute of the meeting. This is specifically noted in the minutes of the payment verification group meeting: “apologies have been received from Internal Audit, on the basis that the process seems very well established with the relevant decision-makers involved. They will receive the minutes of the meeting”<sup>167</sup>.

The general manager appears to be mobilising the reduced input of internal audit to demonstrate that the process is operating effectively and thus to legitimate the

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<sup>166</sup> The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for General Medical Practitioners within the General Medical Services contract, which offers financial rewards in return for achievement of a series of performance indicators across four (previously five) domains. Until 2012/13, the QOF operated on a UK-wide basis; from 2013/14 the QOF differs across the devolved nations. For further information, see <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx> (accessed on 26 August 2013).

<sup>167</sup> OASC paper presented to the meeting of 26 September 2011.

prepayment verification process – if internal audit is satisfied that the process is sound then by definition it is (Power, 2000a:117; Free, Salterio and Shearer, 2009).

However, the presentation of such a sound process was not met with universal acclaim. One OASC member noted that the process appeared resource-intensive to operate but the findings were the same each year, with very few if any irregularities identified. The member thus questioned whether the verification process was excessive and should be scaled back. What first appeared as a positive comment on the robustness of the process was in fact a criticism that the costs of control exceeded the benefits.

The general manager responded very defensively, quoting the value of expenditure in this area and affirming that the level of verification was proportionate to this expenditure. Although there was no current evidence of gaming of achievement of the QOF targets by general medical practitioners, it was still important to have a system in place which would provide such evidence.

However, it is not clear how this reconciles with a statement made in the risks section of another paper: “Since QOF review visits are no longer routinely performed, all of the above issues raise questions regarding how effectively the QOF process is monitored”<sup>168</sup>.

The OASC chair seeks clarification on the total number of practices and the total value of payments made to general medical practitioners. On receiving this information, he notes that the level of assurance provided by the current process is very welcome and does not entertain the suggestion that the process should be scaled-back in future years. He supports the continuation of robust controls and processes to provide assurance, and implicitly functioning as a deterrent control even if they do not detect significant irregularities.

Before moving on to the next item of business, the OASC chair asks what action management is taking to follow up on an Audit Scotland performance audit study of community health partnerships. The executive lead is present at the meeting and

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<sup>168</sup> OASC paper presented to the meeting of 26 September 2011

notes that formal consideration has been delayed pending an anticipated announcement on health and social care integration proposals from the Scottish Government, anticipated within the next couple of weeks. The board's response to the performance audit will be framed in accordance with that announcement.

While this item was not on the agenda, it demonstrates that non-executive members have an awareness of national performance audit studies without them coming directly to them for consideration and furthermore that they expect management to present a timely response to publication of these reports.

#### *Primary care reports – Contractual & statutory pro forma evaluation*

The next item of business was a short report on the outcome of the board's contractual and statutory pro forma evaluation for 2010-11.

This item illustrates how an audit-based approach to assurance can favour controls over substantive performance (Power, 1999:84; Sheffield and Bowerman, 1999). The report summarised the results of a pro forma evaluation issued to all local GP practices seeking assurance over compliance with procedural-based performance measures and contractual key performance indicators. Practices were asked to evidence that processes and policies were in place.

In presenting the report, the manager highlighted concerns relating to clinical governance, including the following.<sup>169</sup>

#### Repeat medication and summarisation of notes within 8 weeks

“Despite practices receiving continual reminders throughout the year to save evidence at year end to demonstrate their achievement in these indicators, 14 [of 126] practices have failed to do this but have still claimed for the indicator.”

#### Cervical screening policy

“52 [of 126] practices were unable to produce a comprehensive protocol that included all the requirements for this indicator. Main areas of missing data are no evidence that staff are clinically trained to perform smears and no

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<sup>169</sup> OASC paper 4.3 presented to the meeting of 26 September 2011

evidence of monitoring of inadequate smear rates by individual smear takers.”

Palliative care – meetings of multi-disciplinary meetings

“3 [of 126] practices are unable to provide complete evidence to support their claim that multi-disciplinary meetings are held at least 3 monthly.”

Fridge logs

“Although some issues remain, this is greatly improved on previous years. Only 13 [of 126] practices have issues compared to 53 last year. Main issues that remain are temperature not recorded every day and min/max temperature not recorded.”

The OASC member who is also a general medical practitioner was quick to clarify that these concerns did not equate to deficiencies in clinical quality. Rather, there was a lack of evidence that the specified process had been followed by a number of practices. Auditable control systems appear to take priority over clinical outcomes (Power, 1999:84).

Practices were subject to financial penalties if evidence could not be produced to support these areas and failure to produce evidence in support of three indicators triggered additional practice inspection visits.

There is no evidence in the paper or the associated discussion that substantive performance is under threat. The underlying financial penalties and threat of increased inspection provide incentives for general medical practices to focus upon procedural issues, potentially without consideration of the impact on true performance, yet there is no evidence in the paper that patient outcomes have been affected. The focus of the contractual and statutory evaluation is on the installation and operation of management controls, not patient outcomes (Sheffield and Bowerman, 1999).

*Primary care reports – payment matrix in primary care*

This item is an explanatory paper, providing background information on the payment streams for the different family health services contractor groups as well as systems and controls over payments to primary care practitioners.

In presenting this paper to the OASC, the manager highlights that the budgets for some of these payments are held by the Scottish Government, and so the Board is not exposed to the risk of overspend against these budgets but there is a risk that these budgets could be transferred to NHS Boards given the growth in spend in these areas in recent years.

There was a clear implication that the Board would pay greater heed to these areas if budgetary responsibility were transferred to them; this is supported by the observation by a non-executive member that there is a greater level of scrutiny over payments made to general medical practitioners (where the budget is held by the Board) than payments to the other contractor groups (pharmacists, NHS dentists and optometrists, the budget for which is held by the Scottish Government).

While the Board does not have budget responsibility for this expenditure, it is nevertheless reported in the audited financial statements produced and signed off annually by the Board, and thus implicitly covered by the Statement on Internal Control. So this suggests that the preoccupation with controls and conception of risk is self-interested to the extent that it is focused upon the Board's financial exposure, as opposed to the global financial risk to NHSScotland, and is not necessarily driven by an ideological belief in internal control systems.

#### *Internal audit reports – Internal audit progress report*

The chief internal auditor presents a progress report to each OASC meeting. Each report includes:

- an update on delivery of the annual audit plan, including the number and percentage of audits still to be started, at the planning stage, at fieldwork stage and at draft and final report (completed) stage;
- a summary of reports issued since the last OASC meeting, including the number or issues raised in each report by severity and the overall opinion provided by internal audit;

- performance against a key performance indicator to issue draft reports within two weeks of the end of fieldwork and convert draft reports to final reports within three weeks thereafter;
- a summary of current fraud referrals and operations (these are the subject of a more detailed report later in the agenda); and
- an update on any other operational issues.

The report also includes a summary of the scope of each audit included within the annual audit plan and an indication of its completion status.

The chief internal auditor comments that the 2010-11 plan is progressing well.

He talks at greater length about the softer, operational matters than about the technical status of the annual audit plan. He highlights that a pay grading appeal for internal audit staff was unsuccessful, but that he intended to appeal the decision further. He notes that this was impacting upon his ability to recruit staff with the appropriate qualifications. While the tone of this update suggests that the chief internal auditor is exasperated by this situation, there is no real discussion of its implications by the OASC, such as the potential impact on the quality of internal audit services, although it is probable that they considered the issue at previous meetings.

The chief internal auditor also provides a verbal update on an issue which he did not record in the progress report. The board received a Freedom of Information request from a journalist at a national newspaper, seeking copies of all internal audit reports issued in the preceding two years. Having provided the journalist with a list of all reports issued during that time period, the journalist requested copies of 17 reports which were subsequently issued to him.

This request prompted senior management to discuss the impact on the organisation of audit reports being made public. The outcome of this discussion, as reported to the OASC by the chief internal auditor, was that the director of human resources and organisational development and the director of communications would both be required to 'approve' draft internal audit reports prior to finalisation.

This is presented as a threat to the independence of the internal audit function, with the implication that it could result in changes being made to valid internal audit findings to protect the public reputation of the organisation. The chief internal officer referred the OASC to provisions in the Board's standing orders designed to protect the independence and integrity of the internal audit function, allowing them to work and report without interference from management.

The OASC chair comes to the defence of internal audit, stating that he would “not accept censored internal audit reports” and noting that the nuances of a report could be lost if language was changed by management. He asks the chief internal auditor to inform him immediately if there is any suggestion that senior management plans to interfere with the content of draft reports.

Despite the impassioned response from the OASC chair, there are no other comments or questions on this item from the other committee members. This issue would be discussed further at the observed meeting of the Audit Committee, and its implications are considered further at section 8.3.2 below. However, the prevailing impression left on the researcher by the OASC discussion was that the organisation perceived negative internal audit findings as a threat to the organisation's public reputation, and that this threat was considered greater than the threat of internal audit findings going unreported.

#### *Internal audit reports – Reports with satisfactory ratings*

The OASC then considers a report from internal audit which summarises the findings of reports issued since the previous meeting where internal audit has rated the control framework as ‘satisfactory’ or ‘fully satisfactory’. The OASC receives only the executive summary of such reports, rather than the full findings so that it can devote its attention to reviews which highlight the need for improvement.

#### *Internal audit reports – Reports with ‘requires improvement’ ratings*

The OASC effectively operationalises managerial accountability within the NHS Board. Managers are required to attend meetings to respond to internal audit reviews

completed in their area where the auditor concluded that the control framework “requires improvement” or is “unsatisfactory”.

Even though managers provide written ‘management responses’ to each internal audit recommendation, they are still required to personally give account to the OASC and face additional questions from OASC members.

The internal audit report is thus transformed from a printed record of a piece of work; it becomes an actor which brings the manager to the OASC to explain how control weaknesses have been allowed to arise in their area and what action they are taking to remedy those weaknesses.

#### *Internal audit reports – Adults at risk of harm*

The first internal audit review with a ‘requires improvement’ rating considers internal controls for protecting adults at risk of harm. The OASC receives a copy of the full audit report and the deputy chief internal auditor presents an overview of the report to the meeting.

The lead manager attends the OASC meeting to detail the actions which she has put in place to address issues raised in the report, and in particular to provide assurance that procedures have now been introduced to evidence that staff complied with the official guidance.

OASC members do not question the manager further, although the chair welcomes the manager’s assurance that audit findings have been accepted and plans are in place to implement recommendations.

One of the findings of the review was that staff are not released for, or are not attending, mandatory training courses. This generates a strong reaction from the OASC chair who is “sick” of this issue recurring in reports, as it exposes the organisation to unacceptable risks. He requests that a “strong paragraph” is included in the minute of the meeting and an action logged for him to raise this issue with the director of human resources. The minute of the meeting is being used to crystallise action and to raise the profile of an issue. This shows how specific internal audit reviews can identify thematic issues which span the whole organisation.

### *Internal audit reports – Business continuity*

The deputy chief internal auditor goes on to present the findings of an internal audit review of business continuity arrangements which concluded that the control framework was in need of improvement. Rather than consider the response to a specific service disruption, the audit looked at the processes in place for responding to a potential disruption.

The executive summary of the report notes that:

“Events such as H1N1<sup>170</sup> and adverse weather<sup>171</sup> indicate that planning has been reasonably effective, with business continuity plans updated following these events. However, the lack of discipline around regular reviewing, testing and updating of plans could undermine how effectively services respond to any future disruptions.”

The review considered theoretical controls and did not consider the substantive response to recent real-life service disruptions (Power, 1994a:15-16).

The responsible senior manager provides an update to the OASC on actions being taken to implement the recommendations. While he accepts the ‘requires improvement’ rating he notes that the lack of progress was “not for want of trying by those with corporate responsibility” and he is evidently frustrated by the lack of action to date. He provides an overview of actions which are in train and an update on some specific real-time examples of continuity planning.

As with the previous internal audit report, the only comment and further questioning is made by the OASC chair, who asks the responsible senior manager whether he needs leverage from the Audit Committee to help secure organisational buy-in to business continuity processes. The offer is respectfully turned down but provides evidence that the chair believes that the Audit Committee is an influential actor in the organisation.

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<sup>170</sup> H1N1 world-wide influenza pandemic, 2009

<sup>171</sup> Scotland suffered severe winter weather in November and December 2010 which caused extensive disruption to transport networks.

### *Internal audit reports – Operating theatres*

Of all the internal audit reports considered by the OASC, the review of operating theatres management prompts the most discussion at the meeting.

The internal audit report refers to deficiencies in controls identified during the audit, but often contextualises these by referring to their impact on substantive performance. The reverse position is also reported; substantive concerns about control or policy breaches are reported to internal audit or management but not formally recorded in the appropriate controls documentation. Examples include:<sup>172</sup>

“Depending on local customs, staff rosters are prepared between 2 and 6 weeks in advance... While no significant concerns with staffing were raised during the audit, standardising practices could help support more effective scheduling.”

“Medical Physics and Anaesthetics & Theatres use the Backtraq system to record theatre equipment, including serial numbers, locations and maintenance dates. Reviewing Backtraq during the audit found that dates when last serviced were not recorded for 32% of equipment and 28% had last service dates ranging between 1995 and 2009. Querying a sample indicated that records on Backtraq are out of date, including listing equipment that is no longer held...”

“Nevertheless, clinical staff report no particular concerns with the availability or reliability of equipment, and only 0.04% of operations were reported as being cancelled due to equipment breakdowns during the year to December 2010.”

“Based on infection control and public perception, the Uniform Policy sets standards of dress when inside or outside of theatres... In July 2009, the Chief Nurse, Quality & Professional Standards, presented a report to [the operating division’s] Partnership Forum raising concerns about staff breaching the policy. During the audit, Clinical Leads and Charge Nurses raised the same concerns, although Datix does not record any incidents being reported.”

Both the internal audit report and the discussion at the OASC meeting refer to parallel management reviews. While the internal audit report does not repeat

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<sup>172</sup> All taken from OASC paper 5.5, presented to the meeting of 26 September 2011

recommendations made in management reviews, it recommends that management should develop “a formal action plan with clear responsibilities and target dates to implement the recommendations from the [other] reviews”.

In addressing the OASC, the responsible senior manager explains that both the internal audit and management reviews tell essentially the same story. The internal audit review raised issues which management had recognised over a period of time. The audit findings provided another lever which management could deploy to build support for changes which they wished to make to their service.

One of internal auditors commented after the OASC meeting that of all the reviews discussed that morning, this review had been the most welcomed and acted upon by management, even though it merely confirmed what they already knew. This shows how an internal audit review can be used as a legitimating device to support management action (Power, 2000a:117).

One of the managers indicates that new attempts to systematise resource planning for theatres introduced in response to the internal audit and management review findings will be an ‘audit’ of the actual length of operations compared to the length of time predicted by surgeons. It is debatable whether the proposed practice constitutes an ‘audit’ in a technical sense. This underlines not only how the language of audit has permeated organisational life (Power, 1999; Lapsley and Pong, 2000), but how the programmatic appeal of audit can outweigh understanding of its technical capacity (Power, 1999).

The OASC chair comments that the presence of management at meetings to respond to internal audit findings brings a degree of “reality” to proceedings, compared to the otherwise potentially abstract discussion of internal control and risk issues. He suggests that “it is a vehicle through which non-executive members can hear passionate people talking about practical things”<sup>173</sup>. It also makes managers directly accountable for internal audit findings, and arguably ‘auditable’ in their own right.

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<sup>173</sup> Paraphrased account of remarks made by the OASC chair at the meeting of 26 September 2011

He also provides a rationale for extending internal audit into ‘clinical’ areas: internal audit is not there to tell other professionals how to do their job, but to provide assurance over the system-wide use of resources.

*Internal audit reports – Patients & volunteers’ expenses*

The OASC considers only one review of financial systems at the meeting; a review of controls over payment of patients’ and volunteers’ expenses.

The chief internal auditor notes that the Scottish Government has issued high level guidance for these areas but the internal audit review highlighted inconsistencies in local practices because there is no system-wide guidance in place within the board. He highlights three instances of suspected fraud against the organisation, which shows that the organisation is exposed to risk in this area. The report also notes that one of the cases of suspected fraud could not be progressed by national Counter Fraud Services because of weaknesses in the board’s internal processes.

The review highlights that trust is placed in staff to operate honestly in the absence of a formal control framework. The chief internal auditor clarifies that while this is not necessarily wrong it introduces a lack of formality into the process around paying expenses.

*Internal audit reports – Property transactions*

The final internal audit review considered by the OASC is an annual audit of property transactions concluded during the year, required by the Scottish Government to test compliance with the NHS Scotland Property Transactions Handbook.

This review shows how internal audit will attempt to secure action where the same control weaknesses are identified in successive reviews and management have not acted upon prior recommendations. The chief internal auditor tells the OASC that one of the recommendations in the report had also been raised in six preceding annual reports, with no evidence that action had been taken to remedy the issue. Internal audit had now increased the grading of the recommendation from

‘significant’ to ‘critical’ to drive action by management and ensure the issue was taken seriously.

The specific recommendation at issue is the requirement in the property transactions handbook for the Chief Executive to sign a certificate at defined stages of the property transaction process. The OASC chair responds by questioning what the risk is to the organisation if the certificate is not signed. Neither internal audit representative can offer a direct or definitive answer. This begins to undermine the seriousness of the recommendation: if the benefit of the initial recommendation cannot be substantiated, it becomes difficult to persuade management of the need to take action.

The OASC chair seeks assurance that the same findings will not be raised again in next year’s audit. The director of facilities confirms that a new certification framework has been introduced and the following audit will show 100% compliance with the requirements of the property transactions handbook. While it is not made explicit, it appears that the escalation of the issue by audit has forced management action.

*General corporate governance – Arm’s length external organisations – are you getting it right?*

The performance audit report, *Arm’s length external organisations – are you getting it right?* (Audit Scotland, 2011c), was about and addressed to the local government sector. However, management had not only read the report but also considered it of relevance to NHS activities, including commissioning services from third sector organisations.

The responsible senior manager informed the OASC that he would use the Audit Scotland report to review the Board’s existing service level agreements with third sector organisations. Audit Scotland is viewed as an authoritative source of good practice information by the organisation.

There is virtually no substantive discussion on the report: the OASC interest is ensuring that the organisation has taken action in response to the Audit Scotland report.

The OASC chair asks the two external audit representatives present to comment on the Board's use of national performance audit studies. The external auditor gives a very short response – she is pleased to see the Board use the report. This is the only contribution which the external auditors present make to the meeting.

*Counter Fraud Services – Counter Fraud Action Group – Staff working elsewhere while on sick leave*

The next report has previously been considered by the board's counter fraud action group, which referred the report to the OASC. It summarises findings that staff worked elsewhere while on sick leave, which had featured in multiple internal audit reviews over the last two years. This paper highlights the associated risks and issues facing the organisation. It also analyses referrals made to Counter Fraud Services, including the outcome of each referral.

The chief internal auditor highlights internal audit's role in ensuring that this issue is publicised throughout the organisation. Internal audit has raised awareness of this risk through updates in the staff newspaper and information bulletins issued to line managers. This shows how internal audit might find informal channels of communication more effective than formal audit reports as a means of raising awareness of control issues.

In responding to the report, the OASC chair notes that he has asked internal audit to highlight themes arising across their audit work. Internal audit is moving away from 'silo' reviews of control frameworks in particular departments to consider organisation-wide issues.

The OASC chair also recognises that internal audit is an organisation-wide resource and source of expertise. He notes that it would be worthwhile to remind operational managers that they should draw on the expertise held by internal audit.

*General corporate governance – Controlled drugs governance team pharmacy presentation*

The lead pharmacist from the controlled drugs governance team is invited to make a presentation on the work of her team to the OASC. While this presentation is for information purposes only, it shows how audit concepts can permeate clinical domains (Power, 2000b). The Lead Pharmacist explained that the Shipman case<sup>174</sup> exposed nationwide weaknesses in the governance of controlled drugs<sup>175</sup> and systems-based regulations were subsequently introduced to strengthen the safety of controlled drugs.

New regulations introduced by the then Scottish Executive in 2006<sup>176</sup> required the organisation to appoint an “accountable officer” for the management of controlled drugs. This is a direct import from the established framework of financial accountability for the Scottish public sector.<sup>177</sup> The regulations also introduced new systems of control for regulated pharmaceutical products, building on existing clinical governance machinery.

The case study Board responded to the new regulations by establishing a new team of pharmacy professionals and an inspection officer to support the controlled drugs accountable officer in the discharge of their duties. The team uses management tools, such as key performance indicators, to identify anomalies in prescribing practice which could indicate irregularities in the prescription of controlled drugs.

The Lead Pharmacist notes that the 2006 regulations<sup>178</sup> require NHS Boards to ‘audit’ their compliance with controlled drugs regulations. The team achieve this

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<sup>174</sup> Harold Shipman, a general medical practitioner, was found guilty of the murder of 15 of his patients in 2000 by administering lethal doses of morphine. A public inquiry found evidence that he may have killed up to 250 patients. The case prompted reviews of access to controlled drugs and medical supervision.

<sup>175</sup> A ‘controlled drug’ is any drug listed in Schedule 2 to the Misuse of Drugs Act 1971 (c. 38). Access to and use of such drugs are regulated because they are considered particularly susceptible to abuse or likely to cause harm.

<sup>176</sup> The Controlled Drugs (Supervision of Management and Use) Regulations 2006, SI No. 3148

<sup>177</sup> See Public Finance and Accountability (Scotland) Act 2000

<sup>178</sup> Regulation 2, The Controlled Drugs (Supervision of Management and Use) Regulations 2006

through the issue of self-assessment forms to managers, who are asked to certify their own performance. The team review the completed forms and instigate follow up actions. Some Chief Nurses also conduct local ‘mini audits’ to monitor their own performance against the regulations.

The Lead Pharmacist made clear in her presentation that her role is not to question prescribing or clinical decisions but to ensure that good practice is followed and to ensure that the Board complies with system-based regulations. Other managers present at the OASC meeting, including an Associate Director of Finance, requested more regular reporting of compliance so that they can evidence that governance arrangements are in place over controlled drugs and there is a supporting audit trail.

The introduction of systems-based regulations to this area of clinical practice had succeeded in rendering that area ‘auditable’ (Power, 1999; 2003a)

### 8.2.3 Observations: November meeting of the OASC

All OASC members were present at the November meeting, unlike the September meeting. There was accordingly a more even balance between non-executive members and management at this meeting. The presence of managers was also more fluid at this meeting, with a greater number of managers attending the meeting to discuss their own agenda items only.

#### *General corporate governance – Audit Scotland – Review of CHPs*

The OASC Chair had added the Audit Scotland (2011a) performance audit of community health partnerships (CHPs) to the meeting agenda. In introducing this item, he comments that although the OASC regularly considers Audit Scotland performance audit reports it has yet to formally consider this report, despite it being published some months earlier. He had previously asked the Director of Strategic Planning to provide an update on the management response to the review at the September meeting.<sup>179</sup>

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<sup>179</sup> See section 8.2.2 above

The Director of Strategic Planning explains that the board has not taken action on the findings of the performance audit, pending an anticipated announcement on health and social care integration by the Scottish Government in December 2011. The board intended to defer formal consideration of the report until there was clarity over the future policy direction. Although not explicitly stated, the director implied that community health partnerships may not continue to exist in their present form.

This response is almost identical to that provided to the verbal question raised by the OASC chair at the September meeting, when the director expected a Scottish Government announcement within a couple of weeks.

The director provides a general overview of the anticipated Scottish Government announcement on integration and the ongoing local work to progress this policy agenda.

There was limited reaction from OASC members who appeared satisfied with the explanation provided by the Director of Strategic Planning and did not engage with him on the specific findings of the Audit Scotland review.

#### *Internal audit reports – Patients’ funds and valuables*

The OASC considers an internal audit review of patients’ funds and valuables which had concluded that the overall associated control framework “requires improvement”. The report raised six issues requiring management attention, all of which were rated as ‘significant’<sup>180</sup>.

The internal audit review was a traditional financial controls review, testing the design, implementation and operation of key controls over the management of patients’ funds across the organisation. The report does not specify the audit methodology but it is apparent that a sample of wards was selected for testing.

The review is presented to the OASC by the deputy chief internal auditor. The presentation and discussion of this item lasted approximately 20 minutes; all business considered by the OASC up to this point had taken up 30 minutes.

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<sup>180</sup> Issues are graded on a three-point scale: critical (material to the wider organisation), significant (material to the subject under review) and important (relevant for the subject under review).

The deputy chief internal auditor highlights the main findings of the review, which include incomplete policies and procedures, infrequent reconciliation of cash held, failure to hold cash and valuables securely at all times, and inappropriate attendance at review meetings.

The OASC chair invites comments from a number of professional groups present at the meeting, including nursing and general management.

All OASC members contribute to this discussion; it is the only item which elicits comment from all members. Members express concern over whether it is appropriate to ask frontline nursing staff to undertake such administrative duties when they should be focusing upon patient care. A potential tension emerges between the demands of frontline patient care and strict adherence to financial control procedures. The discussion is more focused on protecting patients' interests than on upholding a theoretical ideal type of financial control. There is consensus that processes should be reviewed and revised to ensure they meet the needs of patients and of the organisation (cf. Power, 1999:95-97).

The chief internal auditor notes that an internal audit review of the same topic around 10 years earlier had uncovered similar issues. This raises questions about the extent to which internal audit reviews are active in organisational learning and development and how much management effort is directed at introducing substantive changes, rather than just doing enough to demonstrate that an audit recommendation has been implemented (McGivern and Ferlie, 2007).

#### *Internal audit reports – Internal audit progress report*

The chief internal auditor presents the routine progress report to the committee. The format of this report is considered above at section 8.2.2.

He notes that the plan is progressing well, although some changes to the original plan will be proposed to the next meeting of the Audit Committee. One of these changes, the deferral of a planned audit on a regional shared services project because the project was not yet sufficiently advanced, prompts interest from an OASC member who is anxious to understand why the project is not sufficiently advanced to facilitate

audit. This member expects the auditors to report why the project had not progressed.

The chief internal auditor clarifies the role of audit. He suggests it would be more appropriate to ask the executive lead for the project to provide an update in the first instance, rather than to commission an 'audit'. The OASC agree with this suggestion and will invite the executive lead to their next meeting.

This exchange highlights that the perceived role of 'audit', even amongst members of relevant governance committees, can differ significantly from how audit defines its role. The OASC member appears to equate internal audit with an investigatory function which highlights all organisational or management deficiencies. The internal audit function, by contrast, considers itself responsible for the review and testing of control frameworks installed by management. Management is responsible for the delivery of projects, not internal audit.

The OASC chair detects a "vibe" from the chief internal auditor's report, as well as the earlier discussion on management of patient funds, that audit recommendations are not being appropriately followed up by management. The chief internal auditor notes that he had been asked about this issue at a recent meeting with the board chair and Chief Executive. This meeting prompted the production of a paper for the Audit Committee. Responsibility for following up internal audit recommendations is expected to transfer back from the corporate governance and value for money team to internal audit in order to improve reporting of progress.

An associate Director of Finance comments that it is important not to lose sight of the "massive improvement" in recent years in reducing the number of outstanding recommendations. The chief internal auditor counters that it is necessary to distinguish between the number and percentage of recommendations outstanding as a new internal audit approach has reduced the absolute number of recommendations.

It is apparent from the tone of the discussion that this is a sensitive issue for the OASC. The failure to implement internal audit recommendations in a timely fashion raises questions about the efficacy of the internal audit process – audit cannot deliver improvements if management do not take action following a review. Systematic

failure to implement recommendations can contribute to a wider sense that the audit fulfils a ritualistic rather than substantive role in organisational life.

*Internal audit reports – Reports with satisfactory ratings*

The OASC considers a standing report from internal audit on reviews with fully satisfactory or satisfactory ratings which have concluded since the last meeting.

The chief internal auditor notes that the board's external auditors review the controls over stock every year and almost always criticise managers for failing to fully comply with the financial operating procedures. However, he believes that the financial operating procedures for stock management need to be revised as actual practice, while not fully compliant with the formal procedures, is in line with good practice. This indicates a willingness on the part of audit to look beyond the existence of a control to its substantive value, which mirrors the earlier agreement that operating procedures for management of patient funds should be revised to ensure they are fit for purpose.

A review of IT disaster recovery had also received a 'satisfactory' rating. The report concluded that there is a strong control environment within eHealth. The review identified some minor issues with documentation which were also raised by an Audit Scotland review of eHealth service delivery which would be considered later on the agenda.

The director of eHealth highlights the overlap between recent audit reviews carried out by both the internal and external auditors. Both audits were conducted at the same time. The audit functions did not appear to coordinate their work, which increased the burden which the audit placed on management.

*General corporate governance – Audit Scotland – eHealth service delivery 2010/11*

The OASC now turned to consider the findings of the external audit review of eHealth.

The eHealth director told the OASC that this had been one of the "most acrimonious reports" he had ever received from the external auditor. However, this comment is

transformed in the formal minute of the meeting: an “acrimonious” report is minuted as a “challenging” report.

The source of the animosity is highlighted in the covering paper to the report which he wrote for the OASC:

“Whilst agreeing in principle with the spirit of this observation, the eHealth department contend that this is a complex environment and it is neither financially viable nor practical to perform off site tests as with other systems.”<sup>181</sup>

The eHealth director insists to the OASC that he can only accept an audit recommendation if it will deliver real improvement. He comments:

“I’m not just going to come in here and say that I’ve ticked the box, I’ve got a policy. See you again in two months... A piece of paper won’t make the issue go away.”<sup>182</sup>

He claims that the Audit Scotland report raised a real resource issue, not an organisational risk, and that writing a paper-based plan would not address the issue. There were mitigating controls in place to address business continuity risks and the solution proposed by audit is not practicable.

The eHealth director is also frustrated by a recommendation made that the board should be insured against certain risks as it is not NHS, or wider public sector policy, to take out external insurance policies. The audit report sought to impose pre-defined best practice upon the board without any sensitivity to the particular circumstances of the organisation (Power, 1999; Bowerman et al., 2000).

This discussion highlights the potential for tension to arise between the professional expertise of area experts and audit recommendations. It appears that this audit was conducted by an IT specialist, but the OASC is nevertheless faced with a choice between accepting an audit recommendation and accepting the professional judgement of the lead manager with professional expertise in this area.

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<sup>181</sup> OASC paper presented to the meeting held on 28 November 2011.

<sup>182</sup> Paraphrased account of comments made by the eHealth director at the OASC meeting held on 28 November 2011.

*General corporate governance – Audit Scotland – Transport for Health and Social Care*

The OASC chair introduces an Audit Scotland (2011d) performance audit report on transport for health and social care which he had included on the agenda. The transport and access sub-committee of the board, of which he is also chair, is considering how to respond to the report, together with partner organisations and stakeholder groups.

This demonstrates that a substantive committee will also consider the relevance of national performance audit studies. However, it can be speculated that this case arose because of the personal awareness of the chair through his participation in the Audit Committee and OASC, rather than a general awareness of national audit activity by non-executive board members. It appears more likely that audit findings will be taken seriously and influence operational practices when they are taken forward by a subject committee, rather than treated as part of a specialist audit governance system separate from the core organisation (Power, 1999:96).

*General corporate governance – Performance audit process – Six month update*

The final substantive item on the agenda is a six-monthly update on the board's consideration of national performance audits.

The paper provides some background information on the organisational and committee processes for reviewing performance audit reports. The report explains that:

“Once performance audits are published, the established practice is that the lead manager / director will present the report to the OASC, together with a summary of how the report relates to [the board]. Thereafter the Corporate Governance & VFM team receive periodic summary updates from the manager, advising how the report has been considered and responded to by the organisation.”<sup>183</sup>

The OASC also require six-monthly update reports on the status of implementation of recommendations made in performance audits. The update report is “designed to

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<sup>183</sup> OASC paper presented to the meeting held on 28 November 2011

give assurance that all audit reports published on Audit Scotland's website that may be of interest to the OASC are reviewed to determine if they are suitable for the OASC's agenda"<sup>184</sup>. In order to ensure completeness, the report includes a list of all reports published by Audit Scotland but which the corporate governance and value for money team do not consider relevant to the organisation.

The report is presented to the OASC by a member of the corporate governance and value for money team. He briefly summarises the content of the report and there are no comments or questions from committee members.

This is a process-driven paper, designed to provide assurance to the OASC rather than to address any substantive issues. Substantive consideration of issues is evidenced in the earlier agenda items which relate to specific performance audit studies. Performance audit reports tend to be considered by the specialist audit OASC rather than by the relevant substantive committee, increasing the likelihood that performance auditing is not embedded in substantive business (Power, 1999:96).

Audit Scotland is the only source of performance audit activity within the board. The board tends to react to national studies rather than proactively engage in local performance or value for money audits. The internal audit programme is focused on traditional internal control frameworks rather than considering, or influencing, performance. The formal audit structures within the organisation are not concerned with performance issues.

## **8.3 Audit Committee**

### 8.3.1 Background

The Audit Committee is a mandatory committee within the governance structure of Scottish NHS Boards. The same non-executive member of the NHS Board chairs both the Audit Committee and the OASC, although this is not required under the terms of reference of either committee. Committee members and managers within

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<sup>184</sup> Ibid.

the NHS Board often referred to this committee as the ‘Strategic Audit Committee’, distinguishing its interest in organisation-level issues from the OASC which considers the operation of internal controls in greater detail.

The formal remit of the Audit Committee “is to provide assurance to the NHS Board that NHS X acts within the law, regulations and code of conduct applicable to it and that an effective system of internal control is maintained. The duties of the Audit Committee are in accordance with the NHS Scotland Audit Committee Handbook of March 2004.”<sup>185</sup>

The Committee is “responsible for the delivery of the entire remit of the Audit Committee. However the material it receives will be predominantly concerned with all matters concerned with external accountability and the discharge of the Board’s overall corporate governance responsibilities.”<sup>186</sup>

Table 8.5 below summarises who was present at the meeting observed by the researcher.

#### *Relationship with other committees*

The Audit Committee does not have locus over clinical risk which is the responsibility of the Healthcare Governance and Risk Management Committee. The Audit Committee’s interest is thus primarily in matters of financial or managerial control, fraud and irregularity. The Audit Committee does receive copies of the minutes of meetings of the Healthcare Governance and Risk Management Committee (HGRMC), which establishes a formal channel of communication between the two committees.

The parent-child relationship between the Audit Committee and the OASC was evidenced by the tabling of minutes of OASC meetings at the Audit Committee. The common Chair presented the key issues from each meeting. In some instances the

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<sup>185</sup> Terms of reference of the Audit Committee, provided to the researcher by the case study organisation.

<sup>186</sup> Ibid.

same papers, such as the Internal Audit Progress Report, were presented to both Committees without modification.

*Table 8.5: Attendees at observed meeting of the Audit Committee*

<p><u>Committee members</u></p> <ul style="list-style-type: none"><li>• Chair (non-executive member of NHS Board)</li><li>• 3 non-executive members of NHS Board</li></ul> <p><u>In attendance</u></p> <ul style="list-style-type: none"><li>• Chair of the NHS Board</li><li>• Non-executive member of NHS Board (Chair of Healthcare Governance and Risk Management Committee)</li><li>• Chief Internal Auditor</li><li>• External audit Assistant Director and Senior Manager (outgoing and incoming audit teams)</li><li>• Director of Finance</li><li>• Head of Corporate Reporting and Corporate Governance</li><li>• Corporate Governance and value for money manager</li><li>• General Manager, Primary Care Contracts (one agenda item only)</li><li>• Operational manager observing for personal development</li><li>• Committee Secretariat</li></ul>
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*Source: Fieldwork notes*

### 8.3.2 Observations: October meeting of the Audit Committee

*Welcome, introductions, minutes of the previous meeting and running action note*

There had been a discussion at the previous meeting of the Audit Committee about the consideration of organisational risks by board committees. Members had raised concerns about the respective responsibilities of the Audit Committee and the HGRM Committee. The Audit Committee chair agreed to meet with the chair of the

latter committee and reported back to the October meeting. The chair of the HGRMC also attended the October Audit Committee meeting.

The Audit Committee Chair reports that he and the HGRMC chair agree that formal consideration of ‘risk’ sits best with the Audit Committee. He emphasises that there needs to be a rigorous audit trail to support risk management processes: risk management should not be a ‘tick box’ approach to drawing up a risk register and there should be evidence that risks are being managed. He notes that the OASC has a role in making risk management real at operational level through interaction with managers. The chairs of each committee would thus be seeking board approval for appropriate changes in their remits.

It became clear from the ensuing discussion that what was actually being proposed was for the Audit Committee to have responsibility for assuring risk management processes, while the HGRMC would continue to ensure that underlying organisational risks, including clinical risks, were properly managed.

#### *Minutes of the Operational Audit Sub-Committee*

The Committee considers the minutes of the previous two meetings of the OASC. As noted above, the Committee and OASC share a chair but membership of the two committees differs.

The Committee chair highlights key items discussed by the OASC. He notes that the September meeting focused upon primary care issues. This prompted a discussion on the QOF incentive scheme for General Medical Practitioners<sup>187</sup>. The board chair welcomed assurance that payment verification processes were being followed but queried whether the incentive framework encouraged the wrong behaviours and outputs from general medical practitioners. He noted that it felt like there was little local control over what the board was paying for.

The Committee chair also notes that the Audit Scotland performance audit of community health partnerships set a “singularly enormous” challenge for the organisation, which must ensure that robust governance mechanisms are established

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<sup>187</sup> See section 8.2.2

around its CHPs. This provokes a strong reaction from one Audit Committee member, hereinafter referred to as “M”, who is also chair of one of the Board’s community health partnerships. He is “far from impressed” with this performance audit study, which does not accurately “represent CHP world”. He highlights a number of issues which he believed the performance audit study failed to capture, including the constraints placed on CHPs by government policies, such as the abolition of prescription charges and negotiation of national contracts with GPs.

This is the first instance of direct criticism of a national performance audit study during the period of observation. These criticisms were not subsequently minuted and so there is no public trace of the member’s discontent with the national findings.

*Linkages with other board committees – Healthcare Governance and Risk Management Committee*

The Audit Committee chair invites the chair of the HGRMC to present the minutes of two recent meetings. She intimates that there are no particular issues to bring to the attention of the Audit Committee.

Audit Committee member M expresses concerns about the reporting of clinical incidents, noting that such incidents often came to the attention of the HGRMC via M’s personal networks, rather than through formal channels. He suggests that an audit is required to review the efficiency of systems for reporting incidents and to recommend how channels of communication could be strengthened.

The board chair also highlights risks arising from the forthcoming transfer of responsibility for prisoner healthcare from the Scottish Prison Service to the NHS. He suggests that an internal audit of the service would be appropriate and the Committee chair agrees to discuss the topic with the chief internal auditor at a forthcoming meeting on the 2012-13 annual audit plan.

Non-executive board members identified two new opportunities for audit as they reviewed the minutes of a meeting of another board committee: those who are active in the Audit Committee appear to be keen promoters of audit technologies.

### *Linkages with other board committees – Staff governance committee*

Audit Committee member M presented the minutes of the most recent meeting of the staff governance committee, which he chairs. He highlighted two issues: retirement awards and absence management, including return to work processes. Asked to comment on retirement awards, the Director of Finance noted that cash held at ward level might benefit from a follow up internal audit. This is the third suggested topic for an internal audit review made at the meeting, showing not only that the plan can be shaped by Committee activity, but that the organisation recognises audit as an effective technology to identify and address control weaknesses, and thus to provide assurance over the operation of systems and processes.

### *Internal audit reports – Internal audit progress report*

The chief internal auditor presents a progress report to the Committee. This report was previously tabled at the September meeting of the OASC.<sup>188</sup>

The chief internal auditor provides verbal updates on audit reports with below satisfactory opinions, noting that these were discussed in detail by the OASC; developments with fraud referrals and operations which have occurred since the paper was produced; the job grading of the internal audit team; and a Freedom of Information request for copies of internal audit reports.

The chief internal auditor notes that the Freedom of Information request had sparked a debate on the format and style of internal audit reports. He reiterates concerns which he had previously communicated to the OASC<sup>189</sup> that the new requirement to send all reports to the directors of communications and human resources prior to finalisation could threaten the right of internal audit to work without interference from management. This right is protected by both the board's standing orders and by government internal audit standards.

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<sup>188</sup> See Section 8.2.2 above

<sup>189</sup> Ibid.

The Committee chair confirms that, further to discussions at the OASC in September<sup>190</sup>, he met with the director of communications to ensure he understood the requirements in the standing orders. He is reassured that the new process will not interfere in the audit process. The suspected threat to internal audit's independence was a perceived, rather than actual, threat.

However, the Committee chair recognises that Freedom of Information legislation could also apply to the supporting internal audit file. He cautions that internal audit will need to exercise their professional skills carefully when compiling files and drafting reports, and consider whether issues could be taken out of context if they were made public. The organisation's concern with the reputational risks arising from audit activity begins to emerge from these discussions.

Audit Committee member M highlights the internal audit review on property transactions, which was discussed by the OASC in September<sup>191</sup>. He congratulates internal audit on taking action to address recommendations which were implemented by management despite being made in successive audit reports. He notes that it is "our job to go where the organisation does not want us to go"<sup>192</sup>, regardless of who it is in the organisation that is not following rules. He ponders whether non-executive board members should have acted in support of internal audit and ensured that the recommendation was implemented earlier.

#### *Presentation of the Annual Audit Report to the Audit Committee*

The external auditor provides a verbal update on the annual audit report. This update lasts around 30 minutes, around one-sixth of the meeting, despite the report having been finalised three months earlier.

A copy of the report was issued to members with the meeting papers and many of those around the table saw the report earlier in the year. However, the external auditor speaks to the document in detail, talking members through the report section

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<sup>190</sup> Ibid.

<sup>191</sup> Ibid.

<sup>192</sup> References made by non-executive Committee member M to the Audit Committee meeting held on 11 October 2011.

by section. She acknowledges that the report does not tell the Committee anything new but was produced primarily for a “public” audience and would, in due course, be published on the Audit Scotland website<sup>193</sup>.

The annual audit report re-presents a lot of information which originated within the NHS Board. The external auditor repeatedly states that the report “captured existing activities”<sup>194</sup> or “captured messages from materials you [the NHS Board] produce”<sup>195</sup>. Specific issues reflected in the report are “as manifest in your financial plan”<sup>196</sup>. The review of performance draws heavily on the section on performance against targets in the operating and financial review in the Board’s annual accounts.

As well as reporting on the financial statements audit and the financial health of the Board, the annual audit report comments on wider issues including clinical governance, staff governance, performance management and service delivery. The auditor again appears to rely on representations made by the Board and has not performed any audit procedures to provide assurance over these management representations.

The auditor presents itself as an authority on a wider range of issues than traditional financial statements audit without carrying out any in-depth work in these areas. Furthermore, the credibility of the Board’s own view of its performance in these areas is enhanced through adoption of its reports by the external auditor (Free, Salterio and Shearer, 2009).

The external auditor “welcomes the profile” which the Board gives to Audit Scotland performance audit reports. She explained the process which was followed by the

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<sup>193</sup> Audit Scotland publishes the Annual Audit Reports for all public bodies within the responsibilities of the Auditor General for Scotland on its website each year. This includes those bodies where the external audit is contracted out to a private accountancy firm by Audit Scotland. Copies of the Annual Audit Reports of NHSScotland bodies for the 2010-11 financial year are available at: [http://www.audit-scotland.gov.uk/work/health\\_audit.php?year=2010](http://www.audit-scotland.gov.uk/work/health_audit.php?year=2010) (accessed on 26 November 2011).

<sup>194</sup> Comments made by the external auditor during the Audit Committee meeting held on 11 October 2011

<sup>195</sup> Ibid.

<sup>196</sup> Ibid.

Committee, noting that this is a “very effective application of performance audit studies”<sup>197</sup>.

At the behest of the board chair, the Committee discusses the additional review of remuneration of NHS staff earning more than £100,000 per annum.<sup>198</sup> The board chair is interested in the origins of this review. The external auditors appear confused and are unsure how to answer the question. The outgoing assistant director claims that the Cabinet Secretary “commissioned” the review, only for the incoming assistant director to correct her and state that the review was “requested rather than commissioned”. The outgoing assistant director later backtracks further, saying that the Auditor General probably had an opportunity to decline to perform the review but chose not to. The board chair is interested in whether other parties can direct Audit Scotland to undertake specific pieces of work and notes that the NHS Board might consider making requests in future.

One Committee member (hereinafter referred to as “N”) notes that the OASC receives copies of the board’s output from Audit Scotland’s ‘best value’ toolkits but suggests that the Committee needs to consider how it can drive best value and use the output from the toolkits more effectively. The corporate governance and value for money manager cautions that the toolkits are designed for use by auditors and are not a management checklist. He advises that ‘best value’ should be driven by outcomes, not by compliance with a checklist or toolkit (cf. Power, 1999).

#### *General corporate governance – Major hospital development*

The Director of Finance presents a detailed verbal update on a major service development to provide assurance over the management of project risks and the definition of relationships of accountability.

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<sup>197</sup> See section 8.2.3 above

<sup>198</sup> The Deputy First Minister and then Cabinet Secretary for Health and Wellbeing wrote to Chairs of all NHS Boards in November 2010 asking them to undertake a detailed review of the application of pay policies for all staff earning over £100,000. The letter asked external auditors to provide “specific reassurance” that Boards complied with relevant national policies and guidance.

Committee members want to see a comprehensive audit trail of project decisions to support decision-making and to evidence application of risk management practices. Committee member M expresses concern that he cannot see an “auditable” decision-making process, while the Committee chair highlights the need for evidence that the board has formally reviewed the project at key stages.

*General corporate governance – Overseas patients*

The Director of Finance presents a report on arrangements to recover income due from overseas patients who are liable for the costs of clinical care received but who did not make payment at the time of treatment. She notes that the issue attracts a lot of media attention as the board often writes-off debts owed by these patients.

The Director of Finance believes that a retrospective audit is required to understand whether the reported position was understated. However, she reassures the Committee that action is being taken to address the challenges involved, particularly a new requirement to secure a deposit for the cost of emergency treatment. She assesses that the Board is “probably” doing a good job in challenging circumstances.

*General corporate governance – Follow up of audit recommendations*

The final item of business is a paper on the implementation of previous audit recommendations, presented by the corporate governance and value for money manager. This update was requested by Committee members at a previous meeting.

The number of outstanding audit recommendations has recently increased. Although recommendations are usually implemented, this is frequently after the due date agreed between management and the auditor.

This item prompts a short discussion, but one in which a number of individuals participate. Committee member M is disappointed that the Director of Finance, who is executive lead for the Committee, has the greatest number of outstanding recommendations. The Director of Finance does not respond but the report does not indicate the relative performance of the directorate; it is likely that a disproportionate number of audit recommendations made in any one year relate to financial systems and activities.

The chief internal auditor seeks to present the analysis in relative, rather than absolute terms. He noted that 92% of actions are not completed within the target date, with 10% completed within 2 months of the target date, 44% between 2 months and one year and 38% more than a year after the target date.

The HGRMC chair poses a number of questions, including whether target dates are set correctly, taking appropriate account of operational factors, and whether the organisation takes internal audit seriously enough. Managers may need to be educated on the purpose of internal audit to ensure they understand the importance of implementing recommendations within the target date.

M later notes that there is little point in audit making recommendations if it takes a considerable length of time for action to occur. He suggests that it calls the need for an audit into question: if a recommendation is that “important”, then why is it not actioned immediately?

The Committee chair asks that a further update is brought back to the Committee in six months’ time. He agrees with the suggestion made by M that the Committee should write to the Chief Executive if there was not a significant improvement in the reported position.

### 8.3.3 Reflections on the Audit Committee

There was less evidence of consideration of performance issues by this Committee, compared to observation of OASC meetings. A senior official within the board described the Audit Committee as a ‘set piece’. However, the observation provided interesting examples of challenge by non-executive directors and evidence of the collective perception of the committee’s identity.

The observations revealed three main differences between the strategic and operational Audit Committees:

- The operational OASC considers issues in greater detail than its parent committee.

- There was greater dialogue at the operational OASC, especially between OASC members and management. The Audit Committee meeting was more about the presentation of information and reports, but non-executive committee members still challenged the information which was presented to them.
- The Audit Committee discussion contained more explicit references to organisational risk than discussions at the OASC meetings observed.

One Committee member did not speak at all during the meeting; the Committee chair invited him to comment on one item but he declined to do so. As well as the four committee members, two other non-executive board members were present at the committee meeting observed, including the board chair. These non-executive board members provided as much challenge and posed as many questions to managers as the formal Committee members. In particular, the board chair frequently expressed his own views on issues, directed the business of the committee and interacted directly with internal and external audit representatives.

## **8.4 Executive Management Team**

### **8.4.1 Background**

The Executive Management Team (“EMT”) meets fortnightly, and the focus of meetings alternates between “business” and “performance” issues. The researcher attended a “performance” meeting of the EMT at which directors are held to account for delivery of results.

EMT meetings are usually chaired by the Board’s Chief Executive, but he was not present at the observed meeting. The Chief Operating Officer acted as chair and directors were asked to challenge each other’s reports of performance.

The researcher learned from informal discussions with EMT members outside the meeting that the tone of the performance meeting is significantly different when the

Chief Executive is present. The Chief Executive is “demanding” and so issues, including difficulties, can be discussed more openly in his absence.

The influence of the Chief Executive on the meeting is clear despite his physical absence as EMT members frequently refer to his likely view on a particular issue. While some EMT members disagree with that perspective, this dissenting statement is more often than not prefaced with the phrase “this isn’t for minuting, but...”.

In contrast to the Audit Committee and OASC meetings, participants frequently refer to performance targets, including national targets.

Table 8.6 below summarises who was present, and who was absent, from the meeting observed by the researcher.

*Table 8.6: Attendees and apologies at observed meeting of the Executive Management Team*

<p><u>Present</u></p> <ul style="list-style-type: none"><li>• Chief Operating Officer</li><li>• Director of Finance</li><li>• Medical Director</li><li>• Nurse Director</li><li>• Director of Public Health</li><li>• Director of Strategic Planning</li><li>• Director of Human Resources and Organisational Development</li><li>• Senior management representative of each Community Health Partnership</li><li>• Director of Communications</li><li>• Secretariat</li></ul> <p><u>Apologies</u></p> <ul style="list-style-type: none"><li>• Chief Executive</li></ul>
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*Source: Fieldwork notes*

#### 8.4.2 Observations: October meeting of the Executive Management Team

##### *Matters arising*

The longest single discussion during the EMT meeting is the standing agenda item under which directors provide a verbal update on progress made towards achievement of local efficiency savings targets. This is a wide-ranging discussion, lasting around 50 minutes, or one-quarter of the meeting.

Directors highlight potential barriers which could threaten delivery of savings as well as tensions between generating savings and maintaining operational performance. The need to maintain national targets, such as the 4-hour standard for treatment in Accident and Emergency departments and the 6-week maximum standard for delayed discharges,<sup>199</sup> is often cited as a constraint on the delivery of planned savings to support financial balance. The performance of the Board's largest Accident and Emergency department has recently deteriorated dramatically against the standard; the percentage of patients being treated within 4-hours has fallen from 98% to 80%. This is considered to be a knock-on effect of poor performance against the delayed discharge standard which had resulted in a shortage of beds into which to admit patients presenting at Accident and Emergency.

The Board recently commissioned external management consultants to review the provision of beds for older people's services. The review identified scope to reduce the number of post-acute beds but found that more beds were required in acute hospitals. This created a tension with the efficiency savings plans, which assumed that the number of acute beds could be reduced. It becomes evident during the discussion that not all EMT members have seen the consultants' report and one general manager expresses concern that colleagues may have accepted the conclusions of the external consultants without proper scrutiny.

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<sup>199</sup> The Health and Social Care Data Dictionary published by the Information Services Division of NHS National Services Scotland defines a delayed discharge as "a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so... The patient is ready for discharge but the discharge is delayed due to social care reasons, healthcare reasons or patient / carer / family related reasons" (source: <http://www.datadictionaryadmin.scot.nhs.uk/isddd/2206.html> accessed on 21 November 2011).

EMT members are frustrated by the inability of the Board to independently improve delayed discharge performance – the discharge of a patient from an acute or community hospital is usually delayed by the time taken to access local authority care services.

It becomes clear through the discussion that national performance statistics are not sufficiently detailed to support local management of the position. Managers considered it necessary to engage external consultants to expose the scale of the problem and to help identify the main drivers of poor performance.

The discussion highlights the inter-relationships between the activities of different directorates. Almost every area of the organisation represented at the meeting is either affected by or contributing to management of delayed discharges. The Chief Operating Officer, acting Director of Strategic Planning, Director of Finance, Director of Public Health, Nurse Director and community health partnership general managers all offer different perspectives on the same management problem.

One CHP general manager cautions the EMT against “indiscriminate” use of metrics which he claims caused difficulties in the past and led to the creation of operational groups, such as the EMT performance meetings, to better understand the underlying operational context and ensure that remedial actions complemented this. The reliance which senior managers place on proxy quantitative measures of performance, and the associated neglect of qualitative dimensions of organisational performance, is considered a threat to in-depth understanding of the organisation and the ability to take effective action to alleviate problems.

Although the discussion begins with a warning that achievement of internal efficiency targets is contingent on bed reductions, it quickly expands into a wide-ranging discussion of achievement of key performance targets. Achievement of targets appears to be a key driver of organisational activities and a major focus of senior management attention, rather than the natural outcome of core organisational activities.

The discussion eventually returns to progress made in delivering local efficiency targets. Each director is asked to provide a short update on progress in their area.

The updates are fairly high level; EMT members classify their programmes as ‘on track’ or provide assurance that actions are in train to recover any shortfalls against planned trajectory, but do specify the actions taken.

EMT members refer to various internal consultancy and savings programmes currently being deployed across the organisation to improve efficiency and effectiveness. Three different types of management programmes are referenced in the discussion: LEAN<sup>200</sup>, 5x5x5<sup>201</sup> and Harvard reviews<sup>202</sup>. This demonstrates that the organisation embraces new management technologies and appears to be infused with new public management techniques.

### *Financial position*

EMT members consider an update paper on the board’s financial position, which is presented by the Director of Finance. The paper provides a summary of the year-to-date position against budget, an update on the achievement of local efficiency savings targets (which was also the subject of the preceding verbal updates) and an activity analysis.

There is a short discussion on the inclusion of activity data in the paper. The Chief Operating Officer suggests that this data is too simplistic to support management decision-making and the report should focus on performance, rather than basic activity data. Little had been learnt by the organisation from reporting activity data alone and it would be helpful to analyse activity data by Healthcare Resource Group (HRG)<sup>203</sup>, rather than by the board’s management structure.

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<sup>200</sup> A management technique imported from manufacturing companies which aims to eliminate waste and inefficiency from processes by focusing upon what creates value for stakeholders. It also involves staff in the change process to promote ownership of changes.

<sup>201</sup> 5x5x5 was an internal initiative which saw the creation of five multi-disciplinary teams, each with five members, to develop a proposal for one of five organisational priorities by researching and learning from healthcare organisations across the world.

<sup>202</sup> Although the ‘Harvard’ reviews were not defined in the course of the meeting, it appears that an improvement methodology had been imported from the university.

<sup>203</sup> The Health and Social Care Data Dictionary published by the Information Services Division of NHS National Services Scotland defines a Healthcare Resource Group (HRG) as “a set of treatments that are clinically similar and that use roughly the same level of resources. HRGs have been specifically designed to give managers and clinicians the information needed to monitor and evaluate

The Chief Operating Officer, supported by another director, suggests that the board should report on occupied bed days. This is expected to become a Scottish Government indicator for measuring delayed discharges so it is important that the board begins to use and understand this measure.

Current and future national performance targets appear to influence the design of internal management information and reporting systems (Power, 1999:95-97).

#### *Performance management report*

The Director of Strategic Planning presents an update report on performance management, including latest statistics on performance against national HEAT performance targets set by the Scottish Government. This report summarises performance against trajectory for 33 performance ‘items’ and provides narrative analysis of the nine items for which performance data is not yet available. The report includes a narrative analysis of key risks to achievement of performance targets. The appendix to the report lists each target, current performance, performance in the previous period, the milestone performance for the current period and an assessment of the board’s performance against that milestone.

This factual report stimulates little response from EMT members. The length of the discussion on performance which grew organically from the discussion of achievement of efficiency savings contrasts sharply with the very short, almost ritualistic, discussion of the formal paper on performance. While the former discussion lasted up to 50 minutes, the latter is completed in around 5 minutes.

The Director of Strategic Planning highlights performance against the 4-hour A&E treatment waiting time standard, which had been discussed earlier in the meeting. The formal report provides data for an earlier period, when performance was assessed as “on target” as the milestone for that period had been met. By the time of the meeting, performance has deteriorated significantly. This highlights the difficulties posed by retrospective reports on performance; managers may be

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their use of resources and forecast the impact of casemix changes on the cost of care they are providing.” (source: <http://www.datadictionaryadmin.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=H&ID=282&Title=Healthcare Resource Groups> accessed on 19 August 2013).

discussing historical issues which have already been resolved, or may be unaware of current challenges or risks.

The Director of Strategic Planning describes one particular breach of the 4-hour standard, where a patient waited almost 8 hours for treatment at one of the board's hospitals, as "horrendous". This highly emotive language contrasts sharply with the passive language adopted in formal EMT and board papers which consider performance issues. It relates performance targets back to individual patient experience, a perspective which is not evident in other discussions of performance at the observed meeting.

Although the HEAT system does not publicly rank boards' performance, the EMT members evidently assess the board's comparative performance relative to the rest of NHSScotland. One Board is singled out as the main competitor. EMT members are not satisfied if the board achieves a target, they also wish to see evidence that the board is performing above the Scottish average and better than its main "competitor".

The Chief Operating Officer leads a discussion of access (waiting time) targets, which represent six of the nine targets behind trajectory in the performance report. She details actions which are being taken to improve performance against access targets, including negotiating additional capacity from external providers in the NHS and in the private sector.

The Chief Operating Officer notes that Scottish Government officials are considering whether access targets should be maintained for individual stages of treatment, noting that boards are struggling to meet the staged targets. She suggests that this could be a "backward step" in improving access to services. The underlying implication is that performance targets may be scrapped where they are particularly challenging to achieve, even though this might compromise overall performance and patient experience. However, it also suggests that boards prioritise resources to meet targets and the absence of a target will divert resources away from a particular area.

### *Delivering quality in primary care action plan*

The Director of Strategic Planning informs EMT members that national leads have recently attended meetings of board groups responsible for implementing the ‘delivering quality in primary care’ action plan. The board is receiving national recognition for good practice in supporting implementation of the national action plan. EMT members again seek to define local performance relative to national benchmarks.

The Chief Operating Officer challenges the Director of Strategic Planning on the absence of performance metrics in the report. The latter director responds that a list of metrics would be developed and brought to the group in the next calendar year. Performance appears to be conceived as a quantitative, or measurable, domain in EMT discussions (Power, 1996; 1999).

### *Workforce efficiencies*

This report updates EMT members on progress against planned workforce reductions, performance management of sickness absence and use of overtime. The director of human resources presents the paper to the meeting. He highlights key headline information; workforce reductions are ahead of trajectory and the board is making good progress in reducing sickness absences.

He notes that a further paper will be taken to a future business meeting of the EMT, detailing how performance against the sickness absence target could be sustained over the longer-term. Proposals will include dismantling additional bureaucratic structures introduced to deliver a significant improvement of performance in order to embed this level of performance as part of core line management activities.

The report documents the total value of overtime payments made in the month, as well as the number of staff receiving an overtime payment above £1,000. The Chief Operating Officer has concerns about the reporting of overtime and the lack of audit trail to support such payments. The system cannot distinguish genuine overtime from other types of additional payments made to staff, such as salary protection. She proposes an “audit” of data input to the payroll system to solve this problem.

The Director of Public Health suggests that the EMT ask internal audit to conduct a review of overtime payments. The Director of Finance is most emphatic that this would not be appropriate, but does not explain why.

“Audit” is widely accepted by EMT members as an effective management technology (Power, 1999:95-7), but is not the exclusive domain of professional auditors.

#### *Supplementary staffing – performance report*

The performance report on supplementary staffing is presented jointly by the Medical Director and the Nurse Director, who share executive responsibility for use of locum, agency and bank staff resources by their respective professions. The report presents trend and segmental analysis of key data in graphical and tabular formats.

The Nurse Director draws attention to a potential dysfunctional consequence of the internal performance target to reduce nurse bank and agency usage. There has been an increase in the volume of overtime hours worked, with many of the staff working overtime employed at a higher grade than the bank or agency nurses they have replaced. This could create budgetary pressures for clinical areas. The Chief Operating Officer requested details of specific instances of high banded nurses receiving overtime so she could follow up on these cases.

The Chief Operating Officer and Director of Finance both challenge the integrity of the underlying data, noting that the picture presented in the update paper does not accord with their impression of the organisational reality.

#### *Healthcare associated infection update*

The Director of Public Health presents a performance report on healthcare associated infection. The report outlines recent episodes of specified infections, results of the latest hand hygiene audit, an update on implementation of a national screening programme, an update on the results of mandatory surveillance and operational updates on antimicrobial management and domestic services.

The report includes a paragraph on the results of a recent unannounced inspection by the Healthcare Environment Inspectorate (“HEI”) at the board’s main acute hospital. This proves to be the main subject of the EMT discussion of this topic and is considered in further detail below.

In spite of publication of the critical HEI report, the Director of Public Health tells the EMT that the standard report shows “good progress in all areas” and that performance continues to improve. She casually notes that the “big issue” was the HEI report.

#### *Vignette – Healthcare Environment Inspections*

The recent HEI report was very critical of the hospital’s adherence to national infection control standards and attracted significant media interest.

However, the Healthcare Associated Infection Update report to the EMT presents the inspection findings in a neutral way and, unlike the discussion during the meeting and the media response<sup>204</sup> to the report, underplays the significance of the findings.

“The timing of the [HEI] inspection is unfortunate for staff in some of the areas because they had been working hard on improvement programmes but the improvement process had not been completed when the inspection took place. The inspection identified many areas of good practice but also highlighted several areas for action. These included ensuring that good practice was not always fully documented as required, that additional action was required to ensure cleaning and environmental standards were maintained in all areas at the busiest times of the day, that compliance with the hand hygiene and dress codes was not 100% and that continued improvement was required in antimicrobial prescribing and compliance with peripheral bundles.”<sup>205</sup>

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<sup>204</sup> Sources are not quoted here in order to protect the anonymity of the case study site. However, headlines in national newspapers covering the HEI report included “Snap inspection finds stains, dust and dirt at flagship hospital” and “[Hospital] is blasted by inspectors over cleanliness”, while the stories carried quotes from the Scottish Government that the Board “must implement their improvement plan as a matter of urgency” and an opposition politician who branded the report “damning”.

<sup>205</sup> EMT paper presented to the meeting held on 5 October 2011

The Director of Public Health informs the EMT that an action plan to address the weaknesses identified in the report is under development and that the board has started to “feed positive stories into the Scottish Government”<sup>206</sup> to counteract the negative impression created by the HEI report. She is “very disappointed”<sup>207</sup> with the report, which focuses on issues which the Board had already identified and introduced an action plan to address.

The public nature of the Inspection findings appears to have heightened the organisational response to publication of the report. This is the first item of business at the EMT meeting to draw a response from the Director of Communications. He asks colleagues if the inspectors could return; it appeared that he was attempting to assess the likelihood of repeat negative publicity.

A concern with adverse publicity is also evident in the Healthcare Associated Infection Update report which lists the key risk in this area as:

“There is the potential for Healthcare Environment Inspectorate inspectors to find adverse areas of cleanliness or standards of practice, which could lead to adverse publicity for NHS [X].”<sup>208</sup>

Adverse publicity is considered to be the main negative impact if this risk crystallises – there is no reference to patient safety or infection rates which are the substantive risks which the inspection regime is intended to address.

The Chief Executive is looking for individuals to take personal responsibility for the outcome of the inspection. The Chief Executive has already advised the director of human resources that his team should be prepared to give specific advice on whether the employee conduct process should be invoked. He also reminded the Chief Operating Officers that directors are personally accountable for inspection results and the HEI report should not be viewed as an anonymous process.

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<sup>206</sup> Remarks made by the Director of Public Health at the EMT meeting on 5 October 2011

<sup>207</sup> Ibid.

<sup>208</sup> EMT paper 3.8 presented to the meeting held on 5 October 2011

This news draws out tensions between EMT members as to where accountability should lie. This is especially true between the director with responsibility for policy in this area (public health) and the director with operational responsibility (Chief Operating Officer). The latter “disagrees” with the former’s assertion that the issues raised in the report were already well-known and claims that she had not previously had access to this information.

The Chief Operating Officer questions the responsibility of healthcare professionals on the wards to take action – many of the HEI findings would have been visible to them every day, yet nobody appeared to take action until the inspection report was produced. The Medical Director is concerned that the medical community is not sufficiently engaged with the inspection regime or associated findings. The Nurse Director believes that charge nurses are often “unfairly vilified” in inspection reports and other healthcare professionals also have responsibility for infection control.

While there is general agreement around the EMT table that the inspection highlighted unacceptable failings, the directors take some comfort from comparing it to a recent HEI report on a large acute hospital operated by another large Scottish NHS board. While the HEI inspection of this other Board’s hospital had been similarly critical, the inspectors returned to that hospital to conduct a further unannounced inspection within five days of their original visit. As the inspectors had not returned to their own hospital, the EMT members deduce that they had performed relatively better in the inspection. Although not directly in competition with the other board for funding or patients, it is clear that, in reputational terms, this other Board is the primary competitor and EMT members take personal pride in out-performing their neighbours.

This discussion moves on to the forthcoming introduction of inspections of services for older people in acute NHS hospitals<sup>209</sup>. The Nurse Director, who had been

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<sup>209</sup> The Deputy First Minister and then Cabinet Secretary for Health, Wellbeing and Cities Strategy announced in June 2011 that Healthcare Improvement Scotland would carry out a programme of inspections to ensure that hospitals were adhering to published standards for the Care of Older People in Acute Settings. See Scottish Government News Release “Care for older people is top priority”, issued on 6 June 2011, published online at <http://www.scotland.gov.uk/News/Releases/2011/06/06101224> (accessed on 18 August 2013)

assigned responsibility for ensuring the Board is prepared for this new audit regime, appears to be under pressure to ensure a favourable outcome for the Board.

It emerges during the discussion that a major component of the inspection will be observation of clinical staff interacting with patients. One assessment criterion asks whether staff smile when interacting with patients. This generates some light-hearted discussion amongst EMT members who joke about making changes to the recruitment process to determine whether nurses were sufficiently “smiley”.

While this is not a serious discussion, it provides an insight into the organisational reaction to new regulatory or audit requirements and the likelihood that internal behaviours and processes would be changed just to meet the requirements of audit or inspection, rather than to improve patient care *per se* (Power, 1999; 2005).

On a more serious note, EMT members are concerned at being inspected against subjective criteria and question how performance can be evidenced and verified.

The potential for a new inspection regime to influence resourcing decisions is clear in a contribution from a general manager who suggests that the maintenance budget could be targeted towards facilities which were due to be inspected. This meets with an angry response from the Nurse Director who interjects that such an approach “misses the point”. If facilities are not of an acceptable standard then these deficiencies should be addressed, regardless of inspection; patient safety should be the key determinant for prioritising resources. General management appear to be more likely to prioritise organisational resources in order to meet audit objectives than clinical managers.

EMT members are anxious to learn lessons from their experience of HEI inspections in developing organisational processes for the new older people’s inspection regime. It is proposed that a senior medical professional should sit on the project board to ensure engagement from all professional groups. It appeared that the executive directors were anxious to ensure that the new inspection regime was embedded in operational activities, rather than considered a separate activity, divorced from clinical reality (cf. Power, 1994a:28-9). The organisational response to HEI inspections is the responsibility of management, who do not routinely engage with

the clinicians who deliver care on the ground and influence standards of infection control in the course of an average shift. The response to HEI inspection reports appears to be decoupled from substantive clinical practice (Power, 1999:96).

*Section 17c/2c A&E attendances project 2010-11*

The EMT receives a report on the outcome of a recent pilot initiative to reduce inappropriate or avoidable attendances at Accident and Emergency (“A&E”) department, through working in partnership with general medical practitioners. The Director of Strategic Planning notes the opportunity which the initiative offers to improve the board’s performance against the national HEAT target.

He suggests that it might be helpful to carry out an audit in due course to assess how successful the changes in practice are in delivering the desired outcomes. This is a further example of management relying upon audit as a management technology, in this case to evaluate effectiveness rather than to evidence the operation of the internal control framework.

*Participation standard 2010-11 report*

This report informs EMT members of progress made against the 2010-11 Participation Standard. The report presents the Board’s own performance against the national standard, but the verbal update from the Nurse Director benchmarks performance against other large NHSScotland boards. This again demonstrates that performance is defined by senior management in comparative rather than absolute terms, even though the national performance assessment framework does not promote competition between NHS organisations.

*Bi-monthly report on hand hygiene*

The Director of Public Health presents the latest national audit report on compliance with hand hygiene practice.

The national report “describes occasions when NHS staff have taken the opportunity to carry out hand hygiene at the points in delivering clinical care as described in the World Health Organization (WHO) published guidance on ‘Your 5 moments for

hand hygiene’... NHS Boards submit the results of their hand hygiene compliance audits to Health Protection Scotland (HPS) following mandatory bi-monthly audit periods” (Health Protection Scotland, 2011:1). The report notes that audit is recognised by the WHO as an effective measure in reducing and preventing the incidence of avoidable illness.

There is no discussion of the latest report, although the Chief Operating Officer notes that “please wash your hands” signage has been cut into the floor in clinical areas of a new hospital building, which she hopes will improve future performance and reinforce good clinical practice. Audit requirements will be embedded in the design of a new building (Power, 1996; 1999:95-7).

## **8.5 Reflections and concluding remarks**

### 8.5.1 Key findings and reflections

This Chapter has explored how audit and the official performance assessment framework permeate NHS organisations. Through gaining access to meetings of three key committees in the governance of the NHS board, it was possible to observe both how audit is formally built into governance structures, and how audit appears in other settings.

The case study board installed specific structures to review the findings of formal audit and inspection activity. While these attempted to operationalise accountability by calling managers to meetings to account for action plans to address weaknesses identified by auditors, they were decoupled from the substantive organisation. This study found greater evidence of the programmatic qualities of audit in management practices than in the formal audit structures. Formal audit activity within the case study organisation relied upon a narrow, technical interpretation of audit and internal audit activity in particular was focused on the design and implementation of internal controls.

It appeared that formal audit structures were not taken particularly seriously by the wider organisation, and that possibly the internal and external auditors were most

influential within the confines of meetings of the Audit Committee and its operational sub-committee. Internal audit recommendations were not routinely implemented within the agreed timeframe and the same control weaknesses recurred in different parts of the organisation and over a period of years. This implies that audit structures are decoupled from organisational reality.

Indeed, the findings of formal audit reviews and quasi-audit exercises received greatest attention when there was a likelihood that these findings would be made public. The receipt of a Freedom of Information request for internal audit reports generated an organisational response which extended to the chief executive and a formal management report identified adverse publicity as the greatest risk arising from the Healthcare Environment Inspection regime. The implications of this are considered further below.

Senior managers appeared to embrace audit technologies in all aspects of organisational life, and accept audit as an established solution to diagnose issues requiring management attention and to provide assurance over the functioning of key systems. Senior discussions on performance were peppered with references to both performance targets and audit. National performance targets appeared to have a significant influence on the prioritisation of resources, including management attention.

Clinicians appeared to have little interaction with formal audit and inspection activity; these activities were generally facilitated by managers and did not impact on clinical practices.

The organisation adopted its own definition of performance. Although the national performance assessment system (HEAT) did not seek to rank organisations, senior management were preoccupied with assessing their own performance relative to other organisations. This was also true of external audit and inspection activity; the risk of adverse publicity featured more prominently in discussions of negative findings than the risk to patient care.

### 8.5.2 Implications for the *Audit Society*

This case study demonstrates how audit and performance permeate organisational life, often not in the way intended by the policy environment. The audit society can thus emerge independent of institutional and policy frameworks.

This study provides multiple examples of an organisation installing formal structures to cope with audit processes which were largely disconnected from substantive organisational activities. This is prima facie evidence of decoupling, which Power identifies as a potential negative consequence of the audit society (Power, 1999:96). This is perhaps best illustrated by the failure to implement audit recommendations – this undermines the power of audit to deliver organisational improvement and could contribute to a wider sense that audit fulfils a ritualistic rather than substantive role in organisational life.

Not all managers in the case study organisation accepted a ritualistic role for audit. One senior manager refused to accept a recommendation which he did not consider to add value to existing processes and the executive management team also sought to learn from the experience of preparing for Healthcare Environment Inspections in preparing for the introduction of a new audit regime.

These examples suggest that there may be scope for public services to move to a reflexive state beyond the audit society, where substantive performance is prioritised over compliance with audit requirements and the full value of audit as a bearer of independent assurance is realised. This reflexivity is essential if the nature of the assurance offered by audit is to be fully understood and used appropriately to support accountability frameworks.

### 8.5.3 Further issues to be explored

This study has shown that the elements of the audit society can be present at organisational level, even when absent from the official policy framework. It is beyond the scope of this study to consider how features of the audit society become so dominant in these circumstances and future research could consider, for example,

whether these are imported by senior managers with experience of working in other systems.

The systemic failure to implement internal audit recommendations and the decoupling of formal audit structures from organisational life suggest that the internal audit function has relatively low status within the organisation, although managers were willing to use internal audit as a buffer to protect their own position. This is perhaps surprising in light of the dominant presence of audit concepts at senior management meetings. There is scope for future research to consider the status of internal audit in greater depth.

The next chapter draws out key themes from the findings of the four empirical studies and considers the implications of these findings for the audit society.



# **Chapter 9**

## **Discussion**



## **9.1 Introduction**

The preceding chapters have explored the role of audit in managing the performance of the NHS through four related studies. They show how audit can be an influential actor in the performance assessment of NHS bodies, even where it is not given a formal role in the assessment framework. The cases are evidence of Power's audit society in action and provide an insight into the effects of making performance assessment auditable within the NHS in Scotland.

This chapter draws out key themes and findings from the four preceding studies and explores these in the context of the existing literature on the audit society.

## **9.2 Audit and performance measurement: tracing the experiences of the NHS in Scotland and England**

### 9.2.1 Evolution of performance measurement

The study in Chapter 5, of two health policy systems which originated in a single UK-wide NHS system, explores the influence of audit society rhetoric and concepts in performance measurement reforms through a comparative analysis of parallel reforms in Scotland and England. The analysis paints a more complex picture than a simplistic north / south divide in approaches to healthcare governance and management. A ten-year period of study lays bare the oscillations in the approaches taken by two administrations.

The English Department of Health proved to be a more enthusiastic adopter of performance management techniques than its Scottish counterpart, embracing increasingly aggressive performance management techniques to substitute the price-based controls which regulated the NHS internal market in the early 1990s. The English NHS effectively swapped one set of NPM-infused controls for another as it dismantled the internal market which the New Labour government had campaigned strongly against.

The role of performance measures in the English NHS matured over time, with the Department of Health using them to drive service improvements. Independent research by the Nuffield Trust and others (Connolly, Bevan and Mays, 2010) presented evidence that the reported performance of the NHS in England had significantly improved during the reign of performance measures, both in absolute terms and relative to the devolved nations. However, such studies have inevitably focused upon easily quantified benchmarks, namely the measures at the heart of the English performance measurement system.

The myth that the aggressive regime improved performance could be perpetuated through the pursuit of another myth, a myth which the audit society seeks to expose. Reported performance becomes conflated with substantive performance. The core organisational purpose is displaced by the installation of auditable systems as the organisation becomes fixated on compliance with external norms which are reinforced by the audit regime (Power, 1999; 2005:335). The events at Mid Staffordshire NHS Foundation Trust, documented by the Francis Inquiry (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) exposed the worst excesses of an NHS system which prioritises reported performance over patient care.

Ultimately, however, the dysfunctional side-effects of the aggressive performance management regime in the NHS in England began to outweigh the improvements it could deliver, long before the human cost of the reforms was exposed in the popular media (ibid.).

The NHS in Scotland took the opportunity offered by devolution to formally turn its back on managerial-based governance of the healthcare system. It initially adopted a more laissez-faire approach to performance management than its English counterpart. Indeed, it is questionable whether the initial approach could rightfully be termed 'management': there were too many measures to successfully focus the energies of the NHS in delivering key priorities, results against measures were not published, the measures were not part of a formal accountability mechanism, and there were no visible sanctions levied on poorly performing organisations.

Pressure mounted on the NHS in Scotland in the face of research and other evidence that adoption of this softer incarnation of performance management had inhibited improvements in the performance of healthcare services and apparently left the NHS in Scotland lagging behind its nearest neighbour (Alvarez-Rosete et al., 2005; Propper et al., 2008). The internal market may have been dismantled, but devolution introduced a new type of competition into the NHS. Four politically autonomous NHS systems were created in a relatively small space, each system having three easy comparators against which to benchmark performance. This also enabled the media to draw superficial comparisons, leaving each system vulnerable to public criticism for the very divergences in public policy which devolution was intended to deliver.

The performance of the NHS in Scotland became more formally managed through the introduction of a more focused set of performance measures with publically reported results for which NHS organisations would be held to account at annual public meetings. This was strengthened when the SNP administration came into power in 2007 with a policy programme anchored by a National Performance Framework designed to support a national purpose.

The balance of managerialism in the NHS in Scotland and England shifted during the tenure of the New Labour government. The Scottish NHS performance framework adopted NPM-inspired elements as the English framework diluted its most managerial characteristics. And so a divergence in approaches to performance measurement shifted to convergence at the level of official policy rhetoric.

The proliferation of performance indicators in the NHS reflects an institutional need by central government to check up on the activities of NHS delivery bodies (Addicott, 2008). Measurability facilitates auditability (Power, 1996:299) and creates new space for auditors in the performance assessment framework.

### 9.2.2 Creating a role for audit

The New Labour Government embraced the use of audit in supporting the performance measurement regime in England from the outset. This was manifest in the allocation of new roles to existing audit bodies, including the Audit Commission,

and the creation of new regulatory bodies which adopted the language and ethos of audit, such as the Commission for Health Improvement.

A succession of quasi-audit bodies supported the performance assessment regime in England, with the identity and remit of the bodies changing almost as frequently as the performance measurement system. The Commission for Health Improvement was created to provide assurance over clinical quality in the NHS, but its remit was soon expanded to give the Commission responsibility for setting, verifying and reporting on the performance assessment framework. The Commission would be rebranded as the Healthcare Commission and given responsibility for assessing independent, as well as NHS, healthcare providers. The Care Quality Commission was the final incarnation of the quasi-audit body during the period of analysis; it fulfilled a more traditional regulatory role as responsibility for performance assessment transferred back into the Department of Health. These bodies tend to promote controls-based approaches to verifying performance and are symptomatic of the audit society (Power, 2000b).

Audit was virtually absent from the formal NHSScotland performance framework over this period, but this could not prevent the national audit body creating its own space in the NHS performance network. This conflicts with the English experience and suggestions in the literature that the expansion of the audit is driven by governments (Lapsley and Lonsdale, 2010:87).

Power (1998:25) links the rise of medical auditing to the creation of a purchaser/provider split within the National Health Service, brought about by the creation of the internal market by the Conservative Government in the early 1990s. Audit provided a mechanism for building quality assurances into contracts for healthcare. Although New Labour rejected the perceived extremes of the internal market, this purchaser / provider split endured, suggesting that audit could be expected to endure under their new governance model for the NHS. By contrast, Scotland more thoroughly rejected the internal market by re-aggregating Trusts back into unified health boards serving all the healthcare needs of a local population, thus limiting requirements to contract for, or commission, services to specialist services most efficiently provided at national or regional level.

The longitudinal analysis of the annual NHS overview report produced by Audit Scotland in Chapter 6 traces the evolving role of the national audit body in relation to NHS performance.

Audit Scotland initially fulfilled the traditional role of public sector auditor, providing an opinion on the truth and fairness of annual financial statements and undertaking subject-specific value for money or performance audit studies. As the divergence between the Scottish and English approaches to performance management was at its greatest, and the absence of a formal role for the national audit body in Scotland was at its most apparent, in contrast to the expanding role of the Audit Commission, Audit Scotland adopted a more pro-active role in reporting on the financial and operational performance of the NHS in Scotland. Audit Scotland became the primary source of published information on multidimensional NHS performance following the introduction of its biannual performance overview report.

This echoes the international experience; under the influence of the national audit body, the creep of managerialism into the Scottish NHS continued. This supports the existing literature which claims that national audit bodies can be powerful agents of change in introducing or entrenching NPM reforms in public services (Gendron et al, 2007; Skaerbaek, 2009).

The evolution of Audit Scotland's role in the NHSScotland performance network does not end with the national audit body fulfilling the role of modernizer. By the end of the period of study, the national audit body has secured the role of authoritative and trusted commentator on NHS performance. This is a subtly different story from that of national audit body as modernizer as documented in the existing literature. Audit Scotland elevated its role above that of the organisations charged with delivering healthcare.

The detailed implications of these self-made roles for Audit Scotland in relation to NHS performance are considered further at Section 9.3 below.

Meanwhile, audit-inspired reviews and scrutiny programmes became more common in Scotland. The national audit body was not asked to take responsibility for these

new programmes, which were generally owned by national NHSScotland organisations such as NHS Quality Improvement Scotland<sup>210</sup> and NHS National Services Scotland.

Such programmes included Healthcare Environment Inspections, a programme of announced and unannounced inspections of acute hospitals to ensure that infection control standards are implemented and best practice followed, and hand hygiene audits, a bi-monthly programme of audits to ensure 100% compliance with hand hygiene policies. The introduction of these programmes followed an increasing focus on clinical governance in NHSScotland, a construct favoured by the New Labour Government which imposed managerial systems and controls onto clinical practice (Sally and Donaldson, 1998; Goodman, 1998) and thus opened up a previously closed professional domain to audit scrutiny (Power, 2000b). NHS Quality Improvement Scotland, and later Healthcare Improvement Scotland, was allocated responsibility for overseeing the implementation and effectiveness of clinical governance structures across NHSScotland. The Scottish approach to clinical governance is significant as, in contrast to the core performance assessment framework, it distilled organisational performance into a single score. This created an appearance of objectivity which obscured the extent of subjective judgement which underpinned the assessment process (Power, 1999).

These varied programmes shared an audit strategy which prioritised the implementation and operation of control systems over verification of substantive results and placed “focus on the quality of... *systems* rather than the quality of the product or service itself as specified in standards” (Power, 1999:84, emphasis in original).

Audit Scotland chose to reference these audit-inspired reviews in its annual NHS overview reports and so established them as key components of the wider NHSScotland performance assessment regime. The findings of such reviews were integrated into the national audit body’s definition of NHS performance and attempts were made to triangulate these findings with Audit Scotland’s own work in these

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<sup>210</sup> NHS Quality Improvement Scotland became Healthcare Improvement Scotland on 1 April 2011.

areas, although it is doubtful whether external auditors had the requisite expertise to arrive at an informed judgement.

The organisational impact of these audit-based scrutiny programmes was observed in Chapter 8 and will be considered further at Section 9.8 below.

The Scottish response to use of audit in performance managing the NHS was perhaps more nuanced and considered than in England: the New Labour Government passionately embraced the use of audit-based scrutiny and assurance mechanisms from 1997 but later had to dilute these in the face of unintended dysfunctional outcomes; NHSScotland was slower to adopt specific measures but allowed a gradual escalation of such mechanisms in the second half of the period of study, in parallel to Audit Scotland's increasing influence in NHS performance. Nevertheless, both approaches reflect the focus of the audit society on control systems and independent verification.

### 9.2.3 Discretionary recourse to audit in Scotland

The preceding analysis has demonstrated that there was no formal role for audit in the NHSScotland performance assessment framework, yet audit was the policy response of choice when a significant performance crisis emerged in waiting time management practices employed by NHS Lothian.

There was no statutory, or even customary, obligation on the Scottish Government to have recourse to audit mechanisms when the formal performance assessment framework came under threat. The apparent eagerness to rely on audit as a legitimate response mechanism supports findings elsewhere that a voluntary independent audit can bestow legitimacy upon a process (Free, Salterio and Shearer, 2009), particularly a system which has been threatened by scandal (Andon and Free, 2012).

When the results of the internal audits of waiting time management practices were shared with the Scottish Parliament, the new Cabinet Secretary for health and wellbeing states that waiting time management across NHSScotland had now been

reviewed by “independent auditors of world-class standing”<sup>211</sup>. The implication is that waiting time management practices were somehow vindicated by the audit process, that the process of being audited rendered these practices legitimate (Power, 1999; 2000a:117).

#### 9.2.4 In defence of a formal role for audit

Chapter 5 tells the story of a performance measurement regime in the NHS in England which ultimately had to be diluted to limit the damage to substantive performance, including the threat of gaming of the system. There are numerous examples in the recent literature of studies making a direct causal link between the performance assessment framework in the NHS in England and these dysfunctional consequences (Mannion et al., 2005; Bevan and Hood, 2006).

However, the waiting times crisis at NHS Lothian highlights that similar dysfunctionalities can arise within a less aggressive and overtly managerial performance assessment framework favoured by NHSScotland. While the improper practices emerged at a time when the Scottish system was arguably at its most managerial, NHS boards did not face financial sanctions for failure to meet performance targets which were a key driver of gaming behaviour in England.

There was, however, intense political pressure in a relatively small national system to evidence the strong performance of the NHS in Scotland. The organisation at the centre of the scandal was pursuing an ambition to be among the best providers of healthcare in the world, not just in Scotland or the UK.

A more complex picture thus starts to emerge in the Scottish NHS – the existence of a severe official performance measurement system and gaming of the system to present a more favourable image of organisational performance do not appear to be mutually exclusive. The dysfunctional behaviours observed in the NHS in England could also be observed in Scotland where the official framework was much softer. The unofficial political influences and individual organisational ambition created

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<sup>211</sup> Alex Neil, Cabinet Secretary for Health and Wellbeing, quoted in the Official Report of the Scottish Parliament, 20 December 2012, at Column 15059.

equivalent pressures to the official performance assessment framework in England. The excesses of the audit society can be observed in a system which is a half-hearted adopter of New Public Management ideology.

This has implications for the proposition that the audit society is only relevant in an NPM-saturated environment (Pentland, 2000).

It also exposes the corollary of that proposition: the mistaken suggestion that a softer approach to performance assessment and a trust-based governance framework will guard against the negative impacts of the audit society. The waiting times case illustrates that a performance reporting crisis, where reported performance projects an illusory reality and actual performance lags behind these reports, can still emerge in these circumstances.

The organisational implications of this are considered further below.

Despite Maltby's (2008) accusations to the contrary, Power's work does not reject audit as an effective mechanism in a framework of public accountability. This thesis reinforces that view that audit, applied wisely, could be used to reinforce trust and accountability and rather than being the cause of dysfunctional behaviour could actually be a way to safeguard against it:

“...there is a potential for the worst excesses of the audit society to be realized and for something more relevant, effective and sensitive to be created.”

(Power, 2000a:118)

### **9.3 Audit Scotland transformed**

This study has already established that Audit Scotland successfully created a significant and evolving role for itself within the Scottish NHS performance framework. Having started its life as a traditional national audit body, providing an independent assessment of the financial statements produced by devolved public bodies, including NHS Boards (Hollingsworth et al., 1998:80-1), Audit Scotland was transformed during the period of study into a modernizer and commentator. The

following section explores this evolution, alongside the implications for audit at the organisational level.

### 9.3.1 Auditor as trusted expert

The preceding chapters identified many instances of Audit Scotland being recognised as a key source of expertise, not only on financial management and controls, but on performance management more generally.

The observational case study showed that non-executive board members valued performance audit reports produced by Audit Scotland as a source of expertise and good practice. They required executive management to demonstrate that the organisation already complied with best practice, or to develop and implement action plans to ensure that this good practice was integrated into organisational routines.

Organisational auditors also benefit from the generally accepted view of auditors as a source of trusted expertise. The observational case study showed how the chair of the Operational Audit Sub-Committee (OASC) sought to promote the internal audit service as an organisation-wide resource and source of expertise on internal control best practice.

Auditors have succeeded in expanding the reach of their activities and influence beyond financial systems and management. The existing literature suggests that this has been facilitated by the systems-focus of audit which allows auditors to transfer their skills to any setting (Power, 1999; Humphrey and Owen, 2000).

Audit expertise can be problematic when it is applied to these broader domains. The observational case study highlighted the potential for tension to arise between audit findings and the judgement of a lead manager with professional expertise and experience.

Both the NHS overview reports and organisational audit reports contain information and comments on a wide range of issues. Some of these claims are based purely on management representations and are not the outcome of technical audit procedures.

This presents a problem beyond the scope of existing studies: auditors make pronouncements which have no technical underpinning. This highlights one of the

most dangerous excesses of the growing influence of audit: readers mistakenly trust audit statements, assuming they are underpinned by technical procedures and unaware that they are subjective views.

### 9.3.2 Auditor defines performance and drives change

Audit Scotland became an influential actor in the process to define the performance of NHSScotland in the period following devolution.

The national audit body used the NHS overview report (Audit Scotland, 2001) to make a link between the reporting of weaknesses in financial management in NHS Tayside, Scottish Parliament Audit Committee criticism of current financial monitoring and accountability arrangements overseen by the then Scottish Executive Health Department, and the creation of the first Performance Assessment Framework (PAF) in the devolved Scottish NHS. The official documents introducing the PAF in NHSScotland, reviewed in Chapter 5, do not credit Audit Scotland with any role in the development of the new regime.

Nevertheless, Audit Scotland uses the overview report as a vehicle to promote its own influence over the NHSScotland approach to performance assessment.

The then Scottish Executive did not produce a consolidated report on NHS performance. Audit Scotland filled this space in the performance assessment network by producing its own overview of operational performance (Audit Scotland, 2004a). In doing so, Audit Scotland made the performance of NHSScotland auditable (Power, 1996; 1999).

Audit Scotland explains how it approached the task of defining ‘NHS performance’, drawing data from a number of published sources and acting as arbiter of the elements of performance which are most important to patients and the public (Audit Scotland, 2004a). Significantly, this definition is broader than the formal performance management system, which is “taken account of” but is not the primary source of information. This lessens the profile of the PAF in the NHSScotland performance network, with the audit definition of performance placed in competition with the NHS’ own definition.

Similarly, Audit Scotland overview reports promoted “underlying financial performance” as a key measure of the financial health of NHS boards. The national audit body redefined financial performance beyond statutory targets so that bodies could be held to account for how they delivered in-year financial balance. However, the national figures on underlying financial performance presented in successive reports were the product of unaudited returns produced by each NHS board: no audit tests, or indeed any form of independent verification, were applied to these measures. These findings support the existing literature that audit is influential in constructing an auditable environment (Power, 1994a, 1996; 1999) and that performance audit reviews lead the auditor to construct a definition of performance which can be subjected to audit (Day and Klein, 1987; Everett, 2003; Lindeberg, 2007). They also reinforce the risk that auditors proclaim to be experts, or to make authoritative statements, without supporting audit evidence.

The national audit body also transformed public services: both central government and NHS boards changed practices and policies as a direct result of recommendations made in overview reports. A recommendation in the overview report led to the introduction of a new comprehensive performance report by the Scottish Government (Scottish Government, 2008a). The national audit body became a modernizer, which introduced managerial reforms into NHS performance reporting (Power, 2000a; Gendron et al., 2007). Furthermore, the Scottish Government explicitly linked the introduction of the report to a recommendation made by Audit Scotland (Scottish Government, 2008b).

There is now a self-referential legitimacy relationship between Audit Scotland and the Scottish Government; the Scottish Government uses the audit recommendation to legitimate the publication of its own performance report, while Audit Scotland draws on the action taken by the Scottish Government in response to its recommendation to legitimate its earlier findings and reports.

A mutually beneficial legitimacy relationship can be established by the audit process, with both auditor and auditee deriving legitimacy from the implementation of audit recommendations (Free, Salterio and Shearer, 2009).

However, having created new auditable measures of performance, the national audit body does not apply audit procedures to reports of performance against those measures. The purpose of promoting the new measure appears not to be to broaden the application of traditional audit tests but to provide an evidence base for the developing commentary which the national audit body provides on the financial performance of NHSScotland.

A picture begins to emerge of a new identity held by Audit Scotland in the performance network: that of commentator on the operational and financial performance of the NHS.

### 9.3.3 Auditor as trusted commentator

The evolution of Audit Scotland's role did not end when it established itself as an expert on financial and performance management and a modernizer. Chapter 6 traces a further evolution of the role of the national audit body, to trusted commentator on public finances and the NHS in Scotland.

The Auditor General begins to comment upon the merits of macro fiscal policy decisions, looking beyond the value for money of investment or operational decisions taken by specific public sector organisations or the financial control and governance frameworks within individual organisations. For example, the 2009-10 overview report questions the Scottish Government's decision to protect the Health budget and apply greater reductions to the budgets of other services (Audit Scotland, 2010c:15). Where, in earlier reports, Audit Scotland may have focused on the impact which the relative protection of the Health budget would have upon NHSScotland, the overview report now questions the merit of a policy decision to offer that relative protection.

Reports produced by Audit Scotland on behalf of the Auditor General are routinely reviewed by the Scottish Parliament. Audit Scotland and the Auditor General can thus use these reports to implicitly invite MSPs to consider a competing professional viewpoint in addition to the official position of the Scottish Government.

The profile that the overview reports gave to the office of the Auditor General fluctuated over the period of study. The early overview reports were presented as his

personal summary of the findings of NHS audit activity. The middle-period of analysis saw a shift in the narrative style of the reports with the introduction of third person narration as the overall style of reporting became more corporate, in keeping with the role of the audit body as an agent of change, close to a management consultant (Gendron et al, 2007; Skaerbaek, 2009). Finally, the Auditor General as an officeholder grows in significance in the performance network as the national audit body seeks to establish itself as a commentator on public finances and performance. He is the personal face of the expertise of Audit Scotland, a well-respected and authoritative public figure whose views will command the respect of parliamentarians, managers and the public alike.

The role of national audit body as trusted commentator identified in the present research marks a departure from the existing literature, which has focused on the capacity of audit bodies to promote the introduction of managerial reforms through a role akin to a management consultant. This is an important contribution to the debate on the role of a modern national audit body and this finding would benefit from further empirical exploration in future.

#### **9.4 Immunity from criticism**

Audit Scotland developed an identity as trusted expert and authoritative commentator despite the absence of a systematic evidence base to support the efficacy of audit (Power, 2000a:114). The systematic tendency to trust audit discourages such scrutiny of audit practices (Power, 1999:136-7) and can create a climate where there is little public criticism of audit activity (Skaerbaek, 2009:976).

##### **9.4.1 Denying failure**

Selective reporting of the role of the auditor can influence the appearance of the success of audit. The primary function of the national audit body is to scrutinise the financial statements and financial management of public sector organisations, including NHS organisations. However, the performance of the auditor is not subject to equivalent scrutiny (Power, 2000a:114). Coupled with the systematic tendency to

trust audit (Power, 1999:36-7), this creates an environment in which there is little opportunity for audit 'failures' to be made public.

Audit Scotland is quick to infer its own success from the implementation of prior recommendations or findings by audited organisations in annual overview reports, but is more reluctant to associate audit with failure to identify control weaknesses or errors in the financial statements. For example, a £10 million error discovered in the audited accounts of an NHS board (Audit Scotland, 2006:18) and weaknesses in financial management and budgetary control within the then Scottish Executive Health Department (Audit Scotland, 2005:36; 2006:10) are reported in a neutral fashion and there is no implication that the audit process could or should have identified these issues sooner.

#### 9.4.2 No scrutiny of audit

Audit Scotland emerged as one of the heroes of the waiting times case, at least in the eyes of the media and opposition politicians. The national audit body had recently carried out a performance audit (Audit Scotland, 2010a) and follow-up impact report of waiting times management in NHSScotland (Audit Scotland, 2011b). These reports raised concerns regarding the completeness of the audit trail to evidence application of the 'New Ways' waiting times methodology and highlighted variation in practice between NHS boards. These reports reached fairly positive conclusions on the implementation of the 'New Ways' methodology and concluded that no further national audit work was required.

However, these studies by the national audit body failed to uncover either the significant issues which were to emerge in NHS Lothian or the questionable reporting practices adopted by other organisations, which would emerge only four months after publication of the impact report.

The systemic weaknesses in waiting times management were brought into the public domain by a newspaper report, not by a performance audit report.

The national audit body not only escaped criticism of its previous work but was co-opted as a major part of the solution, called upon to diagnose and remedy the weaknesses identified at NHS Lothian and across Scotland. This contrasts with the

ritual sacrifice of auditors in the face of a corporate crisis which has been evidenced in the private sector (Guénin-Paracini and Gendron, 2010). In this instance, the national audit body was not “sacrificed” in the aftermath of a scandal and moved straight to being part of the solution.

The legitimacy of national audit bodies is secured in part by their independence from executive government, underpinned by legislative or constitutional provisions and by maintaining a public image of impartiality. In Westminster systems of government, this constitutional independence is the very foundation of parliament’s ability to hold the financial affairs of executive governments to account (Funnell, 1994:179). Thus, any apparent criticism or threat to the independence of the Auditor General or equivalent can be construed as an attack on the system of democratic accountability which it supports. Public audit can derive credibility, or even invincibility, from its association with fundamental democratic principles. This association also leaves the executive government with little choice but to recognise the value of public audit, at least in a symbolic sense. But it can also offer protection to executive government.

This tension is inherent in a Parliamentary exchange between a Scottish Government minister and an opposition MSP in the aftermath of the PwC review of waiting times management at NHS Lothian.<sup>212</sup> The opposition MSP asked the minister what action she took in response to a finding in the 2010 national performance audit report on waiting time management. Audit Scotland did not consider this to be a serious finding at the time, but it would be politically difficult for a minister to directly criticise the national audit body for failing to identify the significance of an issue which would quickly thereafter become the centre of the biggest national performance crisis in the NHS in Scotland since devolution.

The minister instead refers to the follow-up report to the national performance audit. She can mobilise the national audit body’s decision that no further work was required to validate the government’s actions or in this case apparent lack of action.

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<sup>212</sup> Deputy First Minister and then Cabinet Secretary for Health, Wellbeing and Cities Strategy responds to supplementary question from Dr Richard Simpson MSP. A transcript of the exchange is contained in the Official Report of the Scottish Parliament on 19 April 2012 at Columns 8226 to 8227.

Thus, the national audit body provides a buffer for the government against claims that it should have taken action earlier to prevent the practices which became entrenched in NHS Lothian.

Both executive government and opposition politicians can benefit from the legitimacy offered by audit reviews and so it serves the interests of neither party to apply too much scrutiny to the work of Audit Scotland. The implications of the ritual appeal of audit are considered further at Section 9.6.1 below. This connection is important and could tentatively be regarded as a significant enabler of the climate of near universal acceptance in which national audit bodies function, along with Power's proposition that the "systematic tendency towards uncritical trust in the efficacy of audit processes... results in the absence of evaluation of the audit process itself" (Power, 1999:136-7). The relationship between audit and trust is considered further in the next section.

#### 9.4.3 Private criticism

The observational case study showed that Audit Scotland's immunity from criticism might more accurately be described as immunity from *public* criticism. A comment made by the director of eHealth that an Audit Scotland review of eHealth service delivery was "acrimonious" is reported as "challenging" in the formal minute of the November meeting of the OASC. One Audit Committee noted that he was "far from impressed" with the Audit Scotland performance audit of community health partnerships (CHPs) and that it did not accurately "represent CHP world"<sup>213</sup>. This criticism was not subsequently minuted and so there was no public trace of the member's discontent with the national findings.

There is scope for future research to consider how Audit Scotland secured this immunity from criticism. An untested proposition is that this derived, at least in part, from the national audit body's self-created identity as an authoritative, independent and trusted commentator on NHS performance, as demonstrated by the longitudinal study of the NHS overview report in Chapter 6.

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<sup>213</sup> Paraphrased remarks made at the observed meeting of the Audit Committee held on 11 October 2011.

## **9.5 Audit and trust**

Chapter 5 found that performance management approaches adopted by NHSScotland, while increasingly managerial in content, operated in a high-trust environment, with no formal role for audit in successive official performance management frameworks, from the PAF to HEAT.

This contrasts with the experience in England, where performance management systems were accompanied by formal scrutiny, provided by a national audit body or a bespoke quasi-audit body, and NHS bodies were not trusted to report on their own performance without external verification. The English experience supports the proposition in the literature that audit can displace trust from frontline professionals to auditors (Power, 1994a; 1999).

The study of the NHS Lothian performance crisis traces the creeping entrance of audit into the official response as concerns about waiting list management grew and the high-trust relationship between central government and delivery body was damaged.

### 9.5.1 Audit replaces trust

The Scottish Government did not initially accept the premise that the practices adopted by NHS Lothian amounted to ‘gaming’ and resisted calls from opposition politicians for an independent investigation. But a shift is evident once ministers receive an internal review report and the first indication of damage to the high-trust relationship between the board and central government is given in the request for NHS Lothian to commission an internal audit review to “provide further reassurance” over the positive position reported by the internal investigation.

Trust was further eroded as preliminary findings of the internal audit review, which the board had outsourced to a Big 4 accounting firm, emerged. The Scottish Government intervenes in the internal audit, taking over the contractual relationship with the private firm “in the interests of appropriate governance”. While there is no public trace of the actions culminating in the intervention, the Cabinet Secretary later

admits in the Scottish Parliament<sup>214</sup> that she did not know at the time how serious the problems were at NHS Lothian and who in the organisation might be complicit in the inappropriate management and reporting practices coming to light.

While the Cabinet Secretary does not explicitly state it, the complete breakdown in trust is implicit in her explanation. At this point, she could not even trust the organisation to honestly report the results of an external review of waiting list management and she had to assume a direct relationship with the reviewing firm in order to reassure herself over the veracity and integrity of the position reported to her. And despite the initial assertions that the Scottish Government had intervened in the external review in some higher (but undefined) interest in upholding principles of corporate governance, their real concern was practical not theoretical.

The damage was not contained to the bilateral relationship between the Scottish Government and the organisation under suspicion, but spread to relationships between the Scottish Government and other apparently innocent NHS organisations which were not implicated in the immediate performance crisis. Distrust also spread into the public domain, as repeated criticism and speculation by newspapers and opposition politicians began to undermine public trust in NHS organisations, particularly management (Justesen and Skaerbaek:2005).

Once audit had been introduced as a policy response, it became difficult to control its influence. Audit exploded into every aspect of this performance crisis as new audit reviews were announced to address the erosion of the different levels of trust. The Cabinet Secretary required all NHS organisations to commission their internal auditors to review local waiting time management practice; addressing the breakdown of trust between levels of the official hierarchy. The national audit body announced its own performance audit in the wake of demands from opposition politicians that such an independent study was required to restore public trust.

Politicians perpetuated the narrative that the public could no longer trust performance reported by NHSScotland in comments made in Parliament.

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<sup>214</sup> Nicola Sturgeon, Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy, as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7462

“I am sure that the Cabinet Secretary will agree that the people of Scotland should be able to trust the Scottish Government statistics on waiting times... I ask the Cabinet Secretary to request that Audit Scotland undertakes a full and thorough review of each and every territorial health board in Scotland to restore confidence in the system.”<sup>215</sup>

“Frankly, it is not good enough for health boards to inspect themselves, which is the option that the Cabinet Secretary favours. I believe that the people of Scotland deserve much greater openness and transparency...”<sup>216</sup>

The repeated requests serve to further undermine public trust in NHS organisations – the implication is that internal audits conducted by NHS boards will not secure the necessary transparency in Scotland wide practices. This transparency can only be secured by asking an independent body to conduct a review.

The public was likely to reach judgements on NHS performance based on secondary reporting of the reviews and Parliamentary proceedings in the media, rather than by directly accessing the primary material. Politicians attempted to instruct the public not to trust the wider NHS through the media.

“... We need full transparency to get to the bottom of this once and for all... Anything short of a full, independent investigation carried out by Audit Scotland... simply isn't good enough.”<sup>217</sup>

The media becomes a powerful actor in selecting the political messages to report, wielding significant influence over the development and sustainability of trust between the public and organisations and professionals who are subject to audit (Justesen and Skaerbaek, 2005:340-1).

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<sup>215</sup> Jackie Baillie MSP (Scottish Labour), as quoted in the Official Report of the Scottish Parliament, 21 March 2012, at Column 7460

<sup>216</sup> Jackie Baillie MSP speaking in the Scottish Parliament on Thursday 17 May 2012, as recorded in the Official Report at column 9068.

<sup>217</sup> “Audit Scotland concern over waiting lists”, The Sunday Times (Scotland), Sunday 1 April 2012, p. 7, 1<sup>st</sup> edition, Mark Macaskill

The national audit body perpetuates this atmosphere of mistrust.

“The public needs to be able to trust how public services are managing [waiting time] information and be assured that patients are not being impacted negatively. Audit Scotland is uniquely placed to provide independent public assurance on the management of waiting lists across the NHS in Scotland.”

(Audit Scotland, 2012:3)

Audit Scotland holds itself out as a key intermediary in restoring public trust in the reporting of waiting time targets and in the provision of treatment in accordance with national target times. It also sets out a “unique” position for itself, supporting the findings of the earlier chapter that Audit Scotland carved out a position for itself as an expert on the financial and operational management of the NHS in Scotland.

The present research has not examined the public reaction to these events; it is possible that the breakdown of trust occurs at a rhetorical or political level only and not at the point of individual access to services: “conscientious professionals often find that the public claim to mistrust them – but the public still demand their services” (O’Neill, 2002). High level performance metrics and reports are likely to be less important to the public than their own personal experience of NHS services. An independent review by auditors may have little impact on public perceptions of healthcare services, which are more likely to be based on knowledge of how long friends and family have had to wait for treatment. There is scope for future research to consider whether “trust” in this sense occurs, and can be damaged, in the political sphere only.

By the time Audit Scotland begins its national review of waiting time management practice, there appears to be widespread political acceptance that audit is necessary to restore public confidence in the NHS.

A picture is painted of audit as a first-line policy response when trust breaks down. This is an extension of Pentland’s (1993:606) view that the auditor serve to reassure the public that financial statements are trustworthy, in which it is implicit that the auditor validates an existing relationship of trust. The waiting times case is an illustration of the ultimate breakdown of trust which can occur in the audit society:

performance reports are only valid if they have been verified by an independent third party (Power, 1994a; 1999).

#### 9.5.2 Capacity of audit to restore trust

Audit also fulfilled a restorative function in the waiting time case: the Cabinet Secretary reports to Parliament that the initial review by PwC into waiting time practices in NHS Lothian succeeded in reassuring her that the chair of the organisation was not complicit in any systematic gaming of the performance system. The PwC review went some way to restoring the Cabinet Secretary's trust in the chair of the organisation. The need for independently commissioned reviews of NHS Lothian has subsided.

There are two more nuanced implications which demand further exploration: the speed at which the distrust in NHS organisations becomes contagious and creates a need for a national audit response; and the healing capacity of audit to restore trust (Power, 2000a; Lapsley and Lonsdale, 2010). Audit has the capacity to purify and reassure where an organisation or system has been damaged by scandal (Andon and Free, 2012).

### **9.6 Protection afforded by audit**

#### 9.6.1 Ritual appeal of audit for politicians

The waiting times case study provides clear evidence that audit has a ritual appeal for politicians. One can speculate as to the source of this appeal – could it lie in the credibility bestowed by an independent reviewer, perhaps, or in the role which Audit Scotland in particular has carved out as an authoritative commentator on NHS performance?

The report on waiting time management practices at NHS Lothian, produced by PwC, was the only key actor not to describe the review as an “audit”. In contrast, members of the Scottish Parliament referred to the review as an “audit” 20 times in

the course of a 40 minute session<sup>218</sup>. The programmatic appeal of “audit” appears to be more significant to politicians than its technical definition: the PwC report (PwC, 2012:4) is at pains to make clear that the work carried out by the professional services firm did not constitute an “audit” as defined by professional auditing standards.

The popular ambiguity of “audit” strengthened its appeal to politicians who could derive legitimacy from commissioning an “audit” without a need to consider the technical definition of the underlying work. This supports proposition that the ambiguity of audit is a key source of its influence (Power, 2000a:116) and refutes claims made by critics of Power (Humphrey and Owen, 2000; Lindeberg, 2007) that the audit society cannot exist without an accepted definition of what constitutes an audit.

The extensive parliamentary and media coverage devoted to the NHS Lothian performance crisis and its aftermath is in stark contrast to the response to the recent performance audit study of waiting times management undertaken by Audit Scotland (2010a; 2011b).

Scottish Government ministers mobilise previous studies conducted by Audit Scotland to legitimate their judgement that a further national investigation is not necessary to provide assurance over official reports of performance. They also commit to seeking advice from the national audit body on the terms of the internal audit review which every NHS board has been asked to commission. The respected and recognised professional expertise of the national audit body is being harnessed to legitimate the exercise. Executive government can benefit from the credibility of a national audit body by harnessing its findings in support of its own actions or by recognising it as a source of expertise (Funnell, 1994). There are similarities to the way in which financial analysts mobilise audited financial statements as a symbol which bestows credibility on their own work (Malsch and Gendron, 2009).

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<sup>218</sup> Official Report of the Scottish Parliament, 21 March 2012, at Columns 7456 to 7469

### 9.6.2 Audit offers protection to managers

The legitimacy offered by audit is also mobilised at organisational level to support management action or to evidence that existing processes are operating effectively.

In the observational case study, the primary care general manager cites the reduced involvement of internal audit in a payment verification process as evidence that the underlying process is operating effectively. He appears to be mobilising the reduced input of internal audit to legitimate the underlying process – if internal audit is satisfied that the process is sound then by definition it is (Power, 1999:96; Free, Salterio and Shearer, 2009).

Internal audit findings were also used by managers in the case study organisation to legitimate their own case for service changes, possibly to secure support from higher levels of the organisation. This shows how an internal audit review can be used as a legitimating device to support management action: “that an audit is done can be more important than what is done and to whom any report is made; being audited *per se* is a badge of legitimacy” (Power, 2000a:117).

Audit thus has legitimating properties in both the political space and the organisational space.

## **9.7 Managing reputational risks**

Once audit is established in a network as a trusted source of expertise and assurance, it becomes risky for individuals and organisations to become the subject of negative audit findings.

The observational case study provided evidence that the case study organisation considered that audit findings posed reputational risks to the organisation.

A freedom of information request seeking copies of internal audit reports had prompted senior-level discussions within the organisation on the process for “clearing” reports for finalisation. The prevailing impression left on the researcher by the discussions at the OASC and Audit Committee was that the organisation

perceived negative internal audit findings as a threat to the organisation's public reputation, and that this threat was considered greater than the threat of internal audit findings going unreported.

This impression was heightened by the observation of the Board's Executive Management Team. A paper on the critical results of a recent Healthcare Environment Inspection identified one key risk to the Board:

“There is the potential for Healthcare Environment Inspectorate inspectors to find adverse areas of cleanliness or standards of practice, which could lead to adverse publicity for NHS [X].”<sup>219</sup>

Management perceive adverse publicity as the most damaging outcome of a critical inspection report – there is no reference to patient safety or infection rates which are the substantive risks which the inspection regime is intended to address.

Thus, audit can produce public “discomfort”, as much as it can offer ritualistic reassurance to remote service users or politicians (Justesen and Skaerbaek, 2005; 2010). This is likely to heighten the organisational response to potentially negative audit findings.

## **9.8 Impact of audit on the organisation**

Having explored the role which policy allocates to audit and the role which audit plays in the political oversight and direction of public services, the final substantive chapter brings into focus the impact which audit has on everyday organisational life. The observational case study exposes organisational interactions between audit and performance.

### 9.8.1 Role of non-executives in effectively holding management to account for performance

The waiting times case study highlighted deficiencies in the oversight and scrutiny of management by the board of NHS Lothian. There was evidence in minutes of board

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<sup>219</sup> EMT paper presented to the meeting held on 5 October 2011

meetings that the board accepted information provided by management at face value, with little evidence in board minutes that members engaged in detailed debate or discussion of waiting time performance.

The external review conducted by PwC confirmed that the “board was not presented with a sufficiently comprehensive picture of waiting times to have identified that an issue existed”<sup>220</sup>, yet neither the review nor the statement explored the extent to which the board *should* have challenged the sufficiency of the information provided or asked more searching questions of executive management. The Scottish Government subsequently asked the NHS Lothian chair to ensure an improvement in the quality of performance information reported to the board.

This incident raises questions about the role of non-executives in holding an organisation to account for performance and their ability to fulfil this role if they do not understand the particular operational risks or potential for gaming of reported figures. In the NHS Lothian case, it took an independent review or “audit” to ask questions which could have been posed by non-executive members at an earlier stage, possibly preventing the escalation in gaming behaviour on the part of management. The observational case study showed that non-executives looked to audit to provide assurance over the operation of control systems.

Audit may become a substitute for effective non-executive scrutiny of public services.

### 9.8.2 Controls focus

Audit Scotland is the only source of performance audit activity within the case study board, which tends to react to national studies rather than proactively engage in performance or value for money audits. The internal audit programme appears to be focused on traditional internal control frameworks rather than considering, or influencing, performance. The formal audit structures within the organisation are not concerned with performance issues.

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<sup>220</sup> Statement on Waiting times (NHS Lothian) by the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy to the Scottish Parliament on 21 March 2012, as reported in the Official Report at column 7458.

The observational case study provided examples of the prioritisation of controls over substantive performance. The OASC considered the findings of a contractual and statutory evaluation which focused on the installation and operation of management controls, not patient outcomes. Practices which failed to install or consistently operate these controls are subject to financial penalties yet there is no consideration of the quality of treatment provided by practices in which controls were found to be operating effectively. This case highlights the potential for management evaluation systems to promote controls and processes over substantive delivery (Sheffield and Bowerman, 1999).

### 9.8.3 Decoupling

The case study organisation installed formal structures to cope with audit processes. Power (1999:96) suggests that this can be prima facie evidence of decoupling. Some of these structures were imposed by the NHSScotland governance structure, while others were voluntarily introduced by the board, such as the OASC which operationalises managerial accountability within the NHS Board. Managers are required to attend meetings to respond to internal audit reviews completed in their area where the auditor concluded that the control framework “requires improvement” or is “unsatisfactory”.

The observational case study contained several examples of recurring internal audit recommendations: internal audit reviews of management of patient funds conducted 10 years apart uncovered virtually identical control weaknesses; the same recommendation was made in six annual audits of property transactions before management took remedial action; and there was a build-up of internal audit recommendations which had passed their due date but were not yet implemented. One Audit Committee member speculated whether non-executive members should have done more to ensure that management took action in response to recurring recommendations.

This raises questions about the extent to which internal audit reviews are active in organisational learning and development and how much management effort is directed at introducing substantive changes, rather than just doing enough to

demonstrate that an audit recommendation has been implemented (McGivern and Ferlie, 2007). The failure to implement internal audit recommendations in a timely fashion raises questions about the efficacy of the internal audit process – audit cannot deliver improvements if there is no action following a review. Systematic failure to implement recommendations can contribute to a wider sense that the audit fulfils a ritualistic rather than substantive role in organisational life.

#### 9.8.4 Colonization

This thesis presents strong evidence that the audit society can permeate organisational life, even where it is absent from the overarching policy framework. This can be seen both in the external identity of the organisation, as shown in the waiting times case, and in the internal operations of the organisation, as shown in the observational case study.

In the observational case study, managers outlined how plans to systematise resource planning for theatres introduced in response to the internal audit and management review findings would include an audit of how the actual length of operations compared to the length of time predicted by surgeons. Nursing managers introduced “audits” of recruitment checks in the wake of a fraud investigation which revealed that a nurse had been employed in a professional post despite their professional registration having lapsed some years earlier. While reviewing the minutes of meetings of other Board committees, two non-executive board members present at the Audit Committee and the director of finance identified two processes and one service which would benefit from an audit review.

While it is debatable whether some of the proposed practices constituted an “audit” in a technical sense, it shows how the language of audit permeates management practice. These examples may appear individually insignificant but when considered together paint a picture of an organisation which embraces audit technologies and frequently uses the language of audit in official interactions.

There is scope for future research to study more directly the means by which the negative behaviours encapsulated in the audit society infiltrate organisational life. For example, are they imported from other systems by managers who have worked at

a senior level in both types of system, or are they imbued in professional educational training?

#### 9.8.5 Effects on management and staff

The independent review of NHS Lothian waiting time practices (PwC, 2012) found that “staff were under pressure to find tactical solutions to waiting times rather than to tackle the root causes of the delays”<sup>221</sup>. This finding provides evidence of the dysfunctional consequences which can occur when the reporting of performance becomes more important to an organisation than underlying substantive performance (Power: 1999, 2005:335; Strathern, 2000); when being seen to comply with performance targets or standards becomes more important than the provision of the underlying service, in this case the timely treatment of patients.

A detailed study of the management culture which cultivated the dysfunctional waiting time management practices is beyond the scope of the present study. However, the NHS Lothian case is a manifestation of the personal impact of the worst excesses of audit.

While the ‘star ratings’ performance assessment framework in operation in the NHS in England from 2001 to 2006 was criticised for the pressure which it placed on staff to achieve good results (Mannion et al., 2005), the softer approaches to performance assessment adopted by the NHS in Scotland were seen to promote a collaborative approach to delivering improvements. Although the policy framework discouraged this environment, a damaging culture was still able to develop and prevail within one organisation, highlighting the potential for a significant disconnect between policy rhetoric and operational reality (Blackman et al., 2006).

### **9.9 Beyond the Audit Society: reflexivity emerges?**

The observational case study shows signs that some public services managers are aware of the dysfunctional consequences which can result when performance reports

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<sup>221</sup> Official Report at column 7458

are prioritised over substantive performance and when theoretical controls take precedence over pragmatism.

A senior manager insisted to the OASC that he could only accept an audit recommendation when implementing it will produce something meaningful. He comments:

“I’m not just going to come in here and say that I’ve ticked the box, I’ve got a policy. See you again in two months... A piece of paper won’t make the issue go away.”<sup>222</sup>

The corporate governance and value for money manager also cautioned the Audit Committee that ‘best value’ toolkits were designed for use by auditors and were not a management checklist. He advised that ‘best value’ should be driven by outcomes, not by compliance with a checklist or toolkit.

This contrasts with the finding of Sheffield and Bowerman (1999) who found that the ‘best value’ regime in Scottish local government promoted consideration of decision-making systems and processes above the substance of those decisions and the underlying services. Arnaboldi and Lapsley (2008) later found limited evidence that Scottish local government managers sought to install auditable best value requirements without embedding substantive service changes.

The case study board also sought to learn lessons from the organisational response to audit mechanisms such as the Healthcare Environment Inspectorate where it decoupled the organisational response from clinical reality.

Thus, there may be scope for compromise to emerge, for an approach to public service accountability and performance to be crafted which introduces conscious safeguards against decoupling, colonization and displacement of objectives but which uses audit in a constructive way to effectively scrutinise the actions of executive government and public service organisations.

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<sup>222</sup> Paraphrased account of comments made by the eHealth director at the OASC meeting held on 28 November 2011.

## **9.10 Reflections and concluding remarks**

This study provides evidence of the audit society in action at all levels of NHSScotland: in the political domain; in the strategic governance and leadership of the NHS; and in frontline NHS organisations.

Although the political rhetoric rejected a strongly managerial approach to governance of the NHS in Scotland, this study shows that managerial influences crept into performance assessment as the political imperative for improvements strengthened. The national audit body became a dominant actor in NHS performance assessment even though it was not given an official role in the national framework. Audit was the first choice policy response when a performance crisis emerged. The policy environment and rhetoric presented an idealised image which did not accord with the operational reality (Blackman et al., 2006).



# **Chapter 10**

## **Conclusion**



This thesis has explored the role of audit in managing performance at all levels of NHSScotland. It has exposed the proliferation of audit ideals in organisational life within an official framework which rejected the extremes of managerialism and favoured a collaborative approach to performance assessment. Nevertheless, government resorted to audit to expose the extent of a performance crisis and to rehabilitate the NHS. It has shown how the national audit body became a dominant actor in assessing the performance of NHSScotland, even though it was not afforded a role in successive assessment frameworks.

This rich account of performance assessment within NHSScotland demonstrates that the audit society can exist independent of official rhetoric and structures. There was a clear disconnect between the environment captured in official documents and organisational and political reality. The legitimacy offered by audit has a virtually irresistible appeal for both politicians and managers, which did not appear to be grounded in knowledge of the nature of assurance provided by audit.

This study has found a strong link exists between audit's promise of legitimacy and the lack of public scrutiny of the efficacy of the audit function, particularly in the political sphere. Politicians continued to rely on the national audit body to restore confidence in reported performance, despite recent audit work failing to uncover the original weakness. Opposition politicians were quick to conflate a rejection of the need for audit in a particular situation with a rejection of accountability and transparency, without regard for the technical value of the audit process, or indeed whether audit was being used as a label rather than with any technical meaning.

Official trust in NHS organisations became synonymous with audit assurance during a performance crisis. The present study did not analyse empirical evidence of the impact which this may have on trust of the individual citizen in public service organisations, and there is scope for future research to consider whether the need for audit has any resonance beyond the adversarial world of politics.

The legitimacy, or ritual appeal, of audit within NHSScotland heightens the reputational risks which organisations and politicians are exposed to when they are

subject to audit. It can then become imperative to manage the negative publicity generated by critical audit findings, rather than to focus on substantive performance.

The evolution of the identity of the national audit body to authoritative commentator is highly significant, and represents a development of the findings in the existing literature. The national audit body in the present study propelled itself beyond the agent of change, which is widely documented, to a key player in the wider public and parliamentary dialogue on NHS performance. The dominance of audit is such that this development went virtually unchecked and there was no public debate as to whether it was appropriate for senior public audit figures to pass public judgement on financial strategy and policy decisions made by the government of the day.

It is clear from this study that Power's audit society remains strongly in evidence within the public sector, and furthermore in a policy setting which is not infused with NPM technologies and ideals. Nevertheless, the organisational case study demonstrated that audit society concepts permeated performance discussions at the senior level of an NHS Board. There is scope for future empirical research to consider how the audit society became so evident at operational level without the influence of the policy environment, and whether it is imported by staff with experience working in more managerial settings. There is also a need for further empirical research on the continuing existence and impact of the audit society beyond the public sector.

This study also found that audit can have a positive influence; it can restore trust and improve transparency within public services. There were also indications of reflexive awareness of organisational actors of the negative effects of the audit process and a need to install checks and balances to maintain a focus on substantive performance and the ultimate beneficiaries of public services.

While audit can continue to frustrate the achievement of outcomes and while the technical nature of assurance offered by audit remains elusive, there is hope that the role and nature of public services audit can yet improve transparency and accountability at a lower cost to substantive performance and trust.

## Bibliography and references

Addicott, R. (2008) "Models of governance and the changing role of the board in the 'modernised' UK health sector", *Journal of Health Organization and Management*, Vol. 22(2), pp. 147-163

Ahrens, T. and C. S. Chapman (2006) "Doing qualitative field research in management accounting: Positioning data to contribute to theory", *Accounting, Organizations and Society*, Vol. 31, pp. 819-841

Alvarez-Rosete, A., G. Bevan, N. Mays and J. Dixon (2005) "Effect of diverging policy across the NHS" *British Medical Journal*, 331, pp. 946-950

Andon, P. and C. Free (2012) "Auditing and crisis management: The 2010 Melbourne Storm salary cap scandal", *Accounting, Organizations and Society*, Vol. 37, pp. 131-154

Arnaboldi, M. and I. Lapsley (2008) "Making management auditable: the implementation of Best Value in local government", *Abacus*, Vol. 44(1), pp. 22-47

Atkinson, P. and A. Coffey (2004) "Analysing documentary realities" in Silverman, D. (ed.) *Qualitative Research: Theory, Method and Practice*, 2nd edition, London: Sage

Audit Commission (2006) *Auditor's Local Evaluation 2005/06 Summary results*, London: Audit Commission

Audit Scotland (2000) *Overview of the National Health Service in Scotland 1999-2000*, Edinburgh: Audit Scotland

Audit Scotland (2001) *Overview of the National Health Service in Scotland 2000-01*, Edinburgh: Audit Scotland

Audit Scotland (2003a) *Overview of the National Health Service in Scotland 2001-02*, Edinburgh: Audit Scotland

Audit Scotland (2003b) *Overview of the National Health Service in Scotland 2002-03*, Edinburgh: Audit Scotland

Audit Scotland (2004a) *An overview of the performance of the NHS in Scotland*, Edinburgh: Audit Scotland

Audit Scotland (2004b) *Overview of the financial performance of the NHS in Scotland 2003-04*, Edinburgh: Audit Scotland

Audit Scotland (2005) *Overview of the performance of the NHS in Scotland*, Edinburgh: Audit Scotland

Audit Scotland (2006) *Overview of the financial performance of the NHS in Scotland 2005-06*, Edinburgh: Audit Scotland

Audit Scotland (2007) *Overview of Scotland's health and NHS performance in 2006-07*, Edinburgh: Audit Scotland

Audit Scotland (2008) *Financial overview of the NHS in Scotland 2007-08*, Edinburgh: Audit Scotland

Audit Scotland (2009a) *Scotland's Public Finances: preparing for the future*, Edinburgh: Audit Scotland

Audit Scotland (2009b) *Overview of the NHS in Scotland's performance 2008-09*, Edinburgh: Audit Scotland

Audit Scotland (2010a) *Managing NHS waiting lists – A review of new arrangements*, published online at [http://www.audit-scotland.gov.uk/docs/health/2010/nr\\_100304\\_nhs\\_waiting\\_lists.pdf](http://www.audit-scotland.gov.uk/docs/health/2010/nr_100304_nhs_waiting_lists.pdf) (accessed on 16 July 2012)

Audit Scotland (2010b) *Managing NHS waiting lists – A review of new arrangements: Issues for non-executive board members*, published online at [http://www.audit-scotland.gov.uk/docs/health/2010/nr\\_100304\\_nhs\\_waiting\\_lists\\_non-exec.pdf](http://www.audit-scotland.gov.uk/docs/health/2010/nr_100304_nhs_waiting_lists_non-exec.pdf) (accessed on 16 July 2012)

Audit Scotland (2010c) *Financial overview of the NHS in Scotland 2009-10*, Edinburgh: Audit Scotland

Audit Scotland (2011a) *Review of Community Health Partnerships*, Edinburgh: Audit Scotland

Audit Scotland (2011b) *Managing NHS waiting lists – Twelve month summary impact report*, published online at [http://www.audit-scotland.gov.uk/docs/health/2011/ir\\_110629\\_nhs\\_waiting\\_lists.pdf](http://www.audit-scotland.gov.uk/docs/health/2011/ir_110629_nhs_waiting_lists.pdf) (accessed on 20 July 2012)

Audit Scotland (2011c) *Arm's-length external organisations (ALEOs): Are you getting it right?*, Edinburgh: Audit Scotland

Audit Scotland (2011d) *Transport for health and social care*, Edinburgh: Audit Scotland

Audit Scotland (2012) *Management of NHS waiting lists – Project brief*, Edinburgh: Audit Scotland

Baxter, J. and W. F. Chua (2003) "Alternative management accounting research - whence and whither", *Accounting, Organizations and Society*, Vol. 28, pp. 97-126

Bechhofer, F. and L. Paterson (2000) *Principles of Research Design in the Social Sciences*, Abingdon, Oxon: Routledge

Bevan, G. (2006) "Setting targets for health care performance: lessons from a case study of the English NHS", *National Institute Economic Review*, Vol. 197, pp. 67-79

- Bevan, G. and R. Hamblin (2009) "Hitting and missing targets by ambulance services for emergency calls: effects of different systems of performance measurement within the UK", *Journal of the Royal Statistical Society Series A*, Vol. 172, Part 1, pp. 161-190
- Bevan, G. and C. Hood (2006) "What's measured is what matters: targets and gaming in the English public health care system" *Public Administration*, Vol. 84(3), pp. 517-38
- Blackman, T., E. Elliott, A. Greene, B. Harrington, D. J. Hunter, L. Marks, L. McKee and G. Williams (2006) "Performance assessment and wicked problems: the case of health inequalities", *Public Policy and Administration*, Vol. 21(2), pp. 66-80
- Blaikie, N. (2000) *Designing Social Research*, Cambridge: Polity Press
- Blyth, A. (2003) "Get over it", *Accountancy*, February, pp. 35-37
- Boje, D. M. (2001) *Narrative Methods for Organizational and Communication Research*, London: Sage
- Bowerman, M. (1995) "Auditing performance indicators: the role of the Audit Commission in the Citizen's Charter Initiative", *Financial Accountability and Management*, Vol. 11(2), pp. 173-85
- Bowerman, M., H. Raby and C. Humphrey (2000) "In search of the audit society: some evidence from health care, police and schools", *International Journal of Auditing*, Vol. 4, pp. 71-100
- Bowerman, M., C. Humphrey and D. Owen (2003) "Struggling for supremacy: the case of UK public audit institutions", *Critical Perspectives on Accounting*, Vol. 14, pp. 1-22
- Broadbent, J. and J. Guthrie (1992) "Changes in the public sector: a review of recent 'alternative' accounting research", *Accounting, Auditing and Accountability Journal*, Vol. 5(2), pp. 3-31
- Broadbent, J. and J. Guthrie (2008) "Public sector to public services: 20 years of 'contextual' accounting research", *Accounting, Auditing and Accountability Journal*, Vol. 21(2), pp. 129-169
- Brown, J. S. and P. Duguid (1996) "The social life of documents", *First Monday*, Vol. 1(1), available at <http://firstmonday.org/htbin/cgiwrap/bin/ojs/index.php/fm/article/viewArticle/466/387>
- Bryman, A. (2008) *Social Research Methods*, third edition, Oxford: Oxford University Press
- Burchell, S., C. Clubb, A. Hopwood, J. Hughes and J. Nahapiet (1980) "The roles of accounting in organizations and society", *Accounting, Organizations and Society*, Vol. 5(1), pp. 5-27

- Campbell-Smith, D. (2008) *Follow the Money: The Audit Commission, Public Money and the Management of Public Services, 1983-2008*, London: Allen Lane
- Carrington, T. and B. Catasús (2007) "Auditing stories about discomfort: becoming comfortable with comfort theory", *European Accounting Review*, Vol. 16(1), pp. 35-58
- Checkland, K., N. Marshall and S. Harrison (2004) "Re-thinking accountability: trust versus confidence in medical practice", *Quality and Safety in Health Care*, Vol. 13, pp. 130-135
- Chisholm, H. and S. Shaw (2004) "Prove it! The 'tyranny' of audit and accreditation in the New Zealand outdoors industry", *Leisure Studies*, Vol. 23(4), pp. 317-327
- Christensen, M. and P. Skaerbaek (2007) "Framing and overflowing of public sector accountability innovations: a comparative study of reporting practices", *Accounting, Auditing & Accountability Journal*, Vol. 20(1), pp. 101-132
- Chua, W. F. (1995) "Experts, networks and inscriptions in the fabrication of accounting images: a story of the representation of three public hospitals", *Accounting, Organizations and Society*, vol. 20(2/3), pp. 111-145
- Connolly, S., G. Bevan and N. Mays (2010) *Funding and performance of healthcare systems in the four countries of the UK before and after devolution*, London: The Nuffield Trust
- Czarniawska, B. (2004) *Shadowing and other techniques for doing fieldwork in modern societies*, Copenhagen: Copenhagen Business School Press
- Day, P. and R. Klein (1987) *Accountabilities: Five Public Services*, London: Tavistock
- Dent, M. (2003) "Managing doctors and saving a hospital: irony, rhetoric and actor networks", *Organization*, Vol. 10(1), pp. 107-127
- Denzin, N. K. (1978) *The Research Act*, Second Edition, New York: McGraw Hill
- Department of Health (1989) *Working for Patients*, Cm 555, London: HMSO
- Department of Health (1997) *The New NHS: Modern, Dependable*, London: The Stationery Office, Cm 3807
- Department of Health (2000a) *The NHS Plan: A plan for investment, a plan for reform*, London: The Stationery Office, Cm 4818
- Department of Health (2000b) *NHS Plan Implementation Programme*, London: Department of Health
- Department of Health (2001) *NHS Performance Ratings. Acute Trusts 2000/01*, London: Department of Health
- Department of Health (2002) *Delivering the NHS Plan: Next steps on investment, next steps on reform*, London: The Stationery Office, Cm 5503

- Department of Health (2003) *Raising Standards: Improving Performance in the NHS*, London: Department of Health, May 2003
- Department of Health (2004) *The NHS Improvement Plan – Putting people at the heart of public services*, London: The Stationery Office, Cm 6268
- Department of Health (2008) *High Quality Care For All – NHS Next Stage Review Final Report*, London: The Stationery Office, Cm 7432
- Department of Health (2009) *The NHS Performance Framework: Implementation guidance*, London: Department of Health
- Elliott, J. (2002) "The impact of intensive 'value for money' performance auditing in educational systems", *Educational Action Research*, vol. 10(3), pp. 499-506
- English, L. (2003) "Emasculating public accountability in the name of competition: transformation of state audit in Victoria", *Critical Perspectives on Accounting*, Vol. 14, pp. 51-76
- Everett, J. (2003) "The politics of comprehensive auditing in fields of high outcome and cause uncertainty", *Critical Perspectives on Accounting*, Vol. 14, pp. 77-104
- Farrar, S., F. Harris, T. Scott and L. McKee (2004) *The Performance Assessment Framework: Experiences and Perceptions of NHS Scotland*, report to the Analytical Services Division, Directorate of Performance Management and Finance, Scottish Executive Health Department
- Financial Reporting Council (2009) *International Standard on Auditing (UK and Ireland) 200: Overall objectives of the independent auditor and the conduct of an audit in accordance with international standards on auditing (UK and Ireland)*
- Financial Reporting Council (2012) *The UK Corporate Governance Code*, accessed online at <http://www.frc.org.uk/getattachment/a7f0aa3a-57dd-4341-b3e8-ffa99899e154/UK-Corporate-Governance-Code-September-2012.aspx> (accessed on 10 December 2012)
- Fischbacher, M. and A. Francis (1998) "Purchaser provider relationships and innovation: a case study of GP purchasing in Glasgow", *Financial Accountability and Management*, Vol. 14(4), pp. 281-298
- Free, C., S. E. Salterio and T. Shearer (2009) "The construction of auditability: MBA rankings and assurance in practice", *Accounting, Organizations and Society*, Vol. 34(1), pp. 119-140
- Freeman, R. (2006) "The work the document does: research, policy, and equity in health", *Journal of Health Politics, Policy and Law*, Vol. 31(1), pp. 51-70
- Funnell, W. (1994) "Independence and the state auditor in Britain: a constitutional keystone or a case of reified imagery?", *Abacus*, Vol. 30(2), pp. 175-195

- Funnell, W. (1998) "Executive coercion and state audit. A processual analysis of the responses of the Australian audit office to the dilemmas of efficiency auditing 1978-84", *Accounting, Auditing and Accountability Journal*, Vol. 11(4), pp. 436-458
- Fusaro, P. C. and R. M. Miller (2002) *What Went Wrong at Enron*, Hoboken, New Jersey: John Wiley and Sons
- Gay, O (2005) *Public Service Agreements*, SN/PC/3826, House of Commons Library
- Gendron, Y. and J Bédard (2006) "On the constitution of audit committee effectiveness", *Accounting, Organizations and Society*, Vol. 31(3), pp. 211-239
- Gendron, Y., J. Bédard and M. Gosselin (2004) "Getting inside the black box: a field study of practices in "effective" audit committees", *Auditing: A Journal of Practice & Theory*, Vol. 23(1), pp. 153-171
- Gendron, Y., D.J. Cooper and B. Townley (2001) "In the name of accountability. State auditing, independence and new public management", *Accounting, Auditing and Accountability Journal*, Vol. 14(3), pp. 278-310
- Gendron, Y., D.J. Cooper and B. Townley (2007) "The construction of auditing expertise in measuring government performance", *Accounting, Organizations and Society*, Vol. 32, pp. 101-129
- Goodman, N. W. (1998) "Clinical governance", *British Medical Journal*, Vol. 317, pp. 1725-1727, December
- Greener, I. (2009) *Healthcare in the UK: Understanding Continuity and Change*, Bristol: The Policy Press
- Greer, S. L. (2004) *Four Way Bet: How Devolution Has Led to Four Different Models for the NHS*, London: The Constitution Unit, School of Public Policy, UCL
- Greer, S. L. (2005) "The territorial bases of health policymaking in the UK after devolution", *Regional and Federal Studies*, Vol. 15(4), pp. 501-518
- Guba, E. G. and Y. S. Lincoln (1994) "Competing paradigms in qualitative research" in N. K. Denzin and Y. S. Lincoln (eds.) *Handbook of Qualitative Research* (Thousand Oaks, California: Sage)
- Guénin-Paracini, H. and Y. Gendron (2010) "Auditors as modern pharmakoi: Legitimacy paradoxes and the production of economic order", *Critical Perspectives on Accounting*, Vol. 21, pp. 134-158
- Harrison, S. and C. Smith (2004) "Trust and moral motivation: redundant resources in health and social care?", *Policy & Politics*, Vol. 32(3), pp. 371-386
- Hazell, R. and P. Jervis (1998) *Devolution and Health*, London: The Nuffield Trust
- Health Protection Scotland (2011) *National Hand Hygiene NHS Campaign Compliance with Hand Hygiene – Audit Report – September 2011*, Health Protection Scotland (Report): Glasgow

- Healthcare Commission (2005a) *Assessment for Improvement: The annual health check*
- Healthcare Commission (2005b) *NHS Performance Ratings 2004/2005*
- Healthcare Commission (2006) *The annual health check: assessing and rating the NHS. NHS performance ratings 2005/2006*
- Hinds, P. S., R. J. Vogel and L. Clarke-Steffen (1997) "The possibilities and pitfalls of doing a secondary analysis of a qualitative data set", *Qualitative Health Research*, Vol. 7(3), pp. 408-424
- Hollingsworth, K., F. White and I. Harden (1998) "Audit, accountability and independence: the role of the Audit Commission", *Legal Studies*, pp. 78-100
- Hood, C. (1991) "A public management for all seasons?" *Public Administration*, Vol. 6(3), pp. 3-19
- Hood, C. (1995) "The 'New Public Management' in the 1980s: variations on a theme" *Accounting, Organizations & Society*, Vol. 20(2-3), pp. 93-109
- Hood, C. (2006) "Gaming in targetworld: the targets approach to managing British public services", *Public Administration Review*, Vol. 66(4), pp. 515-521
- Hood, C., O. James, G. Peters and C. Scott (eds.) (2004) *Controlling Modern Government: Variety, Commonality and Change*, Cheltenham: Edward Elgar
- Hopwood, A. G. (1978) "Towards an organizational perspective for the study of accounting and information systems", *Accounting, Organizations and Society*, Vol. 3(1), pp. 3-13
- Hopwood, A. G. (1983) "On trying to study accounting in the contexts in which it operates", *Accounting, Organizations and Society*, Vol. 8(2/3), pp. 287-305
- Humphrey, C. (2008) "Auditing research: a review across the disciplinary divide", *Accounting, Auditing & Accountability Journal*, Vol. 21(2), pp. 170-203
- Humphrey, C., P. Miller and H. Smith (1998) "Financial management in the UK public sector: ambiguities, paradoxes and limits" in O. Olson, J. Guthrie and C. Humphrey *Global Warning! Debating International Developments in New Public Financial Management*, Oslo: Cappelen Akademisk Forlag
- Humphrey, C. and D. Owen (2000) "Debating the 'Power' of audit", *International Journal of Auditing*, Vol. 4, pp. 29-50
- Jeacle, I. and C. Carter (2011) "In TripAdvisor we trust: Rankings, calculative regimes and abstract systems", *Accounting, Organizations and Society*, Vol. 36(4-5), pp. 293-309
- Jones, C. (1993) "Auditing criminal justice", *British Journal of Criminology*, Vol. 33(2), pp. 187-202

- Justesen, L. and J. Mouritsen (2011) "Effects of actor-network theory in accounting research", *Accounting, Auditing and Accountability Journal*, Vol. 24(2), pp. 161-193
- Justesen, L. and P. Skaerbaek (2005) "Performance auditing and the production of discomfort" in S. Jonsson and J. Mouritsen (eds.) *Accounting in Scandinavia: The Northern Lights*, Copenhagen: Copenhagen Business School Press, pp. 321-343
- Justesen, L. and P. Skaerbaek (2010) "Performance auditing and the narrating of a new auditee identity", *Financial Accountability and Management*, Vol. 26(3), pp. 325-343
- Keating, M. and N. McEwen (2005) "Introduction: Devolution and public policy in comparative perspective", *Regional and Federal Studies*, Vol. 15(4), pp. 413-421
- Kerr, D. (2005) *Building a Health Service Fit for the Future*, Edinburgh: The Scottish Executive
- Kerr, D. and D. Feeley (2007) "Collectivism and collaboration in NHS Scotland" in S. L. Greer and D. Rowland (eds.) *Devolving Policy, Diverging Values? The values of the United Kingdom's National Health Services*, London: The Nuffield Trust
- Klein, R (1982) "Performance, evaluation and the NHS: a case study in conceptual perplexity and organizational complexity" *Public Administration* vol. 60 pp. 385-407
- Klein, R. (2006) *The New Politics of the NHS. From Creation to Reinvention*, Fifth Edition, Oxford: Radcliffe Publishing Ltd
- Labour Party (1997) *New Labour Because Britain Deserves Better*, London: Labour Party
- Lapsley, I. (2004) "Making sense of interactions in an investigation of organisational practices and processes" in C. Humphrey and B. Lee (eds.) *The Real Life Guide to Accounting Research: A behind the scenes view of using qualitative research methods*, Paperback Edition, Oxford: Elsevier, pp. 175-190
- Lapsley, I. (2008) "The NPM agenda: back to the future", *Financial Accountability and Management*, Vol. 24(1), pp. 77-96
- Lapsley, I. and J. Lonsdale (2010) "The Audit Society: Helping to develop or undermine trust in government?" in M Adler (ed.) *Administrative Justice in Context*, Oxford: Hart Publishing
- Lapsley, I. and C. K. M. Pong (2000) "Modernization versus problematization: value-for-money audit in public services", *European Accounting Review*, Vol. 9(4), pp. 541-567
- Latour, B. (1987) *Science in Action: How to follow scientists and engineers through society*, Cambridge, Mass: Harvard University Press
- Latour, B. (1991) "Technology is society made durable" in J. Law (ed.) *A Sociology of Monsters: essays on power, technology and domination*, London: Routledge

- Latour, B. (2005) *Reassembling the Social: An Introduction to Actor-Network Theory*, Oxford: Oxford University Press
- Laughlin, R. C. (1991) "Environmental disturbances and organizational transitions and transformations: some alternative models", *Organization Studies*, Vol. 12(2), pp. 209-232
- Lee, N. and J. Hassard (1999) "Organization unbound: actor-network theory, research strategy and institutional flexibility", *Organization*, Vol. 6(3), pp. 391-404
- Lincoln, Y. S. and E. Guba (1985) *Naturalistic Inquiry* (Beverly Hills, California: Sage)
- Lindeberg, T. (2007) "The ambiguous identity of auditing", *Financial Accountability and Management*, Vol. 23(3), pp. 337-350
- Llewellyn, S. (1996) "Performance management in the social services: its meaning and measurement" in I. Lapsley and F. Mitchell (eds.) *Accounting and performance measurement: issues in the private and public sectors*, London: Paul Chapman Publishing
- Lowe, A. (2001) "After ANT. An illustrative discussion of the implications for qualitative accounting case research", *Accounting, Auditing and Accountability Journal*, Vol. 14(3), pp. 327-351
- Lukka, K. And E. Kasanen (1995) "The problem of generalizability: anecdotes and evidence in accounting research", *Accounting, Auditing and Accountability Journal*, Vol. 8(5), pp. 71-90
- Magrane, J. and S. Malthus (2010) "Audit committee effectiveness: a public sector case study", *Managerial Auditing Journal*, Vol. 25(5), pp. 427-443
- Maijoor, S. (2000) "The internal control explosion", *International Journal of Auditing*, Vol. 4, pp. 101-109
- Malsch, B. and Y. Gendron (2009) "Mythical representations of trust in auditors and the preservation of social order in the financial community", *Critical Perspectives on Accounting*, Vol. 20, pp. 735-750
- Maltby, J. (2008) "There is no such thing as audit society", *Paper for presentation at the Conference of Practical Criticism in the Managerial Social Sciences*, Leicester University Management School, 15 – 17 January 2008
- Mannion, R., H. Davies and M. Marshall (2005) "Impact of star performance ratings in English acute hospital trusts" *Journal of Health Service Research and Policy*, Vol. 10(1), pp. 18-24
- Mautz, R. K. and H. A. Sharaf (1961) *The Philosophy of Accounting*, American Accounting Association
- McGivern, G. and E. Ferlie (2007) "Playing tick-box games: Interrelating defences in professional appraisal", *Human Relations*, Vol. 60(9), pp. 1361-1385

- Meyer, J. W. and B. Rowan (1977) "Institutionalised organisations: formal structure as myth and ceremony" *The American Journal of Sociology*, Vol. 83(2), pp. 340-63
- The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) *Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*, HC 947, London: The Stationery Office
- Midwinter, A. and N. McGarvey (2001) "In search of the regulatory state: evidence from Scotland", *Public Administration*, Vol. 79(4), pp. 825-849
- Miller, P. (1994) "Accounting as social and institutional practice: an introduction" in A. G. Hopwood and P. Miller (eds.) *Accounting as Social and Institutional Practice*, Cambridge: Cambridge University Press
- Munro, E. (2004) "The impact of audit on social work practice", *British Journal of Social Work*, Vol. 34, pp. 1075-1095
- NHS Executive (1998) *The new NHS Modern and Dependable: A National Framework for Assessing Performance Consultation Document*, catalogue number 97FP0148, January 1998
- NHS Executive (1999) *The NHS Performance Assessment Framework*, catalogue number 16431, March 1999
- NHS Lothian (2012a) *Waiting time management in Lothian*, report of the NHS Lothian Waiting Time Management Group, January 2012
- NHS Lothian (2012b), Press release: "Waiting Times Review accepted by NHS Lothian", 21 March 2012
- NHS National Services Scotland (2007) *New Ways of defining and measuring waiting times – Applying the Scottish Executive Health Department guidance*, Edinburgh: ISD Scotland Publications, Version 3.0
- Nottingham, C. (2000) "The politics of health in Scotland after devolution" in C. Nottingham (ed.) *The NHS in Scotland. The Legacy of the Past and the Prospect of the Future*, Aldershot: Ashgate Publishing Group
- O'Neill, O. (2002) *A Question of Trust: 2002 BBC Reith Lectures*, transcripts accessed at <http://www.bbc.co.uk/print/radio4/reith2002/>
- Pallot, J. (2003) "A wider accountability? The Audit Office and New Zealand's bureaucratic revolution", *Critical Perspectives on Accounting*, Vol. 14, pp. 133-155
- Parker, L. (2007) "Internal governance in the non-profit boardroom: a participant observer study", *Corporate Governance: An international review*, Vol. 15(5), pp. 923-934
- Pentland, B. T. (1993) "Getting comfortable with the numbers: auditing and the micro-production of macro-order", *Accounting, Organizations and Society*, Vol. 18(7/8), pp. 605-620

- Pentland, B. T. (2000) "Will auditors take over the world? Program, technique and the verification of everything", *Accounting, Organizations and Society*, Vol. 25, pp. 301-12
- Pentland, B. T. and P. Carlile (1996) "Audit the taxpayer, not the return: Tax auditing as an expression game", *Accounting, Organizations and Society*, Vol. 21 (2/3), pp. 269-287
- Pollitt, C. (1984) "Blunt tools: performance measurement in policies for health care" *Omega International Journal of Management Science* 12:2 pp. 131-140
- Pollitt, C. and H. Summa (1999) "Performance audit and public management reform" in C. Pollitt, X. Girre, J. Lonsdale, R. Mul, H. Summa and M. Waerness (1999) *Performance or Compliance? Performance audit and public management in five countries*, Oxford: Oxford University Press
- Power, M. (1993) "The politics of financial auditing", *The Political Quarterly*, Vol. 64(3), pp. 272-284
- Power, M. (1994a) *The Audit Explosion*, London: Demos
- Power, M. (1994b) "The audit society" in A. G. Hopwood and P. Miller (eds.) *Accounting as Social and Institutional Practice*, Cambridge: Cambridge University Press
- Power, M. (1996) "Making things auditable", *Accounting, Organizations and Society*, Vol. 21(2/3), pp. 289-315
- Power, M. (1998) "The audit fixation. Some issues for psychotherapy" in R. Davenhill and M. Patrick (eds.) *Rethinking Clinical Audit: The Case of Psychotherapy Services in the NHS*, London: Routledge
- Power, M. (1999) *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press
- Power, M. (2000a) "The audit society – second thoughts" *International Journal of Auditing*, Vol. 4, pp. 111-119
- Power, M. (2000b) "The evolution of the audit society, its politics of control and the advent of CHI" in A. Miles, J. R. Hampton and B. Hurwitz (eds.) *NICE, CHI and the NHS Reforms. Enabling excellence or imposing control?*, London: Aesculapius Medical Press
- Power, M. (2003a) "Evaluating the audit explosion", *Law and Policy*, Vol. 25(3), pp. 185-202
- Power, M. (2003b) "Auditing and the production of legitimacy", *Accounting, Organizations and Society*, Vol. 28, pp. 379-394
- Power, M. (2004) "Counting, control and calculation: reflections on measuring and management", *Human Relations*, Vol. 57(6), pp. 765-783

- Power, M. (2005) "The Theory of the Audit Explosion" in E. Ferlie, L. E. Lynn and C. Pollitt (eds.) *The Oxford Handbook of Public Management*, Oxford: Oxford University Press
- Power, M. (2008) "In defence of *The Audit Society*: a reply to Maltby", *Ephemera*, Vol. 8(4), pp. 399-402
- PricewaterhouseCoopers (PwC) (2012) *Review of aspects of Waiting time management at NHS Lothian*, March 2012
- Prior, L. (2003) *Using Documents in Social Research*, London: Sage
- Propper, C., M. Sutton, C. Whitnall and F. Windmeijer (2008) "Did 'targets and terror' reduce waiting times in England for hospital care?", *The B. E. Journal of Economic Analysis & Policy*, Vol. 8(2), Article 5
- Radcliffe, V. (1999) "Knowing efficiency: the enactment of efficiency in efficiency auditing", *Accounting, Organizations and Society*, Vol. 24, pp. 333-362
- Rhodes, R. A. W. (1994) "The hollowing out of the state: the changing nature of the public service in Britain", *The Political Quarterly*, Vol. 65(2), pp. 138-151
- Rose, N. and P. Miller (1992) "Political power beyond the state: problematics of government", *British Journal of Sociology*, Vol. 43(2), pp. 173-205
- Scally, G. and L. J. Donaldson (1998) "Clinical governance and the drive for quality improvement in the new NHS in England", *British Medical Journal*, Vol. 317, pp. 61-65, July
- Scott, J (1990) *A matter of record: documentary sources in social research*, Cambridge: Polity
- Scottish Executive (2000) *Our National Health: A plan for action, a plan for change*, Edinburgh: Scottish Executive
- Scottish Executive (2003) *Partnership for Care: Scotland's Health White Paper*, Edinburgh: Scottish Executive
- Scottish Executive (2004) *Fair to All, Personal to Each*, Edinburgh: Scottish Executive
- Scottish Executive (2005) *Delivering for Health*, Edinburgh: Scottish Executive
- Scottish Executive (2007) *Better Health, Better Care – A Discussion Document*, Edinburgh: Scottish Executive
- Scottish Executive Health Department (2001) *Rebuilding our National Health Service: Guidance to NHS Chairs and Chief Executives for implementing 'Our National Health: A plan for action, a plan for change*, Edinburgh: Scottish Executive Health Department
- Scottish Government (2007) *Better Health, Better Care – Action Plan*, Edinburgh: The Scottish Government

- Scottish Government (2008a) *2007/08 NHSScotland Chief Executive's Annual Report*, Edinburgh: The Scottish Government
- Scottish Government (2008b) "Health Check for the NHS", Press release, 28 November 2008, accessed online at <http://www.scotland.gov.uk/News/Releases/2008/11/28104431> (on 14 November 2011)
- Scottish Government (2008c) *The Referral to Treatment Standard: 18 weeks*, Edinburgh: Scottish Government
- Scottish Government (2012) Press release: "NHS to audit waiting times", 3 May 2012
- Scottish National Party (2007) *Manifesto 2007*, accessed online at <http://www2.snp.org/node/13534> (on 7 November 2011)
- The Scottish Office (1997a) *Scotland's Parliament*, Edinburgh: The Stationery Office, Cm 3658
- The Scottish Office (1997b) News release: "Dewar proposes a renewed NHS designed to care for Scotland", 9 December 1997, accessed online at <http://www.scotland.gov.uk/News/Releases/1997/12/a681ebed-fb3f-4e57-a172-a88f04cbf11d> on 30 April 2012
- The Scottish Office (1997c) *Designed to Care. Renewing the National Health Service in Scotland*, Edinburgh: The Stationery Office, Cm 3811
- The Scottish Office Department of Health (1998) *Priorities and Planning Guidance for the NHS in Scotland 1999-2002*, MEL(1998)63
- Sheffield, J. and M. Bowerman (1999) "An emergent audit agenda: comparative lessons drawn from Best Value development in local government in Scotland compared with England", *Public Policy and Administration*, Vol. 14(3), pp. 67-89
- Sikka, P. and H. Willmott (1995) "The power of 'independence': Defending and extending the jurisdiction of accounting in the UK", *Accounting, Organizations and Society*, Vol. 20(6), pp. 547-581
- Skaerbaek, P. (2009) "Public sector auditor identities in making efficiency auditable: The National Audit Office of Denmark as independent auditor and modernizer", *Accounting, Organizations and Society*, Vol. 34, pp. 971-987
- Skaerbaek, P. and S. Thorbjornsen (2007) "The commodification of the Danish defence forces and the troubled identities of its officers", *Financial Accountability and Management*, Vol. 23(3), pp. 243-268
- Spira, L. F. (1999) "Ceremonies of governance: perspectives on the role of the audit committee", *Journal of Management and Governance*, Vol. 3(3), pp. 231-260

- Spry, C. (2002) "Who Decides on Scotland's Health?" in G. Hassan and C. Warhurst (eds.) *Anatomy of the New Scotland: Power, Influence and Change*, Edinburgh: Mainstream Publishing
- Stake, R. E. (1995) *The Art of Case Study Research*, Thousand Oaks, CA: Sage Publications
- Strathern, M. (1997) "'Improving ratings': audit in the British University system", *European Review*, Vol. 5(3), pp. 305-321
- Strathern, M. (2000) "The tyranny of transparency", *British Educational Research Journal*, Vol. 26(3), pp. 309-321
- Tsoukas, H. (1997) "The tyranny of light. The temptations and the paradoxes of the information society", *Futures*, Vol. 29 (9), pp. 827-843
- Turley, S. and M. Zaman (2007) "Audit committee effectiveness: informal processes and behavioural effects", *Accounting, Auditing and Accountability Journal*, Vol. 20(5), pp. 765-788
- Van Maanen, J. and B. T. Pentland (1994) "Cops and auditors: the rhetoric of records" in S. B. Sitkin and R. J. Bies (eds.) *The Legalistic Organization*, Thousand Oaks, CA: Sage Publications
- Vikkelso, S. (2007) "In between curing and counting: performative effects of experiments with healthcare information infrastructure", *Financial Accountability and Management*, Vol. 23(3), pp. 269-288
- Wanless, D. (2002) *Securing our Future Health: Taking a Long-term View*, Final Report, London: HM Treasury
- Wilkins, P. and J. Lonsdale (2007) "Public sector auditing for accountability: new directions, new tricks?" in M.-L. Bemelmans-Videc, J. Lonsdale and B. Perrin (eds.), *Making Accountability Work: Dilemmas for Evaluation and for Audit*, Somerset, NJ: Transaction Publishers
- Woods, K. J. (2004) "Political devolution and the health services in Great Britain", *International Journal of Health Services*, Vol. 34(2), pp. 323-339