An examination of the influential contingencies on the role of management accounting The case of an NHS Community Trust

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A Thesis Submitted in Partial Fulfilment of the Requirements of Nottingham Trent University for the Degree of Doctor of Philosophy

Nottingham Business School

Nottingham Trent University

January 2019

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ABSTRACT

The study seeks to provide a deep and holistic understanding of management accounting's (MA) role in supporting organisational performance in England's community health service. Its main purposes are to illustrate the effectiveness of MA in one community health trust and how this is shaped by a set of internal, external, technical and behavioural factors. Drawing on the contingency theory of MA and the related literature, a framework was developed to investigate the conditions (contingencies) of this context and its possible influence on MA's roles, and to explore why MA is practised as it is.

The chosen research method was the interpretive case study. During an intensive field study lasting four months, data was collected about one community health trust by means of interviews, observations and documentary review. The qualitative content analysis of the collected data provided insights into how the processes and outcomes of MA are embedded in both the organisational and environmental contexts, revealing that MA's effectiveness is influenced not only by contextual and environmental factors but also by the organisation's other (e.g. cultural and administrative) controls. The influence of the context on MA was investigated by adopting the contingency theory of MA.

As the core of the performance management system, MA in the Trust is conceptualised by both environmental and organisational factors, with the result that it is impacted by multiple contingencies which require it to meet different, sometimes conflicting, demands. This limits the role it is able to play to mainly managerial (the budgetary control system is used mainly to ensure the efficient use of departmental resources) rather than strategic or operational. In terms of its operational role, MA in the Trust is tailored to meet external rather than internal demands, leaving clinicians dissatisfied with the information provided. The results suggest that MA could play a more useful role in the Trust with the introduction of practices such as patient-level information and costing systems (PLICS), though this is dependent on contextual and behavioural factors being taken into account,

for example by providing appropriate training and encouraging dialogue and collaboration between clinicians and finance managers. The findings highlight the significant role clinical directors can play in closing the gap between these two groups. They also suggest that the multiple demands of trusts are better served by adopting a more flexible budget than by abandoning the budget altogether.

In terms of MA's strategic contribution, the findings indicate that the Trust engages in strategy formulation but pays little attention to strategy execution; a range of factors, such as efficiency targets, the contract between the Trust and the commissioners, and rising demand, force managers to focus their attention on short-term performance at the expense of strategy execution. However, while MA appears to make little or no contribution to encouraging strategic behaviour (there being no link between the Trust's operations and its strategy), the findings do show that management accountants (MAs) contribute significantly to the strategic decision-making process. The findings suggest that a full application of the BSC, underpinned by a strategy map, would enhance managers' understanding of their role within the broader strategic picture.

The study adds to our knowledge of MA by developing an understanding of MA's particular meaning and significance within the context of NHS community trusts. It shows how MA is both shaped by and shapes this context and thus whether particular MA practices are more or less appropriate for an organisation. The study's main contribution is its proposal of a theoretical framework that features a set of MA contingencies that are specific to NHS community trusts. It provides empirical evidence of the roles played by MA in these trusts and how these roles are influenced by a complex network of political, social and economic conditions, some of which work in opposition to each other. These conditions appear to be the key to understanding and explaining the process and outcome of MA in the NHS community trusts.

In the Name of Allah, Most Gracious, Most Merciful

"اقْرَأْ بِاسْمِ رَبِّكَ الَّذِي خَلَقَ خَلَقَ الْإِنْسَانَ مِنْ عَلَقٍ اقْرَأْ وَرَبُّكَ الْأَكْرَمُ الَّذِي عَلَّمَ بِالْقَلَمِ عَلَّمَ الْإِنْسَانَ مَا لَمْ يَعْلَمْ"

(سورة العلق: الآية 1-5)

"Read in the Name of your Lord who created. Created man from a clot. Read: And your Lord is the Most Generous. He who taught by the pen. Taught man what he never knew".

(Quran 96 :1-5)

ACKNOWLEDGEMENT

Indeed, all praise and thanks are due to Allah, the most merciful, the Lord of all that exists, who has enabled me to finish this endeavour. Prayers and peace be upon the Messenger of Allah.

I would like to express my gratitude to the many people who have been with me throughout this PhD journey. I am very fortunate to be surrounded by many wonderful people who have helped me to finish my thesis; without their support, it would not have been completed.

First of all, I would like to express my genuine thanks and great appreciation and respect to my supervisors, Professor Malcolm Prowle and Dr Donald Harradine, for their invaluable guidance, encouraging support and confident outlook through all stages of the research. They have been tremendous mentors to me. I would also like to express my gratitude to my third supervisor, Dr Roy Stratton.

This study would not have been possible without great collaboration from the Trust. I am very grateful to those staff who spent their precious time sharing their knowledge and experience with me. Their cooperation was invaluable to this research. I would like to express my particular gratitude to A K, Dr P C, S M and M.

Many thanks also to Iraq's Ministry of Higher Education and Scientific Research, the University of Mosul for giving me this chance and to my sponsor, the Office of the Iraqi Cultural Attaché, for its financial support for the duration of this research.

This effort would not have been possible without the extraordinary support of my lovely wife, who has inspired me to keep going when times get difficult. I would like to express my profound appreciation for her love, patience and encouragement. I’m grateful to have you with me on this journey. Special thanks also to my lovely children for their love and support along the way.

Last, but not least, a special thanks to my extended family for their support and prayers to complete this work. I would like to dedicate this thesis to my late mother, whose legacy remains with me and to my father. Special thanks and love go to them and to my father-in-law, mother-in-law, brothers and sisters for their support and encouragement.

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Chapter 1. Introduction

1.1 Background to and Motivation for the Research

Management accounting (MA) is concerned with the provision of financial and non-financial information for the internal purposes of planning, decision making and controlling (Atkinson, et al., 2007). This information plays a vital role in helping an organisation achieve its objectives first, by connecting managers' decisions with these objectives, and second, by rewarding (and thus motivating) those who actively participate in their achievement (Corbett, 1998).

However, MA's relevance to the modern business environment has been widely questioned in the literature, with critics pointing to its inability to provide useful and timely information for decision makers and the inadequacy of its performance measures (Otley, 2001; Johnson and Kaplan, 1991) . Other criticisms include the claims that traditional MA techniques are outdated and inappropriate to today's business environment (Macintosh, 1994), that MA is driven primarily by external financial accounting requirements, that it lacks strategic focus (Bromwich and Bhimani, 1989), that it is too concerned with standardisation at the expense of learning and continuous improvement, and that it focuses on control rather than empowerment and financial performance measures rather than non-financial ones (Hansen and Mouritsen, 2006).

In MA defence, others have argued that MA has shown itself to be dynamic and flexible in nature (Mitchell, et al., 2013), adapting to today's environment and responding to claims of irrelevance by expanding its traditional role of cost measurement and financial control to add greater value for managers (Abdel-Kader and Luther, 2008). Abdel (2011) observes that over the last three decades, MA has adapted to the changing environment by adopting a number of innovative practices and techniques such as activity-based costing (ABC), the balanced scorecard (BSC), beyond budgeting and strategic management accounting (SMA). At the

organisational level, the development of MA should be seen as an ongoing process rather than a discrete movement from one level to another (Nizar, et al., 2015). This explains the slowing down of the development of MA (Burns, et al., 2003).

The evolution of MA has been driven by managers' need for information that can be used to improve organisational efficiency and achieve organisational objectives (Atkinson, et al., 2007). For this reason, Scapens (2006) emphasises the necessity of assessing the relevance of MA in its organisational context rather than in terms of its application of up-to-date practices inspired by some theoretical ideal; the key question is whether it meets organisational needs, not whether it is applying innovative ideas and practices (Boyns and Edwards, 2013). This view is supported by Kaplan (1996) who argues that MA must serve the strategic objectives of the organisation. It cannot exist as a separate discipline, developing its own set of procedures and measurement systems and applying these universally to all firms without regard to the underlying values, goals, and strategies of particular organisation.

Consequently, there is no single framework of MA that can be applied to all organisations. Rather, it encompasses a wide variety of applications, the implementation of which may be complex and challenging (Chenhall, 2003). It requires the use of processes, techniques and systems that must be adapted to the uniqueness of the organisation – its particular needs, industry, objectives, problems, resources and management (Coates, et al., 1996). This context will determine which is the right MA system for the organisation (Chenhall, 2003).

This thesis was motivated by the debate over the relevance of MA in the NHS and questions about what determines its role in this context (Harradine, et al., 2011). The debate about the relevance of MA is particularly significant in public health sector organisations such as NHS trusts. These are highly complex contexts, within which MA has historically been deployed to control expenditure, allocate resources and measure performance (Robson, 2008). MA plays a

critical role in healthcare organisations (Cannavacciuolo, 2015) – policymakers and hospital administrators rely on having relevant and accurate MA information to drive strategic, management and pricing decisions – and over the years, various attempts have been made to find MA approaches that will better support NHS performance. However, the extent to which these initiatives have achieved their objectives has varied considerably, with some, such as management budgeting, failing and being withdrawn, and others surviving but only in a modified form (Harradine and Prowle, 2012).

The variation in results may perhaps be attributed to the nature of the NHS context, in which any new initiative is subject to the influence of a set of complementary, or sometimes contradictory, factors. These factors may be internal in origin, if the MA initiative is being introduced by NHS trust managers to achieve their own particular agenda, or external, if it is being deployed to achieve the political or economic ends of powerful political actors (Jones, Mellett, 2007). Uncertainty around the causes underlying the variation has led to calls for the development and testing of more sophisticated models that show the factors that influence MA in the NHS and give greater insight into the nature and role of MA within this contextual environment (Abernethy, et al., 2006).

1.2 Importance of the Research

The importance of this research arises from the discussion of a number of issues around the role of MA in the NHS. This discussion provides a rich understanding of MA in the NHS context, which may be useful for researchers, practitioners and regulators alike. In particular, the relevance lost debate about MA in the NHS raises a number of questions about the potential and actual role of MA within the context of NHS trusts, such as what potential MA has to impact on clinicians' (the dominant actors in the NHS context) use of resources (Jacobs, et al., 2004). The reasons underlying the success or failure of MA initiatives are not yet clear

(Fiondella, et al., 2016), though the literature does highlight that clinicians' access to, attitude towards and use of MA information is a substantial indicator for success (Jacobs, et al., 2004). How clinicians interact with MA is therefore one of the key considerations when exploring its relevance in NHS trusts. Organisations tend to have a variety of formal and informal controls (Chenhall and Moers, 2015); in other words, MA does not operate in isolation (Malmi and Brown, 2008). How it fits into the context is therefore crucial to its ability to develop successfully.

The budgetary system has long been considered the dominant instrument of MA (Østergren and Stensaker, 2011). However, the last decade has seen the emergence of a beyond budgeting literature, which has to some extent eclipsed relevance lost to become the new focus of debate (Mitchell, et al., 2013). The beyond budgeting concept envisages a shift towards a more adaptive and flexible version of management and away from traditional command-and-control arrangements (Hope and Fraser, 2003). Its proponents argue that this is best achieved by abandoning the budget altogether in favour of a more dynamic system (Mitchell, et al., 2013), but as Harradine and Prowle (2012) assert, budget systems are seen as essential in public sector organisations like the NHS, where changes in organisational arrangements, increasing resource pressures and IT developments have seen them become increasingly sophisticated.

Finally, while MA has traditionally been concerned with aspects of tactical/operational management such as costing, budgeting and cash flow management (Prowle and Lucas, 2016), in recent years, its interaction with strategy has attracted increasing attention (Modell, 2012). In public sector organisations, strategy may be defined as the long-term direction that has been chosen as the best way to raise performance and offer a better service to the public (Genc and Şengul, 2015; Ferreira and Otley, 2009). It is widely believed that strategic management contributes to organisational performance by optimising the use of resources, reducing

ambiguity and motivating staff (Genc, and Şengul, 2015). By measuring strategic performance, MA can help organisations define and achieve their strategic objectives, align behaviours and attitudes and, ultimately, have a positive impact on organisational performance (Micheli and Manzoni, 2010). However, public sector organisations have important specificities that influence the strategising process (Cuganesan, et al., 2012); most importantly, they operate within the constraints imposed by public policy and political short-termism (Elbanna, et al., 2016). As a result, the interplay between MA and the strategy process in public sector organisations is determined by a range of contextual, organisational and political factors (Modell, 2012; Bhimani and Langfield-Smith, 2007) that create strategising imperatives particular to this context. This in turn creates conditions of possibility for certain forms of MA that need to be taken into account when studying the interface between MA and strategy (Cuganesan, et al., 2012).

1.3 Research Aim and Objectives

The provision of effective and efficient public health services has been the central concern of the NHS since its inception (Crinson, 2009), but growing demand and shrinking budgets have placed it under intense pressure in recent years (Prowle, et al., 2013). The NHS is one of the world's largest and most complex organisations, but in the current environment of austerity, it faces huge challenges in its efforts to deliver a comprehensive, high-quality health service (Conrad and Uslu, 2012), under the Five Year Forward View, the service must deliver efficiency savings of 2-3% per year up to 2020/21 if it is to be able to sustain the scope and quality of services provided to the public within the planned budget (Lafond, et al., 2016). NHS trusts are being asked more than ever to find ways of reducing costs and improving efficiency to do more with less (Monitor, 2012). Within this context, MA is considered key to supporting trusts to achieve effective financial management and control (Harradine, et al., 2011; Northcott

and Llewellyn, 2002). Since the 1980s, it has undergone a series of developments in an effort to achieve the level of use and acceptance required to support decision making and cost control at operational and strategic levels (Northcott and Llewellyn, 2002). Despite these attempts, however, it is frequently suggested that the central ambition of MA in the NHS, namely, to provide relevant and accurate MA information to drive strategic, management and operational decision making, has not been realised (Nyland and Pettersen, 2004).

Against this background, the underlying purpose of this study was to investigate the effectiveness of MA in supporting organisational performance at the operational and strategic levels in one NHS trust. The overreaching goal of the study was to explore how MA was conceptualised by a complex set of environmental and contextual factors and identify the gaps between the actual and potential roles of MA. To achieve this, the following objectives were specified:

1- To examine the relevance and role of cost information in decision making in the Trust.
2- To examine the managerial role of budgetary control systems in the Trust.
3- To explore the contribution of management accounting to strategic management in the Trust.
4- To explore the influence and impact of clinician attitudes on the effectiveness of management accounting in the Trust
5- To explore the contingencies that affect the role of management accounting and its development in the Trust.

1.4 Research Questions

The research questions are set to provide explanation and understanding of the process and outcome of MA in an NHS community trust. Therefore, the main research question is how the

NHS community trust's MA roles were conceptualised by a number of contextual and environmental contingencies. In relation to this, four sub-questions were set as follow:

1- What is the role of management accounting in relation to operational performance improvement in the Trust, and how can improvements be made?
2- What the contribution of management accounting to strategic management in the Trust, and how can improvements be made?
3- What are the roles and attitudes of clinicians towards the operation of management accounting in the Trust?
4- What are the contingencies that shape the management accounting role in the Trust?

1.5 The Theoretical Basis of the Study

Post-contingency theory was adopted as the theoretical lens of the study (Wickramasinghe, 2015). The objective was to explore the contingent nature of MA in one NHS community trust (Chapman, 1997), that is, what factors affect the selection and effectiveness of MA initiatives in the trust (Bennett, et al., 2002). The study contributes to the literature on the contingency theory of MA by examining the multiple and conflicting contingencies in NHS community trusts and the appropriateness of MA systems in this context. In this way, it aims to produce a deeper understanding of how MA work within these contingencies or conditions.

The use of contingency theory as a theoretical basis has been criticised in the literature as providing a limited interpretive and critical focus in the context of MA (Chenhall, 2003). It has been argued that the questionnaires and cross-sectional data analysis employed in most contingency studies do not collect rich enough accounts to give a proper understanding of the underlying organisational and social realities affecting MA's role (Wickramasinghe, 2015). Furthermore, classical contingency studies, it is argued, do not show the potential for conflict between individuals and groups or how MA may be implicated in these struggles (Chenhall,

2003). For example, MA is not assumed to lead, necessarily, to enhanced effectiveness; rather, it is used for political and power purposes by groups within the organisation or within society at large (Chenhall, 2003). To address this criticism, the literature recommends grounding contingency theory explanations in the case study approach (Chenhall, 2003; Wickramasinghe, 2015). Accordingly, this was the approach taken in this study in order to provide meaningful explanations of the contingent nature of MA and how it is conceptualised within the context of one NHS community trust.

1.6 Research Methodology

The study investigates the role of MA in an NHS community trust in England, and examines how MA in the context of the Trust is socially constructed. As this process of social construction is shaped by a complex set of factors (see section 1.1), a rich and intensive description of how MA operates in this context was needed. The research objectives required engagement with the real world of MA, instead of means-end dichotomy. Since the focus was on the complexity of individual sense making in emerging situations rather than on dependent and independent variables (Baker and Bettner, 1997), the interpretivist, rather than the positivist, paradigm was adopted.

Cooper and Morgan (2008) describe the case study strategy as particularly appropriate for investigating a complex situation where the relationships between variables are not obvious but are important in the context of the research. The research design was therefore based on the qualitative case study method to provide a holistic and systematic understanding of the role of MA and the factors affecting this role. This strategy was also valuable for gaining a wide understanding of the research context (Cooper and Morgan, 2008). Scapens (1990) argues that case studies allow the possibility of understanding the nature of MA in practice, both in terms of which techniques, procedures and systems are used and the way in which they are used.

Data was collected for the study using qualitative methods. This enabled the examination of MA's role in the Trust beyond its potential role that mainly serves rational management purposes. According to Vaivio (2008), qualitative research has an important part to play in introducing a deeper perspective into MA research. It can be used to discover what MA contributes beyond its functional role and to reveal MA as an imperfect practice applied in different ways to reflect organisational reality. The qualitative approach also allowed for the use of multiple sources of evidence to explain MA and achieve the research objectives, including interviews, observation and document analysis (Cooper and Morgan, 2008). Apart from increasing the richness of the gathered information, the use of multiple evidence sources also helped address the risk of bias, a common criticism of the single case study method, and improve the validity and reliability of the project (Cooper and Morgan, 2008).

The collected data was subjected to qualitative content analysis using NVivo 11 software. The analysis process comprised three stages: coding or unitising the data, categorising the data, and conceptualising the data. The aim was to develop categories that would ultimately provide a better understanding of the role of MA in the context of the Trust and the factors that affect this role.

1.7 Structure of the Thesis

The thesis consists of eight chapters. The current chapter presents an overview of the study. It starts with a discussion of the background to and motivation for the research before explaining the importance of the research and outlining the research objectives and questions. It briefly describes the key points of the methodology that was employed before concluding with a summary of the structure of the thesis.

Chapters Two, presents and discusses the literature pertaining to MA and its development, including its development within the context of the NHS. It starts by describing and discussing

the traditional view of MA. It considers the scope and role of MA in today's business environment and describes the role of MA in supporting organisational performance. It focuses particularly on the dynamic nature of the modern business environment and the ways in which traditional MA is seen as ill-equipped to respond to this environment. However, it also discusses the contemporary view of MA and its dynamic nature, focusing particularly on the emergence of strategic MA. These underpin the role of MA in supporting organisational performance, especially in terms of the integration of long-term strategy and operational goals.

The chapter also discusses the evolution of MA and its role in England's NHS trusts by presenting a historical review of its deployment in the NHS. This historical review is divided into three main eras: the early era (1948-early 1990s), the internal market era (early 1990s-1997), and the present era (1997 to date).

Chapter three discusses the theoretical basis of the thesis and presents its conceptual framework. It argues some problems of contingency-based studies in MA and the alternative approach applied in this thesis to eliminate these problems. Also, the chapter discusses the importance of adopting the Balanced scorecard (BSC) to enable MA system to meet the conflict needs of information.

Chapter four sets out the research methodology that was employed. The research design was based on the qualitative case study method to provide a holistic and systematic understanding of the role of MA. The chapter discusses the rationale behind the adoption of the interpretivist philosophical paradigm and case study strategy, and describes how data was collected using the interview, observation and document analysis methods. It goes on to describe the content analysis process that was conducted to analyse the data before outlining the steps that were taken to maximise the credibility of the findings.

Chapters five six, and seven present and discuss these findings. Chapter five discusses the findings relating to the role played by the Trust's cost accounting system, while Chapter six discusses those relating to its budgetary control system. Chapter seven discusses the strategic role of MA in the Trust

Chapter eight presents a summary of the study's findings and discusses its theoretical and practical contributions. Finally, the chapter acknowledges the limitations of the research before suggesting areas for further investigation.

Chapter 2. The literature reviews

2.1 Introduction

The literature review of the thesis discusses the dynamic nature of MA, showing how it has developed from a simple cybernetic system of control into a complex system that combines traditional and new practices to support organisational performance (Chenhall and Moers, 2015). How simple or complex this system is will depend upon the goals and structure of the organisation, as well as the specific circumstances or situation in which it operates (Hoque, 2002). No universal design exists; indeed, a MA system will only help in creating organisational value if it is adapted to suit the particular setting (McWatters and Zimmerman, 2015).To understand the diversity in MA practice, it is necessary to understand the complex mish-mash of inter-related influences which shape practices in individual organisations (Scapens, 2006). The literature review will, therefore, discuss these key forces and factors. This is likely to be useful in considering the various individual scenarios within which MA is applied and in analysing the likely or observed outcomes of its application (Coombs, et al., 2005). The chapter draws on the literature around the relevance lost debate to shed light on the dynamic nature of MA. The thesis follows Kaplan's pragmatic-interpretive approach to MA in that it aims to provide a descriptive account of current practice, identify prevailing problems and formulate solutions. It starts from the assumption that the way to make MA more relevant is to refine MA techniques so that they better support decision making and management control (Wickramasinghe and Alawattage, 2012). The chapter highlights how MA has adapted to organisational change (McWatters and Zimmerman, 2015), showing how it has evolved from a traditional, cybernetic approach to control, operating within a closed system and paying little attention to adaptive processes, into a more dynamic, complex, and open approach to management control (Chenhall and Moers, 2015).

As part of its efforts to improve the provision of public health services in the UK, the NHS (the context of the thesis) has in recent decades undergone significant reforms, which have resulted in substantial changes to the funding, governance and accountability of its operation and control systems (Lapsley, 2001b). MA has played a part in these reforms (Jones and Mellett, 2007), but efforts to find the MA approaches that best support performance in the NHS context have met with mixed results, with some, such as management budgeting, failing and being withdrawn and others surviving only in a modified form (Harradine Prowle, 2012).

The chapter provides a critical review of the historical development of the NHS and the effectiveness of the various MA initiatives pursued in the course of this development. According to Jones and Mellett (2007), understanding the present position requires an appreciation of management accounting accretions occurring over many years. Compiling a historical review of MA development allows us to describe events and trace the timeline of change, uncovering the truth about the past, explaining the present, influencing the future and illustrating the cause-and-effect of development (MacDonald and Richardson, 2002). In particular, this historical review is designed to give insight into the actual role of MA in NHS trusts, whether it raises or hinders performance and the factors that affect its role. The review may also give insight into how MA can be better used to support organisational performance in NHS trusts.

The chapter is organised as follows. Section 2.2 discusses the definition and scope of management accounting (MA). Section 2.3 then considers the role of MA in supporting organisational performance. MA's planning role is discussed in section 2.3.1, while section 2.3.2 discusses its control role, including management accounting control systems (MACS) and budgetary control. Section 2.3.3 covers the performance measurement role of MA. The chapter discusses the dynamic nature of the modern business environment (section 2.4) before

outlining the limitations of traditional MA systems in this environment (section 2.5). Section 2.6 addresses the dynamic nature of management accounting, while section 2.7 discusses the emergence of strategic management accounting. Section 2.8 reviews and discusses the historical development of MA in NHS trusts. This review is divided into three sub-sections: the early era (2.8.1), the mid-era (2.8.2) and the present era (2.8.3). Section 2.9 determines the research gaps that have arisen from the literature review. The chapter concludes with a brief summary in section 2.10.

2.2 Management Accounting (Definition, Role and Scope)

Management accounting is generally regarded as having been developed to meet the specific needs of management (Weetman, 2010; Coombs, et al., 2005). It relies upon a set of techniques and processes that work together to provide financial and non-financial information (Coombs, et al., 2005). MA has been defined in various ways, but common to all these definitions is the assertion that its aim is to furnish managers with the information they need for their decision making (Made Gowda, 2007). For example, MA is defined as the process of identifying, measuring, analysing, interpreting, and communicating information in pursuit of an organisation's goals (Oliver, 2018; Hilton, 1999). Managers charged with developing, communicating and implementing strategy and with directing, planning and controlling operations (Prowle and Lucas, 2016) – whether in a private-sector business or a public-sector service provider (Weetman, 2010) – use MA information in their decision making to create value for their organisation (Prowle and Lucas, 2016). This information directs their attention to potential areas of concern, helps them keep score and resolve problems (Weetman, 2010). There is no consensus in the literature on what constitutes the definitive list of MA practices or techniques, but researchers have identified a wide range of practices that organisations use to create value including budgeting, inventory management, activity-based costing, balanced

scorecard, target costing, life-cycle costing, benchmarking, total quality management and lean accounting (Hansen and Moen, 2006).

Recent attempts to define the scope of MA have sought to position management accountants as active participants within the decision-making process; the US's Institute of Management Accountants, for example, defines MA as "a profession that involves partnering in management decision making, devising planning and performance management systems, and providing expertise in financial reporting and control to assist management in the formulation and implementation of an organization's strategy" (Prowle and Lucas, 2016). This definition presents MA as not merely a system for providing financial and non-financial information for internal users, but as a powerful vehicle and an integral part of managing and shaping organisations to create value (Hoque, 2014). Coombs, et al., (2005) attribute the difficulties of defining the scope of MA to its dynamic nature, pointing out that over the years, some functions have become obsolete and been abandoned, while others have gradually become accepted as mainstream MA activities. Table 2.1 lists the main areas in which MA may be used, as suggested by Coombs, et al., (2005).

Table 2.1 Areas in which MA may be used

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Source : (Coombs, et al., 2005, p. 7)

2.3 The Role of MA in Supporting Organisational Performance

By facilitating the collection, analysis and communication of information to internal decision makers, MA aims to improve decision making and thus organisational performance (Adler, 2018). Organisational performance refers to the value an organisation may create using its resources in comparison to the expected value (Verweire and Van Den Berghe, 2004). Measuring this value allows the organisation to see the extent to which it is achieving its objectives and strategy (Chenhall, 2006). MA offers a formal system for monitoring its progress in this regard (Amaratunga and Baldry, 2002).

MA's role has been defined in various ways (Prowle and Lucas, 2016; Weetman, 2010; Atkinson, et al., 2007), but Prowle and Lucas, (2016) see its main purpose as being to support decision makers in performing the key management functions of planning, controlling and performance measurement (see Figure 2.1).

Source:(Prowle and Lucas, 2016, p. 41)

Figure 2.1 The role of MA in the Management Process

2.3.1 The Planning Role of Management Accounting

It is generally accepted that organisations should make formalised, detailed plans to provide direction for the organisation and to facilitate the establishment of operational plans (Cress and Pettijohn, 1985). Planning is the process of determining firstly, the goals and objectives that an organisation intends to achieve and secondly, how it will deploy its resources to achieve these objectives (Drury, 2013; Shim and Siegel, 2008). This involves making and then evaluating decisions (Ackoff, 1970). Coates, et al., (1996) describe this as the practical implementation of the planning process, but it requires managers to be properly informed; they must have access to data about the full range of actions that are available to them if they are to be able to evaluate which will best meet the organisation's objectives (Shim and Siegel, 2008). MA has the potential to provide this information (Sprinkle, 2003).

Most organisations follow a hierarchical planning system in which a distinction is made between short-term (budgeting) and long-term (strategic) planning (Drury, 2013). At the top of the hierarchy, senior executives determine the organisation's long-term strategic goals, policies and resource allocation (Kaplan and Norton, 1996b). Executives then translate these strategic objectives into instructions for managers and staff (Kaplan and Norton, 1996b). Further down

the organisation, short-term (operational) planning focuses on the resources, tools and approaches that will be required to achieve the strategic objectives (Kaplan and Norton, 1996b). Both types of planning are discussed in the following sub-sections.

1. Strategic Planning

Strategic planning has been defined as "an integrated set of actions aimed at securing a sustainable competitive advantage" (Weetman, 2010). Mainly geared towards improving organisational performance (O'Regan and Ghobadian, 2002), the strategic plan aims to strengthen the organisation's competitive position (Weetman, 2010) and set out its long-term direction (Ferreira and Otley, 2009). This involves developing long-term strategic goals that take into account the internal and external environment and the organisation's own strengths and weaknesses, and determining how it will use its capital, financial and human resources to achieve these goals (Atkinson, et al., 1997).

Formulated by the chief executive officer and his or her staff, the strategic plan relies largely on external information in addition of course to internal information for strengths and weakness analysis (Shim and Siegel, 2008). What kind of information is required and when will vary from one organisation to another, but MA plays a critical role in ensuring that the information given to managers is adequate and relevant (Frezatti, et al., 2011). This may include financial and non-financial information and analysis not only about the business and the resources it needs to achieve its strategic objectives but also about its competitors (Nixon and Burns, 2012); by enabling comparison with relevant data from other similar organisations, MA can help sharpen managers' focus on their own organisation's strategic priorities and direction (Weetman, 2010). How the strategic plan will be implemented is determined in the short-term planning stage (Frezatti, et al., 2011). Here too, MA can play a key role in ensuring that the strategic plan is being implemented effectively (Frezatti, et al., 2011).

2. Short-Term Planning (Tactical/Operational Planning)

Short-term planning focuses on the resources, tools and approaches that will be required to achieve the strategic objectives. At this stage, the strategic plan is translated into objectives for each function and detailed action plans are developed and put into practice across the organization (Frezatti, et al., 2011). An estimation is made of the likely cost of implementing the plan in terms of the resources required, and of the revenues that may be expected each year the plan is in operation (Hans, et al., 2012).

The main MA tool guiding all organizational efforts towards achieving the strategic objectives is the budget (Frezatti, et al., 2007). The budget is a plan, expressed in monetary terms, covering a future time period (typically a year broken down into months) and based on either expected sales revenues (if market demand is the limiting factor) or capacity (if that is the limiting factor) (Collier, 2015). It allows the organization to express in quantitative terms how it will allocate financial resources across departments for the purpose of carrying out planned activities and achieving short-term objectives (Atkinson, 2012). It aids strategy implementation by matching resources to strategic goals, encouraging coordination and communication between various part of the organisation, motivating managers to meet targets, controlling their activities, and facilitating the evaluation of their performance (Collier, 2015).

The budget and the strategic plan should be tightly linked, particularly since budgets tend to be short run in nature (Mowen, et al., 2011). The importance of defining the link between long-term strategic planning and the short-term budget has been discussed widely in the literature (Atkinson, 2006), with the inability of traditional MA to provide this link being highlighted as its main deficiency (Voelker, et al., 2001). As Kaplan and Norton (2008) highlight, alignment between long-term strategy and short-term planning is crucial for strategy implementation, but this alignment is rarely evident in practice.

2.3.2 The Controlling Role of Management Accounting

Anthony (1965 cited in Emmanuel, et al., 1990), defines management control as "a process by which managers ensure that resources are obtained and used effectively and efficiently in the accomplishment of the organisation's objectives". As this involves reporting regularly on all aspects of organisational performance, it relies on formal rules, standardised operating procedures and routines (Ylinen and Gullkvist, 2014). Management control serves to connect strategic planning and operational control by ensuring that the day-to-day tasks carried out in the organisation result in overall goal attainment (Davila, et al., 2009). This is usually facilitated by the use of management control systems (MCS), which allow managers to direct employees' behaviours and decisions so as to ensure that they produce outcomes that are in line with the organisation's strategic plan and objectives (Weetman, 2010; Henri, 2006; Malmi and Brown, 2008).

The concept of MCS was introduced by Anthony (1965) as a hierarchical framework for the various planning and control functions performed by decentralised organisations (Merchant and Otley, 2006). Its main purpose was to achieve coherence by focusing on the systematic properties of control systems (Otley, 1994). However, it has been argued that Anthony's MCS framework has led to a disproportionate emphasis being placed on accounting-based performance measures (Goebel and Weißenberger, 2017). Management control involves the formal, regular, systematic review of organisational performance; since MA information is routinely collected from all parts of an organisation in a standard manner and summarised in quantitative (monetary) form, it is perhaps not surprising that it has come to be seen as the main tool for achieving management control (Emmanuel, et al., 1990).

As criticism of this narrow understanding of management control has grown, the traditional concept of management control has been expanded into something more holistic,

encompassing both formal and informal systems (Goebel and Weißenberger, 2017). Hence, Malmi and Brown (2008, p. 290) describe management control as including "all the devices and systems managers use to ensure that the behaviours and decisions of their employees are consistent with the organisation's objectives and strategies". In this broadened perspective, MCS may be seen as a set of mechanisms that organisations can apply to regulate themselves (Malmi and Brown, 2008; Otley, 1987). These mechanisms may include formal or mechanistic controls such as performance evaluation, budgetary control and compensation systems, detailed rules and standard operating procedures to ensure that organisational performance is consistent with predetermined targets and financial viability is maintained. At the same time, organisations may also apply informal or organic mechanisms of control to improve understanding of the overall organisational objectives and reduce divergent individual preferences – in other words, to modify organisational behaviours (Eisenhardt, 1985). It should be noted, however, that while the concept of MCS has expanded to encompass different forms of controls, the literature suggests that MA remains the main instrument within MCS to affect the behaviour and performance of decision makers (Agyei-Ampomah and Collier, 2009; Drury, 2013). The following section discusses the controlling role of MA.

1. Management Accounting Control Systems (MACS)

Management accounting control systems (MACS) are used to regulate and guide the organisation's effort in a complementary manner against the attainment of common objectives (Coates, et al., 1996). MACS are based on the traditional view that without an effective system to control employees' performance, resources will be used inefficiently. The underlying threat of control is supposed to motivate employees to achieve a higher level of performance (Harrison and Lock, 2004). This control may take different forms, such as action control, cultural control and output control (Drury, 2013). Cunningham (1992) explains that MA is

traditionally described as an output or administrative control because it focuses on measuring anticipated and actual outputs. Similarly, Drury (2013) explains that MACS generally involve collecting and reporting information on work outputs, and that they rely on outcome reports to verify whether the intended outputs have been achieved. These outputs are mainly described in monetary and ratio terms such as cost, revenues, profit and return on investment, but they may also include non-accounting items such as the number of defective production units.

MACS rely upon cybernetic mechanisms and regulatory processes to direct individual and organisational efforts towards meeting a specific set of organisational objectives (Green and Welsh, 1988). This requires the establishment of a set of procedures for monitoring, directing, evaluating and compensating employees to improve organisational performance (Rodrigues, et al., 2015). Henri (2006) suggests that cybernetic control mechanisms can motivate employees to attain pre-set objectives by helping them focus on and correct deviations from pre-defined standards of performance. A simple cybernetic control usually involves four assumptions: a pre-defined standard of performance designed to support the achievement of the organisation's objectives; a means of measuring the actual achievement or result of performance; a means of comparing this result with the performance standard; and a way of feeding back information regarding any unwanted variance in performance so that corrective action can be taken (Collier, 2015; Malmi and Brown, 2008; Hofstede, 1978).

Drury, (2013) describes MACS as consisting of two core elements. The first is the formal planning process, from long-term planning to short-term budgeting. The second – the budgetary control system – is discussed below.

2. The Budgetary Control System

The budget has been described as an MA practice that performs the dual roles of planning and controlling (Otley, 1987). It is central in terms of setting constraints on an organisation's

activities and determining which of its planned activities are feasible. In terms of its control role, the budget is a device for ensuring that agreed policies have been implemented (Otley, 1987). By limiting expenditure to individual departments or functions, it can also be used to modify employee behaviour (Atkinson, 2012).

The preparation of the budget follows the organisational structure of authority and responsibility. Responsibility accounting is a system of accounting in which costs and revenue are analysed by area of responsibility, with individual budget holders being held accountable for their centre's output relative to their inputs (Coates, et al., 1996). The overall budget is developed based on the budget of each individual responsibility centre within the organisational hierarchy (Emmanuel, et al., 1990). The main goal of responsibility accounting is to determine costs and revenues for each individual responsibility centre so that the origin of any variance from a performance target (usually the budget) can be easily identified (Drury, 2013). In this way, the performance of budget holders can be monitored in financial terms (Lucey, 2003).

The budgetary control process provides a formal basis for monitoring the progress being made by the organisation and its component parts towards the achievement of the objectives specified in the planning budget (Lucey, 2003). The budget is traditionally seen as a simple and logical process in which top managers communicate a set of performance standards to middle managers and then use these standards to evaluate managerial performance and set the next budget (Birnberg, et al., 1983). As such, budgetary control is the main element of MACS given its influence on managers' behaviour that is described as the sinews of the budget (Buckley and McKenna, 1972). According to Otley (1987), within all previous role of budget information, the performance evaluation role is probably the most crucial one.

The main focus of debate in the literature is on how budget targets can be used to motivate and maximise the outcome of employees (Reid, 2002). Setting budget targets is an obvious way of giving individuals measurable, specific goals, but Merchant and Otley (2006) argue that these targets must strike the right balance between being challenging and achievable if they are to motivate managers. Of course, this assumes that managers are rewarded for their performance (i.e. meeting budget targets) rather than seniority (Reid, 2002). Where this is the case, the budget can have a major influence on managerial performance as managers strive to achieve their target (Otley, 1999; Emmanuel, et al., 1990). It has been argued that linking rewards and budget performance encourages greater congruence between individual and organisational goals and consequently more desirable behaviour among workers (Reid, 2002).

However, much consideration has also been given over the years to what may be described as the negative aspects of budgeting: the fact that budgets may constrain innovation and learning, and that budgetary pressure may lead to unintended behavioural side effects (Frow, et al., 2010). Budgetary systems frequently receive criticism for being unsuited to changing environmental or organisational demands, making people feel undervalued, strengthening command-and-control relationships and creating little value, especially considering the time needed for their preparation (Derfuss, 2009). Much of this criticism is linked to the way such systems are used (Merchant and Otley, 2006). Budgetary systems have been variously characterised as diagnostic versus interactive in style (Simons, 1994), tight versus loose (Van der Stede, 2001b) and budget-constrained versus profit conscious (Hopwood, 1972). The common theme in these categorisations is the distinction between rigidity and flexibility. A rigid budgetary control style is one in which employees, mostly at the management level, are evaluated primarily on whether or not they achieve their budget (Van der Stede, 2000). In contrast, a flexible budgetary control style is one in which employees are evaluated based on their ability to maintain longer-term effectiveness (Macintosh, 1985). So-called dysfunctional

behaviour is widely attributed to rigidity in the budgetary control system (Van der Stede, 2000), with a high emphasis on budget attainment being seen as liable to lead to behavioural side effects such as data manipulation, interdepartmental strife, job-related tension, group-based anti-management behaviour, gaming and short-termism (Frow, et al., 2010).

The negative aspects of budgeting are generally ascribed to the financial, top-down, command-and-control-oriented nature of the traditional annual budgeting planning and control process (Hansen, et al., 2003). Notwithstanding the criticisms, however, the vast majority of organisations continue to use budgets because of their vital role in both planning and performance evaluation (Derfuss, 2009). The next section focuses specifically on the performance measurement role of MA.

2.3.3 The Performance Measurement Role of Management Accounting

Short-term planning involves setting operational objectives at the lower levels of management. These operational objectives address short-term actions within specific operational processes, as carried out by front-line staff. In general, they involve deploying materials, facilities and people to produce services and products to meet customer demand (Collier, 2015). Measuring operational performance allows managers to create a connection between planning, decision making, action and outcomes within the organisation (Micheli and Mari, 2014) so that information related to revenue and cost that reflect current realities of organisation and their future regarding objectives, customers, finances and resources would be produced (Lockamy III, 2003). It also offers a basis for evaluating organizational progress against the pre-determined operational objectives and for determining which areas need to improve (Amaratunga and Baldry, 2002).

An integral part of MA, cost accounting systems are normally designed to provide information regarding day-to-day operational performance to assist managers in controlling operations and

making decisions (De Zoysa and Kanthi Herath, 2007). Cost accounting systems are concerned with cost accumulation for goods produced or services rendered and are designed to address both external reporting requirements (e.g. the preparation of the financial statement) and the need for internal profit measurement (Drury, 2013). For decades, volume-based costing and traditional cost-based accounting systems have been used to measure operational performance. The full-costing system and the standard cost system have been the most popular choices for measuring cost and efficiency, the first being the most common choice for measuring the elemental costs of different functions or departments (Draman, et al., 2002), and the second being widely used to provide operational measures of cost and efficiency for evaluating the performance of operational managers (Sheu, et al., 2003).

Cost accounting systems provide a range of financial measures that can be used to evaluate operational performance, such as productivity, efficiency, break-even points, product costs, product margin, return on investment and profit (Draman, et al., 2002). A lot of information is produced by these measures. Standard cost variance analysis, for example, gives information about actual performance and the financial consequences of unexpected events. The measures may assist managers in identifying the cause of any variances and ways of dealing with them. Productivity measures that show the ability of the organization to create the desired output could provide information about the financial impact of operation (Kaplan and Atkinson, 1998). Collectively, the financial measures play an important role by showing the consequences of managers' performance in a comparable measurement unit, controlling costs and supporting markets and contractual relationships (Henri, 2006).

As noted above, cost accounting systems are seen as providing useful information for decision making (Lucey, 2003). Corbett, (1998) suggests that these systems support the achievement of organisational objectives by producing information that reduces pre-decision uncertainty

and enhances decision makers' ability to choose the most appropriate course of action (Leitner and Wall, 2015; Sprinkle, 2003). Essentially, cost accounting information needs to fill the gap between what decision makers know and what they need to know to make a decision (Hartmann and Maas, 2011); the scope of this information will be determined by the extent of this gap. Generally speaking, MA information may be broad or narrow in scope (Chong and Eggleton, 2003); narrow scope information is likely to be concerned primarily with events internal to the organisation (e.g. financial or historic), while broad scope information is more likely to include external, non-financial and future-oriented data (Hammad, et al., 2010; Chenhall and Morris, 1986).

An organisation without accurate cost information is at financial risk when making decisions regarding current operations or long-term plans (Cannavacciuolo, et al., 2015). Conversely, a cost system that is able to generate up-to-date, accurate cost information creates value by enabling individuals to improve their decision performance (Michael, 2011). The organisational value of cost systems has been discussed in the literature from two main perspectives: technical and behavioural (Michael, 2011; Abernethy, et al., 2001).

Authors considering the technical perspective distinguish between sophisticated and non-sophisticated costing systems (Leitner, 2013). The level of sophistication or complexity of the system depends on the number and nature of cost pools, and the nature of the cost allocation basis (Abernethy, et al., 2001). Traditional cost systems, for example, tend to feature a single, organisation-wide cost pool that uses cost drivers at the unit-level and is responsibility-based, while more sophisticated systems tend to feature multiple cost pools and hierarchical cost drivers and are activity-based (Leitner, 2013; Abernethy, et al., 2001). The literature suggests that more sophisticated systems provide a broader scope of more accurate and relevant

information for strategic and operational decision making (Schoute and Budding, 2017; Gupta and Gunasekaran, 2005; Lockamy III, 2003).

Authors examining the behavioural perspective argue that the value of any cost system relies upon the ability and willingness of users to use all available information in their decision-making process (Michael, 2011). In healthcare organisations, the cost system's value may be reduced because the strong culture of professional autonomy may make clinicians reluctant to let cost information drive their clinical decisions (Cannavacciuolo, et al., 2015). It has been argued that the kind of behaviour the cost accounting system promotes depends mainly on why the system is deployed (Micheli and Manzoni, 2010); for example, whether it is adopted primarily to satisfy financial reporting regulations or for internal decision-making purposes (Gupta and Gunasekaran, 2005). Traditional cost accounting systems, as (Johnson and Kaplan, 1991) highlight, tend to be driven mainly by the former motive, which limits their usefulness to decision makers.

Such concerns have highlighted the need for the development of more robust systems that are able to address the limitations of traditional cost accounting; Gupta and Gunasekaran (2005) note the relentless efforts being made to ensure that the information produced by cost accounting systems remains relevant and meaningful in terms of operational decision making. These efforts have led to the development of alternative systems such as activity-based costing (ABC) (Cooper and Kaplan, 1988), constraint-based accounting (Draman, et al., 2002) and value stream costing (VSC) (Baggaley and Maskell, 2003). However, given the significance of individuals' uses of cost information in determining values of cost-system, the question on its values cannot be answered without developing an understanding of when and how different types of cost information are used in individuals' decision-making processes (Michael, 2011).

2.4 The Dynamic Nature of Today's Business Environment

Over the last few decades, the development of information technology, deregulation, global competitive pressures, and growth in the service industry have led to dramatic changes in the global economy and, indeed, to how business is done (Hansen and Mowen, 2006). Blocher, et al., (2005) list the main changes in the business environment as being: (1) intensifying worldwide competition; (2) the introduction of lean thinking; (3) advances in information technology; (4) increased customer focus; (5) the arrival of new management styles; and (6) changes in the wider political, cultural and social environment. These environmental developments have raised the levels of complexity and uncertainty faced by businesses, forcing them to become more focused on customer service and strategy (Smith, 2005; Baines and Langfield-Smith, 2003). They must respond to everything from technological change and globalisation to strengthening competition and shifting customer preferences (McWatters and Zimmerman, 2015); those that fail to adapt to environmental forces will not be able to survive in the long term (McWatters and Zimmerman, 2015).

Finding new ways of working is crucial to improve organisational value (Bhuiyan and Baghel, 2005). Henri (2006b) speaks of the need for continuous development, while Danneels (2002) argues that organisations must continuously renew themselves in order to survive and prosper. Many organisations have sought to respond to environmental challenges by adopting a strategy of continuous improvement (Kennedy and Widener, 2008); to create value for their customers, they must continually raise performance in terms of cost, quality, time and innovation (Horngren, et al., 2012). Hoque (2005) sees this rethink in strategic philosophy – and in the role of MA – as the key to adaptation. McWatters and Zimmerman (2015) also emphasise that as the organisation adapts to its changing environment, the MA system must adapt to the changing organisation. They argue that if the development of the MA systems lags behind the

development of the organisation, it risks acting as an anchor and may even prevent the organisation from successfully dealing with the changing environment.

As discussed in section 2.3.2, traditional MA relies predominantly on cybernetic control and management by exception. The cybernetic model of control is widely regarded as delivering efficiency in mechanistic organisations characterised by formal rules, standardised operating procedures and routines. However, dynamic organisations tend to be fluid and responsive, having fewer rules and standardised procedures. Here, organisational success has primarily been associated with flexibility and intensive, free-flowing communication (Ahrens and Chapman, 2004). The following section discusses in more detail the ways in which traditional MA systems are unsuited to the current dynamic business environment.

2.5 Limitations of Traditional MA Systems in Today's Business Environment

The MA literature has widely discussed the ways in which traditional MA systems, including cost accounting and budgetary systems, work against the dynamic nature of today's business environment (Hope and Fraser, 2003; Kaplan and Atkinson,1998). Since the 1980s, concern has been expressed at the inability of MA to align with the new business environment and provide useful and timely information about process control, performance management and service and product costing (Johnson and Kaplan, 1991). Macintosh (1994) outlines three main problems: the conflict between responsibility centre managers' objectives and overall organisational objectives, the use of outdated and inappropriate MA techniques, and poor relationships between managers and management accountants. Hansen and Mouritsen (2007), meanwhile, note four main concerns: MA's emphasis on financial performance measures at the expense of non-financial ones, on hierarchical rather than lateral organisational relationships, on standardisation rather than learning and continuous improvement, and on control rather than empowerment. Finally, Lord (2007) argues that the chief limitation of traditional MA systems

is that the information they provide tends to be short-term, narrow in scope, historical, financial, reactive and focused on regular internal events. As such, it is of limited use in strategic decision making.

In his notes on the relevance lost debate, Drury (1990) sorts the major criticisms of MA into two groups (Johnson and Kaplan, 1991): problems with cost accounting systems, and a perceived lack of strategic orientation. The main issues highlighted in the first group include the use of inappropriate methods to assign overhead costs to products or services, the dominance of external reporting requirements, an over-emphasis on the control of direct labour, the demands placed on managers by the monthly reporting cycle, and the lack of help for operating managers as they attempt to reduce costs and improve productivity. The reports produced under traditional cost accounting systems have also been criticised as not timely and for being too complex for non-financial users to understand. Driven mainly by external reporting requirements, they have been seen as primarily focused on responding to regulatory standards rather than customer demands (Fullerton, et al., 2014). Finally, the information provided by cost accounting methods has been criticised as incompatible with dynamic management and performance improvement and as diverting managers' attention away from the most important factors (Fullerton, et al., 2014; Otley, 2001; Johnson and Kaplan, 1991). In the second group (lack of strategic orientation), Drury notes two main issues: the lack of performance measurement metrics relevant to the modern environment, and the fact that traditional MA distracts managers from strategic concerns by encouraging them to focus excessively on short-term performance (Drury 1990, Johnson and Kaplan, 1991).

In contrast, Johnson (1994) argues that MA has not lost relevance because it produces the wrong sort of or poor-quality information, but rather because this information has been poorly used. He suggests that traditional MA has failed because it has been deployed as an instrument

of top-down control within a culture that treats customers as objects of persuasion and employees as cogs in the gears of a deterministic machine. This is out of step with the modern dynamic culture, where the focus is on empowering employees to control processes and removing the constraints that stand in the way of meeting customer needs. To Johnson, the solution to MA's perceived lack of relevance is to use it to manage the process and remove constraints rather than as a way of simply maximising results within existing constraints.

To sum up, the main limitation of traditional MA control systems is their emphasis on historical financial information that is internally focused and short-term in orientation (the scope is generally limited to the organisation's financial accounting period or calendar time). Cost objects are typically products or responsibility centres, and cost drivers are normally unit-level, such as production volume, labour hours and machine hours (Nimtrakoon and Tayles, 2015). As a consequence, the information generated often comes too late and is too aggregated and distorted by the financial reporting process to be useful for decision making or the communication or implementation of strategy (Bjørnenak, 2013).

Budgetary control system is traditionally portrayed as serving a number of organisational functions, such as planning, coordination, performance evaluation, resource allocation and organisational learning (Hartmann and Maas, 2011). As Hansen, et al., (2003) highlight, this system has been widely adopted because they are able to weave together all the disparate threats of an organisation into a comprehensive plan that serves multiple purposes, particularly performance planning and ex-post evaluation of actual performance vis-a-vis the plan. As one form of MA, budgeting has traditionally been viewed as a means of achieving control over activities performed at the middle and lower organisational levels via the downward flow of information (Covaleski and Dirsmith, 1983). However, it has been argued that while the traditional budgetary system's focus on command, hierarchy and control may have been useful

during the industrial age, it is incapable of meeting the challenges of the information age (Ekholm and Wallin, 2000). Its hierarchical, command-and-control orientation and precisely delineated responsibilities are seen to limit the scope of empowered managers to operate flexibly, militate against team-working within and between departments, inhibit innovative responses to unforeseen contingencies, and stifle the creativity required for innovation and learning (Frow, et al., 2010). It has even been criticised as at best inappropriate to modern business practice and at worst potentially harmful (Hope and Fraser, 2003).

Drawing on the practitioner literature, Neely, et al., (2001, cited in Otley 2006) list a number of the shortcomings of budgetary control. These include:

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In their discussion about the shortcomings of budgetary systems, Hansen, et al., (2003) concentrate on three main issues. The first is the inability of these systems to capture the uncertainty that comes with a rapidly changing environment. To be useful, budgetary systems require a high degree of stability so that they can provide a valid plan for a reasonable period of time (typically the next year). They also require good predictive models to provide a

reasonable performance standard against which to hold managers accountable. However, organisations operating in more dynamic environments will find it difficult to establish these two conditions. The second problem highlighted by Hansen, et al. (2003) is that budgetary systems often hinder the pursuit of strategic goals by supporting mechanical practices such as last year-plus budget setting, while their exclusive focus on annual financial performance may be out of step with operational and strategic decisions that target non-financial goals and cut across the annual planning cycle. The final problem is that vertical, command-and-control, responsibility centre-focused budgetary controls are incompatible with flat, network or value chain-based organisational designs and impede empowered employees from making the best decisions.

The criticisms discussed above have led in recent decades to the emergence of a new concept and area of academic debate: beyond budgeting (Hope and Fraser, 2003). The main argument of beyond budgeting is that when the environment is unstable and shifting, the best solution is to abandon the budget and substitute a more dynamic system that is flexible and responsive to environmental change (Mitchell, et al., 2013). The next section discusses how MA has responded to this message and to the requirements of the dynamic environment.

2.6 The Dynamic Nature of MA

The previous section reflects the multi-faceted nature of the relevance lost debate, which addresses MA's role in different levels of the organisation and in a different way. The overriding message that emerges from this debate is that the business environment in which MA operates is changing, and that MA systems must change with it (Mitchell, et al., 2013). Numerous studies have responded to this message by focusing on how MA can regain its relevance and develop its role (Nizar, et al., 2015), but while the general consensus is that MA needs to become more dynamic and flexible in nature (Thomas, 2016), there is also widespread

recognition that organisations may find this change extremely challenging (Burns and Vaivio, 2001). Mouritsen (2005), for example, argues that changing MA takes a long time and needs a lot of energy and motivation as it often involves a complex implementation and consolidation process, while Sulaiman and Mitchell (2005) highlight that as MA has traditionally been seen as a bastion of conservatism, any change is likely to be slow and restricted rather than rapid and extreme. Change is more likely to be gradual than radical, especially as it takes time to become institutionalised, so the development of MA is more likely to be seen as an ongoing process within an organisation rather than as a discrete movement from one level to another (Nizar, et al., 2015).

If it plays no part in organisational transformation, MA is at risk of being seen as unimportant and thus perhaps unnecessary. However, a significant body of literature provides evidence that change has become a central feature of contemporary MA (Nizar, et al., 2015). Mouritsen (2005) argues that MA is in fact continuously evolving, acquiring new functionalities as time passes and it is required to operate in new situations and circumstances, while Abdel-Kader and Luther (2008) suggest that MA has sought to become more relevant to the modern business environment and generate increased organisational value by expanding its focus beyond the traditional cost measurement and financial control functions and by changing how information is used. From limiting itself to internal events and the provision of formal historical and financial information, it has expanded its scope to external events in order to provide non-financial, less formal and future information. Instrumental to this development has been the introduction over the last three decades of innovative practices and techniques such as activity-based costing (ABC), life cycle costing, target costing, quality costing, the balanced scorecard, beyond budgeting, strategic management accounting and environmental management accounting (Abdel, 2011). This development has in turn changed the role of management accountants from that of merely preparing standard reports and reacting to budget variances

and aspects of financial performance to a more proactive role as business partners with a part to play in organisational change and improvement (Mitchell, et al., 2013).

2.7 The Emergence of Strategic Management Accounting

Prompted in part by the relevance lost debate (Johnson and Kaplan, 1991), the focus of MA has in recent decades expanded beyond financial statement reporting cycles to encompass the information needs of strategic decision makers (Mitchell, et al., 2013). Since the 1980s, as strategic concerns have become more critical for managers, these have been incorporated into MA (Demartini, 2014) through the introduction of strategic management accounting (SMA) practices. These SMA practices have gradually become essential to management accountants involved in supporting strategic decision making (Ma and Tayles, 2009).

Although the term SMA was coined around 1980 by Simmonds (1981), it was not widely adopted until the late 1980s (Otley, 2001), as accounting evolved from a function concerned primarily with conventional/routine operations to one with a strategic dimension (Ma and Tayles, 2009). According to Otley (2001), SMA represents a change of orientation in the use and application of MA from historic to forward-looking, from control to planning, from internal to external (customers, competitors etc.), from cost to value and from production to marketing. Over the past two decades SMA, which has attracted considerable interest among researchers, has become a sub-set of MA focusing mainly on accounting's facilitation of strategic decisions and strategic management processes (Cadez and Guilding, 2012). Ma and Tayles (2009) observe that it is seen as a practical solution to the problems arising from a changing competitive and technological environment and as a way of making MA relevant once more (and boosting its position) within organisations.

The literature offers no agreed definition of or conceptual framework for SMA, but it may be broadly understood as a concept in which strategy is formulated and implemented using the

techniques and language of management accountants (Nixon and Burns, 2012). The SMA concept combines two main facets. The first is a set of strategically oriented accounting techniques. Cadez and Guilding (2008) list 16 techniques that organisations can deploy to support strategy, which they divide into five categories: costing; planning, control and performance measurement; strategic decision making; competitor accounting; and customer accounting. Certain techniques promote quality, while others promote innovation or low cost; how much emphasis an organisation puts on each technique will depend on its chosen strategy, and matching MA technique to strategy is critical (McWatters and Zimmerman, 2015). The second facet of SMA is the management accountant's participation in strategic management processes (Cadez and Guilding, 2008). The term strategic management accountant is often used to distinguish this newly identified group, who are proactive in analysing broader business issues, from their traditional historical/financial/operationally-oriented counterparts (Aver, et al., 2009).

In terms of the performance measurement and management that are the focus of this thesis, SMA is seen as helping organisations pursue their strategic agenda by providing an understanding of how operations support strategic priorities and the interdependencies of activities across the organisation (Chenhall and Langfield-Smith, 1998). According to Chapman (2006), the relationship between abstract strategy and the details of day-to-day activity underpins much of the analysis of more active and strategically oriented MA. One of the main limitations of traditional MA performance measures is their inability to track progress in strategy implementation (Chenhall and Langfield-Smith, 1998).

2.8 Historical Development of MA in the NHS

The NHS is one of the largest and most complex public organisations in the world (Conrad and Uslu, 2012), but it may be broadly summed up in the following three characteristics: it operates

within a highly politicised environment (it is under extensive government influence), its clinicians have significant power over operational processes, and it is accountable to a wide range of influential stakeholders (Abernethy, et al., 2006). In an NHS trust hospital, individual clinicians make decisions about and supply procedures, tests and diagnoses to patients, with the cost being borne by government or insurance companies (Pizzini, 2006). In this complex environment, MA plays several key roles (FlachÃ¨re, 2014) first, as a top management tool for implementing strategic objectives; second, in supporting the decision-making process; and third, in driving organisational performance.

In this thesis, MA is defined as the process of guiding an organisation into a viable pattern of behaviour in a changing environment (Simons, 1987). This historical review will therefore focus on MA's ability to influence the behaviour of clinicians by providing them with useful information for decision making and control. The review is divided into three broad eras which, according to Smith (2005), correspond to the command-and-control era, the market era and the regulatory era.

2.8.1 The Early Era: Command and Control (1948-early 1990s)

The UK NHS was established in July 1948 with the objective of providing free national health services – funded primarily by general taxation – at the point of delivery. Clinicians had enjoyed a high degree of autonomy in the pre-NHS healthcare structure, which the government not only preserved under the 1946 NHS Act but extended to include new powers. Clinicians were a self-regulated profession, largely unaccountable to the public and its representatives, with a discretionary power over the everyday allocation of resources, while the role of the state was confined to deciding the level of overall state funding allocated to the NHS (Crinson, 2009). This left them free to carry out their professional responsibility of doing their utmost for the individual patient without any consideration to the cost. The high level of autonomy and power given to medical professionals, not just in terms of deciding how resources should be allocated

to patients but also how quality should be assessed and what kind of services are needed (Newdick, 1997), has been a significant feature of the NHS ever since (Lapsley and Schofield, 2009).

The provision of health services involves a multitude of decisions, from the decision whether to admit a patient to the hospital or discharge them, to which diagnostic test to use and what type of treatment to administer (Drummond, 1989). All of these decisions have resource consequences. In the 1970s, for example, it was observed that clinicians were using additional financial resources to treat fewer patients more intensively, rather than treating more patients. Decisions were being made without reference to those planning, managing and funding the healthcare system (Drummond, 1989), with the result that waiting lists lengthened (Llewellyn, et al., 2005). Newdick (1997) describes a situation where resource allocation within hospitals was dominated by clinicians, who were not held accountable for the financial results of these decisions, rather than by managers or administrators. He points to a lack of mechanisms or accounting practices motivating clinicians to align with the values and objectives of the hospital, explaining that their decisions were consequently often not directed towards enacting the overall objectives of the organisation. In other words, there were no ways of identifying and controlling the resource consequences of their actions. This raises the question of whether MA played any role in controlling and allocating hospital resources in this era.

When Robson (2007) examined accounting and managerial reform in NHS hospitals between 1958 and 1974 he found that by the end of the 1950s, hospitals had become more complex organisations with a multitude of departments offering medical services (radiology, pathology, operating theatres) and hotel functions (catering, heating and maintenance etc.). The pressure grew for cost data and unit output to be differentiated by department, but this was almost impossible when budgets were based on hospital group and many costs were absorbed under

general headings such as salaries or medical and surgical equipment. In other words, the budget was of little use for internal decision making in the hospital because it gave inadequate information about department performance (Cutler, 2011). As controlling the spiralling cost of the NHS became an increasingly pressing issue, departmental costing was introduced. In a gesture of accountability, the figures were submitted each month by the Hospital Management Committee (HMC) to the Regional Health Authority, but they were also used for internal management control (Robson, 2007). The figures compared the monthly expenses with the approved budget and the cumulative expenditure with the budget to date. Hospital expenditure was reported by subject or type such as salary (medical, nursing, etc.), drugs and dressings, fuel and light; and these were combined with an overall cost measure, the cost per in-patient week (Cutler, 2011).

The departmental or functional budget was applied in 1958 to express at aggregated levels costs such as catering, nursing, pharmacy and building maintenance. Breaking down the unit cost by department allowed hospitals not only to compare their financial performance with the national or regional average but also with that of similar groups of hospitals. In other words, they could compare departmental unit costs with those of the same departments in other hospitals. The departmental budget was able to provide a range of measures and information regarding performance at the department and hospital levels, such as cost per patient fed for catering, cost per meal supplied for kitchens and cost per case for wards. This made it much easier to measure how efficient individual departments were in their use of resources (Cutler, 2011; Robson, 2007; Rea, 1994).

However, despite its valuable contribution to health service administration during the 1960s, 1970s and 1980s, the functional department budget has been criticised for being administratively rather than clinically focused (Robson, 2008). It has been argued that as unit

costs are more likely to be expressed using administrative measures such as cost per meal supplied rather than clinical measures such as cost per operation or treatment (Robson 2008), this approach captures the efficiency of the hospital's administrative and hotel services rather than its clinical efficiency. Prowle (1987) noted that although a range of cost information is provided, it tends to be department-oriented; it is not directed towards specific clinical areas or specialities, specific groups of patients or even individual patients. This leads to a lack of information related to the resource consequences of clinical decision making. By the 1980s, although MA in the NHS had made good progress in terms of financial performance management and administrative control (Cutler, 2011), it was being criticised by many for having little power to influence clinicians to make better use of hospital resources (Davies and Prowle, 1984).

The Griffiths Report (the 1980s)

By the early 1980s, demands were growing for clinicians to be more involved in the management of the NHS on the grounds that this would ensure that resources were used more efficiently (Robson, 2008). This demand was supported by the Griffiths Report, published in 1983 (Lapsley, 2001), which criticised the management of the NHS for its lack of leadership and weak accountability systems (Ferry and Scarparo, 2015). The main objectives of the report were to draw clinicians' attention to the cost effects of their decisions and to motivate them to be more involved in resource management (Gebreiter, 2015). To achieve these objectives, the report recommended that general managers should involve clinicians more closely in the management process, consistent with the freedom of clinical practice (Lapsley, 2001).

It was expected that general managers would change the management style in the NHS to increase the emphasis on authority and accountability at national, regional, district and unit levels (Perrin,1988). To this end, a central recommendation of the Griffiths Report, as Gebreiter,

(2015) notes, was the creation of management budgets, a form of clinical budgeting. According to Perrin (1988, p. 102), this was "a relatively structured and standardised system for planning or forecasting costs and expenditure classified by a consultant or by speciality, leading to monthly progress reports for monitoring and annual reports for performance reviews and refinement to the next year's budgets". The main principle of the management budget was the distribution of all the hospital's expenditure between clinical budget holders. However, as this budget was based on the available cost information rather than all costs (e.g. it did not include overheads) (Lapsley, 2001a), it was rejected as crude and unacceptable by clinicians (Gebreiter, 2015), who resisted engaging with either budgetary information or processes (Ferry and Scarparo, 2015). As a result, the management budget was declared a failure after only one year.

In 1986, after the management budget had failed to encourage clinicians to become more involved in the management process, the NHS Management Board announced a new initiative: resource management (RM). A new style of management budget (Lapsley, 2001a), RM has been described as a form of responsibility accounting in which budget information facilitates planning and reporting facilitates control and appraisal (Rea, 1994). The declared objective in adopting RM was actually the same as that for adopting the management budget – to help clinicians and other managers make better-informed judgements about the resources they control – but RM placed greater emphasis on providing clinicians and other managers with the clinical and cost information they need to use these resources more efficiently, the idea being that this should result in better patient care (Rea,1994).

RM was supported by a case-mix costing system that was supposed to provide a complete financial picture of the treatment costs for individual patients and for different patient groups (Lehtonen, 2007), but as Rea (1994) observes, the information system needed to operate RM was incomplete; case-mix accounting (where it existed) was crude, and work on outcome

measurement was still mainly at the research stage. Gebreiter (2015) also argues that the target of providing accurate, timely and relevant information about the clinical activity was mostly not met. Furthermore, most of the information generated by RM was for administrative and financial rather than clinical purposes. The resulting decoupling of the clinical system from the administrative and finance systems led to RM being deemed another MA failure as far as encouraging clinicians to become involved in resource management was concerned (Lapsley 2001a), though it did have some success in improving their cost awareness (Jacobs, et al., 2004; Rea, 1994), and the concept did lay the first stone for the calculation of treatment tariffs, which subsequently became the basis of commercial contracts between providers and purchasers(Lapsley, 2001a).

In summary, although this era witnessed many attempts to develop the role of MA in supporting the NHS to deploy its resources more efficiently, these efforts were largely frustrated by a lack of accurate and relevant information about the cost implications of clinicians' decisions. Most of the information MA provided was put to managerial rather than clinical use, and it was deployed primarily as an instrument of managerial control (Jacobs, et al., 2004; Rea, 1994). As a result, it did nothing to encourage clinicians to engage with the objective of efficiency, but rather fostered resistance among many at the perceived intrusion of the bureaucratic process into their clinical work (Jacobs, et al., 2004).

2.8.2 The Mid-Era: The Internal Market (Early 1990s-1997)

In 1989, the government published a white paper, *Working for Patients,* proposing the creation of an internal market in the NHS (Department of Health, Self Governing Hospitals 1989). The main feature of this reform was the separation of the NHS into purchasers (health authorities and fund-holding GPs) and providers (NHS trust hospitals) (Newdick, 1997), with the former being made responsible for placing contracts with the latter to provide healthcare for patients (Lapsley, 1994). The reform's main aims were to encourage competition between trusts (Jones,

1999a) and strengthen management (Ferry and Scarparo, 2015). The government believed that delegating responsibility as near as possible to the point of delivery would lead to performance improvement in hospitals (Harradine and Prowle, 2012), while the competition was expected to constrain costs (Robson, 2008) and motivate hospitals to use the available resources more efficiently (Allen, 2009).

To facilitate this competition between hospitals, trusts were allowed to become self-governing, and by 1994, about 95% of hospitals and community health services were operating as trusts (Jones, 1999a) outside district health authority control. These trusts worked as independent business units, earning their income from the services they provided. However, the new mechanism put hospitals on the hierarchies-market continuum, with significant consequences for their existing performance relationships and accountability (Jones, 1999a). Furthermore, since the government expected competition within the market to be relatively weak, trusts were set an efficiency target of an annual reduction in unit costs of 2-3% (Dawson, et al., 2001). In fact, trusts were largely held to account on the basis of their financial performance. This included being required to break even on income and expenditure, to secure a 6% return on their net assets, and to operate within their external financing limit, set annually by the NHS Executive (Ferry and Scarparo, 2015; Goddard, et al., 1999).

The internal market era has been seen as a time of significant change in the organisation of and accounting for UK healthcare (Robson, 2008). Jones and Dewing (1997) describe the internal market as a radical step in the quest for efficiency and cost reduction, but the contracting and pricing requirements of this new market, and the accompanying devolution of financial responsibility to organisational divisions, increased the need for significantly improved MA and costing systems (Jones 1999b). Lapsley and Wright (2004) argue that the internal market was a major catalyst in the development of MA in the NHS because of the big burden it placed

on accountants to accurately cost health services. To support the new reform, the government made two significant changes to the accounting system. The first of these was the introduction of private sector-style accounts for NHS trust hospitals; that is, traditional cash accounting was replaced by the accrual-based accounting method. NHS trust annual reports included an income and expenditure statement, balance sheet and cash flow statement. To these were attached an accounting policy statement and a disclosure note statement. The balance sheet covered fixed assets, stocks, debtors and creditors (Hodges and Mellett, 2003; Ellwood, 2002). This was supported with a system of deprecation accounting in which fixed assets in the balance sheet were measured to determine their current values. This provided a base to account for depreciation charge for the use of assets through the year in the income statement (Hodges and Mellett, 2003).

The second significant change in terms of MA was the introduction of full-cost pricing for healthcare contracts. The basic principle in pricing NHS services was cost equals price including a capital charge (6% return on net assets), depreciation in addition to an interest element based on annual assessment; cost determined according to full-cost basis and no planned mutual support between specialities, procedures or contracts (Robson, 2008). In fact, prices were set in advance and based on expected costs and levels of activity. Most contracts provided whole specialities at an agreed volume (block contracts), reflecting local monopolies in service provision (Bryan and Beech, 1991). Contracts would set out what was required of each trust in terms of price, quality and nature of the service to be provided (Gebreiter, 2015). The main aim of using the price/cost mechanism was to encourage providers (trust hospitals) to improve their productive efficiency and purchasers to improve their allocative efficiency (Bryan and Beech, 1991). It was assumed that as purchasers shopped around for the best price, resources would over time flow to the most competitive provider, encouraging both sides to behave more efficiently (Ballantine, et al., 1998).

The challenge MA faced in meeting the requirements of the internal market demanded major changes in NHS costing and financial information systems (Ellwood, 1990; Robson, 2008). Gebreiter (2015) argues that MA was expected to contribute to the internal market in two main ways: firstly, by using clinical budgets as a mechanism to control expenditure and support clinicians' involvement in managing resources (perceived as key to raising trust efficiency); and secondly, by facilitating the use of the price/cost mechanism in the contracting process and contract-related decision making. The demand grew for cost and volume data about health products and activities that was more comprehensive and more detailed (Lowe, 2000). The minimum required costing standard was set out in the *Costing for Contracting Manual* issued by the NHS Executive. The objective, as Ellwood (1996b) observes, was to achieve consistent, representative and comparable prices to help purchasers place contracts with the most efficient provider.

This era saw radical changes in the nature (the introduction of trusts with devolved powers), structure (budgeting devolved to clinical directors) and operational context (the arrival of the internal market) of the NHS. However, the clinical budgeting initiative was rejected (Lapsley, 2001a) by medical professionals, who saw the costing and budgeting that was supposed to underpin the system of performance evaluation as undermining clinical practice (Ferry and Scarparo, 2015). As with RM a decade earlier, the systems required for the internal market reform to work properly were not in place (Ballantine, et al., 1998), with the costing systems that were supposed to support the clinical budget still basic and crude (Gebreiter, 2015). Furthermore, many trusts had only a limited understanding of what drove their costs (or what their prices should be), with the result that it was common for block contracts to rely on notional costs (Ballantine, et al., 1998). Ferry and Scarparo (2015) argue that high-cost variability, the lack of robust or comparable costing data and of integrated systems of cost and quality data,

and the inability of the accounting system to capture the complexity of health services all contributed to clinicians' distrust of, and disengagement from, managerial reforms.

To conclude, the mechanism of the internal market contract based on a purchaser/provider split had little effect on patterns of service delivery because of its crude costing system and use of incremental budgeting (Lapsley, 1994). Rather than relying on carefully priced diagnostic groups, the purchasing activities of health authorities continued to rely on block contracts which covered a large and often fairly ill-defined set of services (Gebreiter, 2015). Generally speaking, cost-based pricing failed to provide appropriate or accurate price signals to purchasers. On the other hand, transaction costs rose significantly because of the extra staff resources needed to prepare contracts. In 1997, these high transaction costs and the divisiveness caused by the internal market led the new Labour government to abandon the initiative in favour of longer-term contracts (Jones and Mellett, 2007; Jones, 1999; Ballantine, et al., 1998, Ellwood 1996a; Ellwood, 1996b).

2.8.3 The Present Era: The Regulator Era (Since 1997)

Management budgeting and market-driven incentives introduced in the 1980s and 1990s were intended to create a system of performance management that could improve NHS productivity and efficiency and reduce waiting times (Ferry and Scarparo, 2015). The reforms were inspired by Griffiths' recommendation that greater managerialism was needed in the NHS (Klein, 2010), but the under-developed state of the costing system, the difficulties of defining and measuring healthcare outputs and clinicians' resistance made the move towards managerialism expensive and difficult (Jones, 1999b). When the Labour government was elected in 1997, it concluded that the competition-focused internal market had produced only dysfunctional behaviour and high transaction costs (Uslu and Conrad, 2008). In a turn away from the free market, it announced that the NHS would enter a new era in which the split between provider and

purchaser would be retained but the emphasis would be on cooperation, rather than competition, between purchaser and providers, and between providers (Harradine and Prowle, 2012).

In its 1997 white paper *The New NHS: Modern and Dependable*, the government envisaged a move towards a system of accountability centred primarily on quality. This was to be achieved by improving clinical government and aligning the clinical and financial functions more closely (Ferry and Scarparo, 2015; Crilly and Le Grand, 2004). The management control system that was introduced did not rely on moving funds between competing providers, but was instead a target-and-terror system designed to deliver specific national targets and standards (Ferry and Scarparo, 2015; Morgan and Yeung, 2007). This target-and-terror system of control and governance was operationalised through a star-rating system from 2001 to 2005, the Annual Health Check from 2006 and the NHS Performance Framework from 2008 onwards (Ferry and Scarparo, 2015). Uslu (2005) explains that with the target-and-terror system came a new efficiency/quality strategy focused on setting, delivering and monitoring performance standards, and promoting clinical effectiveness, clinical governance and continuous learning. The government also announced that in an effort to incentivise performance improvement, services would be assessed against performance benchmarks (McMaster, 2002). Accordingly, since 1998, relative performance evaluations for NHS trusts have been published annually in the form of comparative league tables (Uslu, 2005). An assessment tool for benchmarking, trusts are ranked across a broad range of performance indicators on two scales for the quality of their services and their use of resources (Birrell and Gray, 2016).

However, the new reforms did not just highlight the importance of cooperation and comparison; they also placed emphasis on command and control (Lapsley, 2001b). The government declared that "For the first time there will be a system of inspection and accountability for all parts of the NHS", though what it in fact did was replace existing mechanisms with a new set

of regulatory agencies (Conrada and Uslu, 2012). Bodies such as the Commission for Health Improvement (CHI) and the National Institute for Clinical Excellence (NICE) were created to encourage innovation, to enhance the diffusion of good practice, and most importantly, to impose the implementation of the tools of control (Le Grand, 2002).

At the heart of this management control process lies the detailed costing of medical procedures (Uslu and Conrad, 2011). The National Reference Costing Exercise (NRCE) was introduced within the performance framework as a new costing initiative (Northcott and Llewellyn, 2002), with a national schedule of reference costs being established to identify variations in individual treatment costs in different parts of the NHS. Described as a mechanism for achieving efficiency rather than economy (Lapsley, 2001b), the NRCE was refined over a number of years to enable benchmarking of hospital costs against each other. Another benchmarking tool is the National Reference Cost Index (NRCI), which gives the average baseline unit cost incurred by each NHS trust, encapsulated in a single figure (Conrad and Uslu, 2011). This is calculated from the average cost of providing a pre-determined group of treatments, known as healthcare resource groups (HRGs) (Conrad and Uslu, 2011), over the course of a year. HRGs are treatments that can be grouped together because they are clinically alike and carry a similar range of associated costs (Northcott and Llewellyn, 2003; Jones, 2001). The groups are derived from the International Classification of Diseases and the Office of Population Censuses and Surveys (Robson, 2008). These HRGs are then used in a weighted average statistical process to calculate the NRCI.

This initiative, which has been described as a central feature of the new system, reflects the commitment of the NHS to produce reference costs on a consistent basis and to publish them in a national schedule (Ellwood, 2000). The NRCE has been seen as substantially changing the way in which healthcare cost information is compiled, reported and used to manage NHS trusts.

(Northcott and Llewellyn, 2002). It was expected to give significant insight into how costs are incurred in NHS trusts and how cost efficiency, and in turn performance, might be improved (Northcott and Llewellyn, 2002). Most importantly, the NRCE was supposed to provide a more developed language for the interaction between clinicians and administrators, which would be useful in terms of encouraging clinicians to be more committed to the managerial aspect of performance. Similarly, it was hoped that the publication of the NRCI would help trusts to develop a new, shared language (Robson, 2008; Jones, 1999b). However, while the calculation of HRG costs has gone some way towards encouraging the involvement and interest of clinicians, questions remain about the NRCE's rigour and usefulness, which rely upon cost information being standardised across hospital trusts (Northcott and Llewellyn, 2002). This is problematic because the high proportion of indirect costs involved and the variety of methods used to allocate costs to HRGs make healthcare costs difficult to define with a high degree of consistency (Ellwood, 2000).

Northcott and Llewellyn, (2002) identify three main challenges that need to be tackled if the NRCE is to be an effective tool for cost benchmarking. These include the diversity in costing practices, particularly in how trusts establish their cost care profiles and attribute indirect costs; problems with information quality, particularly the calculation and coding of individual patients' healthcare activities and limitations in the NHS's information systems; and the heterogeneous nature of cost objects, particularly the assumptions pertaining to HRG case-mix and length of stay, which are seen as flawed. However, despite its perceived shortcomings, the NRCE has become routine practice in trusts, and refined versions of reference costs have continued to be published annually, reflecting the average cost per defined procedure in each hospital (Uslu and Conrad, 2011).

The focus on performance improvement was coupled with a huge increase in funding for the NHS, along with changes to the procedures by which resources are allocated (Allen 2009). For the first time, patients were given the choice of when they were treated and where. The significance of the patient choice policy is that it determines not only who provides the care, but which hospital trust gets the resources (Ferry and Scarparo, 2015). Patient choice is intended to give individuals more choice and a stronger voice, and to serve as a mechanism for enhancing service quality, given that patients are likely to avoid under-performing hospitals (Allen, 2009). The new funding system introduced alongside patient choice was the payment by results (PbR) policy (Harradine and Prowle, 2012). The latest development in over two decades of experimentation in resource allocation (Allen, 2009), PbR broke new ground by giving greater visibility to clinical activity, and by using national average HRG costs as a basis for paying hospitals for the actual activity carried out (Conrad and Uslu, 2011).

Under PbR, hospitals are paid a standard tariff price (the national average of reported reference costs for defined procedures) for their actual activity rather than, as previously, on the basis of block contracts (Uslu and Conrad, 2011). Prior to PbR, the price per activity unit was as a consequence of the negotiation regarding the overall contract. Now that tariffs are determined nationally based on the average cost for the whole country, trusts are able to know in advance how much funding they will receive if they increase their activity (Mannion, et al., 2008). The policy aims to give trusts a financial incentive to attract additional patients and provide a better service (e.g. by improving quality and access times). Conversely, if they fail to raise performance and patients go elsewhere, they risk losing the funding that follows those patients. The result is to forge a closer link between the actual activities carried out by trusts and the funding they receive (Ferry and Scarparo, 2015; Allen, 2009).

The introduction of PbR has led trusts to focus increasingly on the profitability of individual treatments (Kurunmäki and Miller, 2008). This in turn has led the NHS to introduce service-line reporting (SLR), a new approach to providing information on profitability at service-line level (Harradine and Prowle, 2012; Kurunmäki and Miller, 2008). SLR is a financial reporting system that links the income earned from a business activity with the associated costs, allowing the contribution or profit derived from that activity to be easily identified (Harradine and Prowle, 2012). SLR provides a framework for NHS trusts to capture an overall view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at directorate or trust level (Grant, 2015). It was anticipated that SLR would produce numerous benefits, including more efficient use of resources, enhanced operational and strategic decision making and greater clinical engagement (Harradine and Prowle, 2012). Overall, it was expected to allow managers and clinicians to develop a better understanding both of the financial and operational performance of individual specialities within the service line and of the trust as a whole (Kurunmäki and Miller, 2008). However, methodologically speaking, SLR is simply a top-down cost allocation exercise in which known direct costs are assigned to individual service lines and topped up with a centrally decided portion of general overhead (Grant, 2015). Consequently, although the system gives a financial and operational picture of a service line (Vogl, 2013), which might be useful in showing which services are more profitable, which need improvement, and which need to be developed (CIMA, 2008), it does not show the cause-and-effect relationship between cost and activity (Vogl, 2013). Nor does it explain why certain costs are incurred, why they are at a particular level or who is responsible for them (CIMA, 2008).

It has been argued that the introduction of PbR has given MA a substantial role in performance management (Conrad and Uslu, 2011). One of the most important benefits of PbR is the development of the relationship between clinicians and managers through the attachment of

funding and costing to specific medical procedures (Ferry and Scarparo, 2015). In this context, MA acts as a channel for different actors to communicate about hospital activities; Uslu and Conrad, (2011) argue that both accountants and clinicians are motivated to communicate information for the purpose of performance improvement and that, despite the challenges of communicating technical ideas (be they medical or financial) to the other side and the continuing influence of a long-established power relationship, the two groups work more closely together than ever before. The main issue as far as MA's usefulness is concerned is the quality of the clinical and cost data it generates; since payment under PbR is based on the trust's actual activity, this data must be accurate and comprehensive if the policy is to be successful (Mannion, et al., 2008; Grant, 2015). This has led some to argue that the increasing importance of accurate coding of medical activity for the purposes of income management has had a direct influence on the need for, and been the catalyst of, improved communication between accountants and clinicians (Conrad and Uslu, 2012; Uslu and Conrad, 2011).

The above discussion highlights the importance of integrating clinical activity data and cost data, and the need for a more sophisticated system to link the two in hospital trusts. The government has responded by introducing patient-level costing into the NHS using patient-level information and cost systems (PLICS) (Harradine and Prowle, 2012). These IT systems combine activity, financial and operational data to cost individual episodes of patient care (Ellwood, et al., 2015). As opposed to the top-down approach, in which costs are collected into departments or cost centres, in PLICS, the patient is the basic unit into which costs are collected (CIMA, 2008). In a bottom-up process, the unit cost is identified for every intervention or resource and these costs linked to individual activities to assign the value of consumption at the patient level. Although overhead allocation is a part of the process, there is a transparency of logic for this, resulting in more accurate costs on a case-by-case basis (Grant, 2015).

NHS Improvement (NHSI), the sector regulator established in 2016, has strongly emphasised the necessity of adopting PLICS in all NHS trusts, pointing to a range of potential benefits including: (1) an enhanced ability to understand financial drivers, enabling cost benchmarking at patient, specialty and hospital level; (2) dramatically improved clinical ownership of costs that will enable comparison of the cost profiles of different clinicians for similar patients; (3) a more detailed understanding of individual patient costs to better inform patient classification (compared to relying on average cost); (4) facilitation of the progress of PbR by calculating a long-term sustainable price to an efficient provider; and (5) informed dialogue between providers and commissioners (Llewellyn, et al., 2016).

The main principle of PLICS is that utilisation data is linked to cost data, which can then be aggregated into activities that contribute to the final outcome of patient care. This allows the cost of activities to be determined even when they extend across multiple departments (Blunt and Bardsley; 2012). PLICS allow the trust to capture costs at the level of individual patient activities, enabling it to determine the treatment cost for an individual patient throughout their care episode, in a way that reflects the complexities of each case. As a result, a desirable level of analysis can be provided (CIMA, 2008). NHSI expects the system to transform cooperation between accountants and clinicians (Llewellyn, et al., 2016), but sceptics have pointed out that changing MA is difficult in almost any organisation, especially when it necessitates overcoming the resistance of professionals (Padovani, et al., 2014). The environment must be receptive to change, but the initiative is also more likely to be accepted if it is seen as a choice rather than as something centrally imposed (Abernethy, et al., 2006). Fiondella, et al., (2016) argue that the literature has generally struggled to clarify the reasons why successive MA initiatives have succeeded or failed within healthcare organisations, but as Malmi (1997) points out, a correct diagnosis and a clear strategy for enabling change are central to implementing new initiatives successfully.

2.9 Research Gaps

From the existing literature reviewed in the previous sections, there seems to be a gap in relation to the context in which MA it operates. Most of which focuses on acute care context rather than community care context. The literature of MA practices in the NHS shows a very little or no empirical evidence on the role of MA in the community health services (e.g. mental health services and families, young people and children services). The MA literature has long advocated the importance of studying the role of MA within its organisational context (Hopwood, 1974; Chapman, et al., 2009). According to Roberts and Scapens (1985), the only way to understand MA practices is by understanding the organisational reality in which they operate and for which the accounting systems are designed. The role of MA in the community health services has been ignored in the literature focusing only on its role in the acute health services. Little is known about the complexity of factors that determine and shape the MA role in the community health services in the NHS. Accordingly, this study seeks to bridge that gap in the MA literature between acute and community health services by locating and conceptualising MA within its organisational context (i.e. community healthcare).

In this thesis, the discussion is around the relevant lost debate of MA in the community health services of the NHS. The literature review reveals a lack of empirical evidence regarding various perspectives of that debate. There are gaps need to be addressed in issues such as the strategic role of MA, the business partner role of MAs, the balance conception and conflict between quality and efficiency, the interaction of front-line clinicians with MA information, the beyond budgeting debate, the complexities, conflicts and tensions of adopting and implementing new MA techniques such as PLICS system. All of these issues about the role of MA in the community health service are really worth further investigation. Considering these related research gaps; this study thus aimed to analyse the process and outcome of MA at the strategic, managerial and operational level in the community health services of the NHS. In the

following chapter, the conceptual framework with the theoretical approach used to explain the interaction of MA with its context (the community health service) are discussed.

2.10 Conclusion

The chapter begins with a brief definition of MA and its role within today's business environment. The discussion emphasises the broadening scope of MA, which is now understood not just as a set of practices but as a function that has the potential, in partnership with other functions, to add value to an organisation. The chapter summarises the main role of MA as being to support decision makers in performing a variety of management tasks including planning, controlling and performance measurement, though the information it generates can also be used in turn to monitor, measure, evaluate and reward the action and performance of these decision makers (Sprinkle, 2003). However, growing awareness of the limitations of traditional MA has led to attempts to give it a more dynamic role (Gupta and Gunasekaran, 2005).

The chapter shows how MA has responded to the changes in the business environment not just with the introduction of a variety of new techniques but also with the evolution of the role of management accountants into hybrid accountants. It explains how the traditional version of MA has developed into a management control system better suited to the increasingly complex and dynamic modern business environment (Chenhall and Moers, 2015). Indeed, the review of the literature confirms that far from being static in nature, dynamism has become a defining feature of contemporary MA practices (Sulaiman and Mitchell, 2005).

The chapter shows that MA in NHS trusts has developed from being customised, inward-looking and control-based to being market-based (Jones and Mellett, 2007). Its role in the implementation of the policy has evolved significantly over the years. Most importantly, it has come to play a much more prominent and broader role within the domain of clinical activities,

with cost accounting now closely linked to clinical effectiveness and quality of care, data being gathered on a national basis for scrutiny and benchmarking, and budgets being aligned with clinical responsibilities (Lapsley, 2001b).

The chapter shows the lack of empirical evidence regarding the role of MA in community health services. The role of MA in the community health service is largely unexplored thus the thesis seeks to fill the research gap in the literature of MA between acute health service and community health service

Chapter 3. The Theoretical basis and Conceptual framework

3.1 Introduction

The literature review discussed in the previous chapter indicates that MA has steadily evolved from a traditional, cybernetic approach to control, operating within a closed system and paying little attention to adaptive processes, into a more dynamic, complex, open system designed to facilitate internal processes for better resource management (Chenhall and Moers, 2015). It shows that MA's role in general, and particularly in NHS trusts, is shaped by a complex fabrication process that is highly contingent on political, social and economic conditions (Jones and Mellett, 2007; Pettersen, 2001). The contingent nature of MA calls for the adoption of the contingency theory perspective. Accordingly, this chapter provides an overview of the contingency theory of MA that underpins the empirical investigation of the contingencies influencing the role of MA in the community health services. It discusses the criticisms of contingency based studies in MA and support the significant of adoption post contingency theory to fill the gap in the literature. The chapter also presents a contingency framework employed in this thesis to explore the role of MA within the context of one NHS community health trust. The framework is proposed to understand the complex mish-mash of inter-related influences which shape practices of MA in the community health Trust.

The chapter is organised as follows. Section 3.2 gives an overview of contingency theory of Management Accounting. Section 3.3 then considers the criticisms of contingency-based studies in MA. An alternative approach to applying the contingency theory in this thesis discusses in section 3.4, while section 3.5 provides an overview of the balanced scorecard (BSC) and its superior in this research. Section 3.6 presents the conceptual framework proposed in the thesis. The chapter concludes with a brief summary in section 3.7.

3.2 An overview of Contingency Theory of Management Accounting

The contingency theory of management accounting was formulated in the 1970s as part of a broader attempt to explain the range of MA practices that were in use at the time (Otley, 2016). It relied heavily upon the contingency theory of organisational structure that had been evolved over the previous twenty years to codify which forms of the organisational structure were most appropriate to specific circumstances (Otley, 2016). The contingency approach to management accounting assumes that there is no universally appropriate MA system that applies equally to all organisations in all circumstances (Otley, 1980). Under contingency theory (CT), MA is not seen as a separate discipline with its own set of procedures and measurement systems to be applied in all firms regardless of their underlying values, goals and strategies (Kaplan, 1996), but as a system that must be adapted to suit each organisation's unique needs, industry, objectives, problems, resources and style of management (Coates, et al., 1996).

Since the 1970s a lot of contingency-based studies in MA have been conducted to explore the contingent nature of MA and how it is influenced by a set of contingencies within which the organization operates. These studies have tried to explain the effectiveness of MA, in assisting managers to achieve some desire organisational outcomes or organisational goals, by examining designs that best suit the nature of the environment, technology, size, structure, strategy and culture (Chenhall,2003). They tend to explore under what circumstances management accounting systems work better or worse (Wickramasinghe and Alawattage, 2012).

Otley (1980) identifies three main concerns for researchers adopting CT to investigate MA. The first of these is to identify which specific aspects of MA are associated with certain defined circumstances and whether they are an appropriate match. However, the challenge here is to determine the specific characteristics of the MA system. The literature emphasises the importance of adopting a package of practices rather than focusing solely on one practice in

isolation (Malmi and Brown, 2008). This is reflected in the emergence of the concept of MCS as a package of practices that are used by managers to ensure that the behaviours and decisions of their employees are consistent with the objectives and strategies of the organisation (Malmi and Brown, 2008). Héroux and Henri (2010) explain that the concept of MCS is understood in a wide range of ways, from the narrow view of MCS as traditional feedback and cybernetic process to a broader view encompassing almost everything managers do to acquire, deploy and manage resources.

The second concern for MA researchers employing CT is how the defined circumstances should be selected (Otley, 1980). Understanding why accounting is practised in a particular way and how it influences behaviour involve considering MA as part of a bigger context within which it carries a specific meaning and significance (Messner, 2016). Under CT, context is conceptualised as a set of factors that determine whether a particular MA system is more or less appropriate for an organisation (Messner, 2016; Chenhall, 2003). The premise of CT is that since MA is adopted to assist in achieving specific desired organisational outcomes, it will inevitably be influenced by the organisation's features and environment (Otley, 1999); the particular features of the chosen MA will, therefore, reflect the specific circumstances surrounding it (Otley, 1980). CT focuses on the contingent factors associated with these circumstances and their relationship with MA systems and effectiveness (Wickramasinghe and Alawattage, 2012). These factors can be categorised as either environmental or organisational (Wickramasinghe and Alawattage, 2012); major environmental factors include technology, market competition or hostility, environmental uncertainty and national culture, while organisational factors include organisational size, structure, strategy, compensation systems, information systems, psychological variables (e.g. tolerance for ambiguity), the level of employee participation in the control systems, market position, product life-cycle stage, and system change (Otley, 2016).

Although often used interchangeably with MA, MCS is generally seen as broader in scope, encompassing MA plus other controls such as personal or clan controls (Chenhall, 2003). Within the MCS package, MA can be seen as the calculative practices that facilitate better resource management (Chenhall and Moers, 2015; Wickramasinghe and Alawattage, 2012). However, as explained in section 2.7, MA has been developed into a more complex system combining traditional budgetary control and cost accounting systems with new practices such as strategic MA, BSC and ABC (Chenhall and Moers, 2015).

The final concern for researchers is to identify how MA practices fit with the organisational context; in other words, the matching of MA mechanisms to contingencies. Drazin and Van de Ven (1985) identify three forms of fit, namely selection, interaction and systems. These forms have been adopted widely in the literature to describe the relationship between context and MA (Chenhall, 2003). The researcher's choice of form will influence both how they interpret CT and the empirical results they can expect to get. Those concentrating on selection describe the MA-context relationship but are not generally interested in its influence on performance. Those concentrating on interaction are more interested in exploring how context moderates the relationship between MA and performance, while those focusing on systems aim to describe the interactions between MA and various dimensions of context with a view to improving effectiveness (Drazin and Van de Ven, 1985; Chenhall, 2003).

3.3 Criticisms of contingency-based studies in MA

Contingency-based studies in MA have been criticised in the literature due to several shortcomings. In his critical review of the literature on the contingency theory of MA, Otley, (2016), trace the expansion of this literature and criticise the contingency approach used to discover the effectiveness of MA as it has not yet provided the universal solution to the problems in organisational control. He notes that although studies over the past four decades have come up with an extended list of possibly significant contingencies that are faced by

organizations, many of which suggest conflicting recommendations in determining the effectiveness of MA. Wickramasinghe and Alawattage, (2012) discuss the criticisms of contingency-based studies in MA and categorise them into conceptual and methodological problems. The conceptual problems of contingency-based studies in MA are related to the narrow definition of the MA and the circumstances in which it operates (the context) (Otley 2016). According to Wickramasinghe and Alawattage, (2012), contingency-based studies neglect the evolution of the meaning of 'management accounting and control systems' into post mechanistic form whereby MA has shifted into a regime of providing more informal and non-financial information, and , to a large extent, still focuses on traditional accounting tools such as budgeting, rather than on emerging techniques, such ABC and the BSC. Chenhall, (2003) confirms the difficulty in studying specific elements of MA in isolation from other organizational controls. Thus, if specific accounting controls are systematically linked with other organizational controls, studies that exclude these elements within the research method may report false findings.

In terms of the context problem, Wickramasinghe and Alawattage, (2012), note the lack of clarity in the definitions of variables (contingencies) which has led to replicate what seminal writers found, rather than making a real contribution to knowledge. For example, most of the studies did not contextually define what 'environment' means. Researchers inadvertently have neglected an important environmental aspect of how broader socio-economic and institutional contexts shape accounting systems in organizations. There are also practical limitations to understanding the complex interactions that may exist between more than a very few contingent variables at a time (Otley,2016). A further criticism related to the context is that the public and non-profit sector is largely absent in these studies (Helden, and Reichard, 2019). Contingency theory as Woods, (2009) argues has been developed within a private, manufacturing-oriented organisational context, which is contextually very different from the world of public sector

service provision, where services are not sold in the open market for a profit. He asserts the importance of discuses a set of contingencies that are specific to the public sector since the general contingent factors discussed in the literature is not well suited to the public sector. Consequently, and as Chenhall, (2003) indicates, there is a need for more studies into service and not-for-profit organizations as these entities become increasingly important within most economies.

On the other hand, contingency-based studies in MA suffer from methodological problems relying on traditional, functionalist theories and has not applied more interpretive and critical views (Chnehall,2003). In his review, Otley, (2016) observes that survey-based studies are by far dominant, while in-depth qualitative studies form a small minority. He comments "*it is perhaps unfortunate that the term 'contingency' has now become associated only with the methods typically employed in this strand of research. Whilst recognizing the knowledge that has been gained from these studies it seems likely that further progress is most likely to be obtained from deploying a much wider range of research approaches, given the complex nature of the phenomena being studied"*. Wickramasinghe and Alawattage, (2012) argue that this method did not produce a deeper understanding of how organizations and their accounting systems react to contingencies, while the data collected is analysed through cross-sectional analysis methods. These methods merely test the relationship between dependent (accounting information system) and independent (contingency) variables. Other than discovering whether the relationship is statistically significant or not, nothing can be explained. The only methodological advantage is to test predetermined hypotheses. Therefore, researchers have called for more detailed and in-depth studies to eliminate this methodological problem. Responding to these calls, some researchers conducted a case study and provided contingency theory explanations. Wood, (2009) conducts a case study to explore the contingencies in government. He highlights the way in which different styles of research can reveal very

different stories. He emphasises that Using a survey-based approach, provides the researcher with a generic picture of the control system, but case study research can be used to “fill the gaps” and enrich the findings. Survey-based studies could be useful for determining broad trends in practice and specific features of MA across a number of organisations but do not provide substantively rich and details understanding of underlying organizational and social realities about the functioning of MA (Wickramasinghe and Alawattage, 2012).

3.4 An alternative approach to applying the contingency theory in this thesis

CT is particularly relevant in this thesis because it can provide an explanation of how organisational and environmental context are implicated in the processes and outcomes of MA (Chenhall and Moers, 2015). It can thus help in exploring organisations and the role of MA within the organisational context (Chenhall, 2003). According to Scapens (2006), explaining MA requires one to make sense of the complex web of factors which shape its role in individual organisations. In the case of the healthcare sector, the systematic effect of a broad range of internal and external factors on MA implementation processes is still unexplored (Fiondella, et al., 2016). From a conceptual perspective, MA represents a resolution of a set of forces acting on it. Some of these are internal while others are external, and some may complement each other while others work in opposition (Jones and Mellett, 2007).

The thesis strives to eliminate the conceptual and methodological problems of CT in MA studies discussed earlier and provide an interpretive and critical view to bridge the gaps in contingency-based studies. A post contingency theory is applied to investigate in more depth the broader aspect of the contingent nature of MA by taking the broader package approach to explore the role of MA in one community health trust. Although often used interchangeably with MA, MCS is generally seen as broader in scope, encompassing MA plus other controls

such as personal or clan controls (Chenhall, 2003). Within the MCS package, MA can be seen as the calculative practices that facilitate better resource management (Chenhall and Moers, 2015; Wickramasinghe and Alawattage, 2012). However, as explained in section 2.6, MA has been developed into a more complex system combining traditional budgetary control and cost accounting systems with new practices such as strategic MA, BSC and ABC (Chenhall and Moers, 2015).

Prowle and Lucas (2016) argue that MA has developed to meet the needs of managers at different organisational levels, from its initial concern with tactical/operational management to its growing focus on strategic management issues. As a consequence, and from a conceptual perspective (see Figure 3.1), the potential role of MA and its actual role may be discerned in its contribution to strategic, managerial and operational performance. For practical purposes, it was necessary to focus on MA practices that fit with the objectives of the thesis: the balanced scorecard (BSC), budgetary control systems, cost accounting systems and the role played by management accountants. However, to reflect the interpretive view adopted in the thesis, and to fill the methodological gap of contingency-based studies in MA, the focus is not just on the existence of these practices but on how they are applied and the organisational consequences of their application (Otley, 1980). The researcher conducts an intensive single case study and spends significant time within the trust. The data collected using mainly interviews and observations to provide a deeper understanding of how the trust and its MA react to contingencies rather than for example cross-sectional analysis based on survey method that create a distance between the knowledge of practices and the data being collected.

The context explored in this thesis is one community NHS trust, a public-sector organisation. This fills the gap with regard to the organisational context in which the majority of contingency-based studies focused (a private, manufacturing-oriented organisational context). The researcher has drawn on the literature to identify a set of factors that are particularly

appropriate for exploring MA in the context of the public health sector. These factors are categorised under four headings: environmental, organisational, control packages and manner of MA use. In the trust featured in this thesis, MA is employed to serve various, often contradictory demands. To reflect these circumstances, the system approach has been adopted to provide a more holistic view of the appropriateness of the trust's MA systems in relation to the multiple contingencies of the context (Fisher, 1995). Fisher (1995) argues that the demands placed on MA systems in multiple contingency contexts such as NHS trusts may be conflicting; attempts to satisfy one demand may mean that other demands cannot be satisfied. The thesis, therefore, assumes a state of so-called sub-optimal equifinality, in which top managers must make a trade-off between contextual demands. The factor that is seen as most important will determine what the MA structure looks like (Gerdin, 2005). The conflicting contingency approach recognises that there may be a degree of a misfit as the organisation attempts to respond to multiple contingencies (Fisher, 1995) and that MA may, therefore, play a sub-optimal role.

The idea of a contingency fit, as Otley (2016) discuses, requires some measure of effectiveness to act as a criterion variable. A good contingent fit, rather than poor fit, would lead to achieving higher effectiveness. In this thesis, the effectiveness of MA in supporting organisational performance contingent on its ability to provide information useful for achieving "*equilibrium conditions*". The effectiveness of the MA role relies upon its ability to support the trust adapt to its environment. In other words, it depends on its ability to fit with the organisational context. In this environment, the necessity of satisfying multiple and potentially contracting goals and aligning operative goals with strategic goals is crucial for achieving the equilibrium or fit condition (Chenhall, 2003). Due to the complexity of the political and social context of the NHS and the variety of information needs with conflicting objectives, more advanced practices of MA such as BSC needs to be applied if MA is to be kept in the state of fit (equilibrium)

which is essential for survival. The BSC has promise for addressing diverse of these needs because the core idea of the BSC lies with the balancing of multiple organisational goals (Bobe, et al,2017). This thesis considers MA as a mix of elements within the package of MCS. These elements combine traditional (discussed in chapter two) and innovative practices such as BSC to enable management accountants to deploy resources more effectively.

3.5 An overview of the balanced scored card (BSC)

As explained in chapter two, traditional MA, especially in the public sector, pays much more attention to the outcomes reports that are mainly described in monetary and ratio terms to verify whether the intended outputs have been achieved, while issues (means and determinants) that lead to these outcomes are neglected. This is particularly true in the NHS context where MA pay much more attention to measuring the result (i.e. meeting the budget target) at the expense of what Fitzgerald, et al, (1991 cited in Kloot and Martin, 2000), describe the determinants (secondary objectives) of organisation performance. This thesis argues that although performance measurement plays a critical role in an organisation revealing how well the organisation achieve its primary objectives and identify required improvement, it should not be an end in itself. Measuring performance will have no impact unless action is taken as a consequence of the performance measure (Fitzgerald,2007). Therefore, MA in NHS trusts should pay much more attention to performance management when measurement system is linked in an integrated, holistic way to the trusts' strategic choices so that overall efficiency and effectiveness of the trusts' operations are improved (Kloot and Martin,2000). The BSC that has been developed from the communication and measurement tool to a strategic management system can provide this desire. It is built on the idea that the success of any organisation depends not just on the financial dimension but also on other dimensions such as product and service quality, employee capability and customer loyalty (Kaplan and Norton, 1996). These non-financial measures have been seen as drivers of financial performance and

leading indicators of future success (Fitzgerald, 2007). The BSC enables an organisation to measure how it creates value for public and to identify ways of improving future performance (Kaplan and Norton, 1996); it maintains focus on the financial objectives while also taking account of the drivers that help it achieve these financial objectives. Otley (2001) sums up the main strength of the BSC as being its ability to deal with multiple dimensions of performance and many different stakeholders, including those with conflicting interests. Albright and Lam (2006) argue that the main advantage of the BSC is that it employs a range of measures – common and unique, financial and non-financial – to link strategy with performance. In the BSC, mission and strategy are translated into measures and objectives across four dimensions: financial, customer, internal business process, and learning and growth. In the financial dimension, measures such as revenue growth, cost reduction/productivity improvement and asset utilisation/investment strategy are used to give shareholders a picture of the organisation's progress in terms of meeting its long-term objectives. In the customer dimension, measures such as customer satisfaction, customer retention, customer profitability and new customer acquisition give a picture of the organisation's relationship with this set of stakeholders, while the internal business process dimension focuses on those areas in which the organisation must excel to satisfy both customers and shareholders, such as quality, cycle time and cost. Finally, in the learning and growth dimension, the focus is on the internal skills and capability that are necessary to achieve the strategic objectives for the financial, customer and internal process dimensions. This dimension includes measures such as employee satisfaction, training and skills; the time given to training employees; and the alignment between employee reward and organisational success factors (Kaplan and Norton, 1996).

The BSC was initially created as a holistic performance measurement tool that would translate the strategy of an organisation into measures and actions to support its achievement of the desired level of organisational performance (Hoque and Adams, 2011). Each one of the four

dimensions within the BSC includes objectives, measures and targets, along with the actions and procedures needed to achieve these targets (Kaplan and Norton, 2001a). At the core of the BSC is the assumption that the four sets of measures are linked together in a causal chain relationship; the learning and growth measures lead to the internal business process measures that lead to the customer measures that finally lead to the financial measures. Each dimension should include both lead and lag indicators, with a good balanced scorecard including a mix of outcome measures (lag indicators) and performance drivers (lead indicators) creating two-directional causal chains (lead and lag indicators apply horizontally within the dimensions and vertically between dimensions). The cause-and-effect paths from the measure indicators on the scorecard should finally be linked to the financial objectives (Kaplan and Norton, 2001b; Kaplan and Norton, 1996). Strategy is thus translated into a group of hypotheses about cause and effect (Norreklit, 2000). This allows managers continually to monitor the most important issues in the organisation's day-to-day work and to direct their efforts to those areas needing improvement (Hoque, 2001).

In the so-called first generation of BSCs, objectives and measures were set out in each dimension, along with specific targets to facilitate success at the three levels of goal, perspective and overall scorecard. The aim was to provide information that would enable organisations to direct their performance towards the achievement of strategic objectives (Schobel and Scholey, 2012). In later versions, the BSC was refined to become a framework for a strategic management system designed around long-term strategy (Kaplan and Norton, 2001a). Kaplan and Norton (2001b) argue that the BSC is not simply a set of financial and non-financial measures categorised into four or five dimensions but a comprehensive and coherent system of linked measurements connecting performance measurement to strategy and revealing the cause-and-effect links that explain the strategy's underlying hypotheses. What makes the BSC a comprehensive and coherent system for implementing strategy rather than just an

operational checklist is the tighter linkage between the measurement system and the strategic function. Organisations have come to realise that the BSC can play a substantial role in the strategic management process, assisting managers in explaining and obtaining general agreement upon the strategic objectives, helping them communicate the selected strategy, and thus aligning the efforts of departments and individuals (Barnabè, 2011).

This has led some to argue that the starting point in designing a BSC should not be the setting of goals or the creation of a set of measures, but a narrative description of the organisation's strategy, articulated in highly concrete terms (Bisbe and Barrubés, 2012). Strategy maps may be used in this context to aid organisations in describing and implementing strategy. Translating strategy into the logical and comprehensive architecture of a strategy map and balanced scorecard enables organisations to create a common and understandable point of reference for all units and employees within the organisation. The map offers a visual representation of the cause-and-effect relationships among the components of an organisation's strategy, starting at the top with the intended destination and charting the tracks that will lead there (Kaplan and Norton, 2001b). Strategy maps develop the notion of strategic linkages not only between measures but also between strategic objectives, strengthening these strategic linkages by articulating their cause-and-effect nature (Lawrie and Cobbold, 2004). The aim is to enable managers to determine what changes are most likely to yield the desired outcomes (Perkins, et al., 2014), but strategy maps may also be useful for organisations in terms of showing how one objective drives another and hypothesising how a given strategy might be achieved within an integrated and cohesive system. Barnabè (2011) defines strategy maps as essentially diagrams that are used to describe how an organisation produces value by linking strategic objectives into causal relationships within the four dimensions. They offer a qualitative tool for looking at organisational strategy at the micro level, before formulating measures for evaluating the organisation's performance against strategic targets. The measures

in this second generation of BCSs are thus selected directly according to specific strategic objectives, with each strategic objective being linked to one or more measures and attached to one of the four BSC dimensions (Kaplan and Norton, 2001b).

To sum up, the BSC in this thesis is seen as superior to the others because of its ability to highlight the links between various areas of organisational performance such as financial and non-financial or internal and external. It provides a holistic framework for translating an organisation's strategic objectives into a coherent group of performance measures. These measures, aligned with strategy, not only provide substantial information regarding the progress of strategy implementation but also encourage organisational behaviour to be more consistent with this strategy (Hoque,2014).

3.6 Conceptual Framework

The literature review indicates that MA has steadily evolved from a traditional, cybernetic approach to control, operating within a closed system and paying little attention to adaptive processes, into a more dynamic, complex, open system designed to facilitate internal processes for better resource management (Chenhall and Moers, 2015). It shows that MA's role in general, and particularly in NHS trusts, is shaped by a complex fabrication process that is highly contingent on political, social and economic conditions (Jones and Mellett, 2007; Pettersen, 2001). The contingent nature of MA calls for the adoption of the contingency theory perspective. Accordingly, this thesis employs a contingency framework to explore the role of MA within the context of one NHS community health trust.

From the conceptual perspective, the potential role of MA, or what Scapens (1994) calls the conventional wisdom of MA (i.e. the theory), depends on whether it is a simple or complex system. A simple, traditional MA system may be more relevant for organisations operating in a static business environment with clearly defined conditions and formal rules. This kind of

system focuses mainly on delivering efficiency and is likely to feature responsibility accounting, budgetary control and formal top-down reporting. In contrast, more complex systems, which may be more relevant where business conditions are uncertain, tend to place a greater focus on flexibility. Such systems are likely to incorporate non-financial performance measures and may feature the deployment of ABC, BSC and MAs as business partners (Wickramasinghe, 2015).

MA's actual role in community healthcare is shaped by the multiple contingencies faced by trusts and their efforts to serve varied, often contradictory, demands. The first of these contingencies is the extent to which the organisation is oriented towards either control or flexibility (seen as competing values in the literature) (Henri, 2006a); more flexible organisations tend to focus on long-term strategic performance, innovation and bottom-up empowerment, while more control-oriented organisations prioritise short-term performance, efficiency and top-down control. Another contingency that has a major impact on the role of MA in NHS community trusts is the government's priorities and policies (Woods, 2009), with external political and regulatory pressures to comply with these policies and meet targets being a key determinant in MA adoption (Ma and Tayles, 2009). These pressures may even outweigh technical criteria or concerns about economic efficiency (Woods, 2009) and lead trusts to adopt practices such as the BSC or ABC which are not economically rational in the circumstances (Hoque and Adams, 2011). Where MA is aligned with regulator pressure, it may help facilitate the marginalisation of some constituent interests (Modell, 2012).

Another contingency influencing the effectiveness of MA is clinicians' information needs and their attitudes toward MA information (Jacobs, et al., 2004). The problem in the relationship between MA and clinicians is that clinicians regard MA as a managerial tool aimed at controlling and driving clinical decisions – that is, as a threat to their professional autonomy (Cannavacciuolo, et al., 2015, Lapsley, 2007). Over the years, MA initiatives have failed in the

NHS either because they ignored the information needs of clinicians or because they were perceived as designed to suit regulatory requirements rather than to support clinical performance (Jacobs, et al., 2004). The effectiveness of MA's role has been restricted because it has been unable to adapt to the dominance of clinicians and overcome their resistance (Jacobs, et al. 2004). To be effective or even useful to clinicians, MA practices must provide information that draws their attention to the importance of resource management and the cost consequences of clinical decision making (Abernethy and Vagnoni, 2004). The evidence from the literature suggests that MA practices will not be welcomed by clinicians unless they are seen as part of a system of medical quality control (Fiondella, et al., 2016).

The final contingency considered in the framework is the management control package. MA was considered as only one part of an overall organisational/management control package. Otley (1980) argues that the control package may be narrow (i.e. the traditional feedback and cybernetic process) or broad (everything the organisation does to acquire, deploy and manage resources) in scope (Héroux and Henri, 2010). In this study, the management control package is understood as a set of formal and informal controls that are used by management to ensure that the behaviours and decisions of employees are consistent with the objectives and strategies of the organisation (Malmi and Brown, 2008). Consequently, this study assumes that MA's effectiveness is influenced not only by contextual factors but also by other controls such as the organisation's cultural values and structure (Grabner and Moers, 2013; Mitchell, et al., 2013). In this aspect, it is important to consider which factors would be classified as management control packages and which ones as contextual factors. Otley (1980) discusses this issue and defines the contingent factors as those that are outside of the control of the organisation, while those factors believed to be controllable by the organization are not considered to be contingent variables, but rather part of the package of organizational controls selected for use. This thesis considers this classification and thus factors such as organisational structure, strategy, training,

IT, Block contract, the degree of budget delegation and all financial and organisational arrangements were treated as part of the Trust's management control package. It has been argued that organisations need to consider and if necessary adjust the mix of practices, and the way these practices are used within their management control package, to balance competing demands and to control the inherent tensions between freedom and constraint, empowerment and accountability, top-down direction and bottom-up creativity, and flexibility and efficiency (Kominis and Dudau, 2012). MA's role depends on how it is deployed within the control package but meeting the demands of conflicting contingencies may leave it unable to achieve optimal performance. Figure 4.1 illustrates the concept and the thematic relationships that form the conceptual framework of the thesis that provides the means to the analysis and the interpretation of the process and outcome of MA in the Trust. It demonstrates the contingencies that determine its effectiveness to serve different roles within the trust and then identifies how can improvement to its role be made.

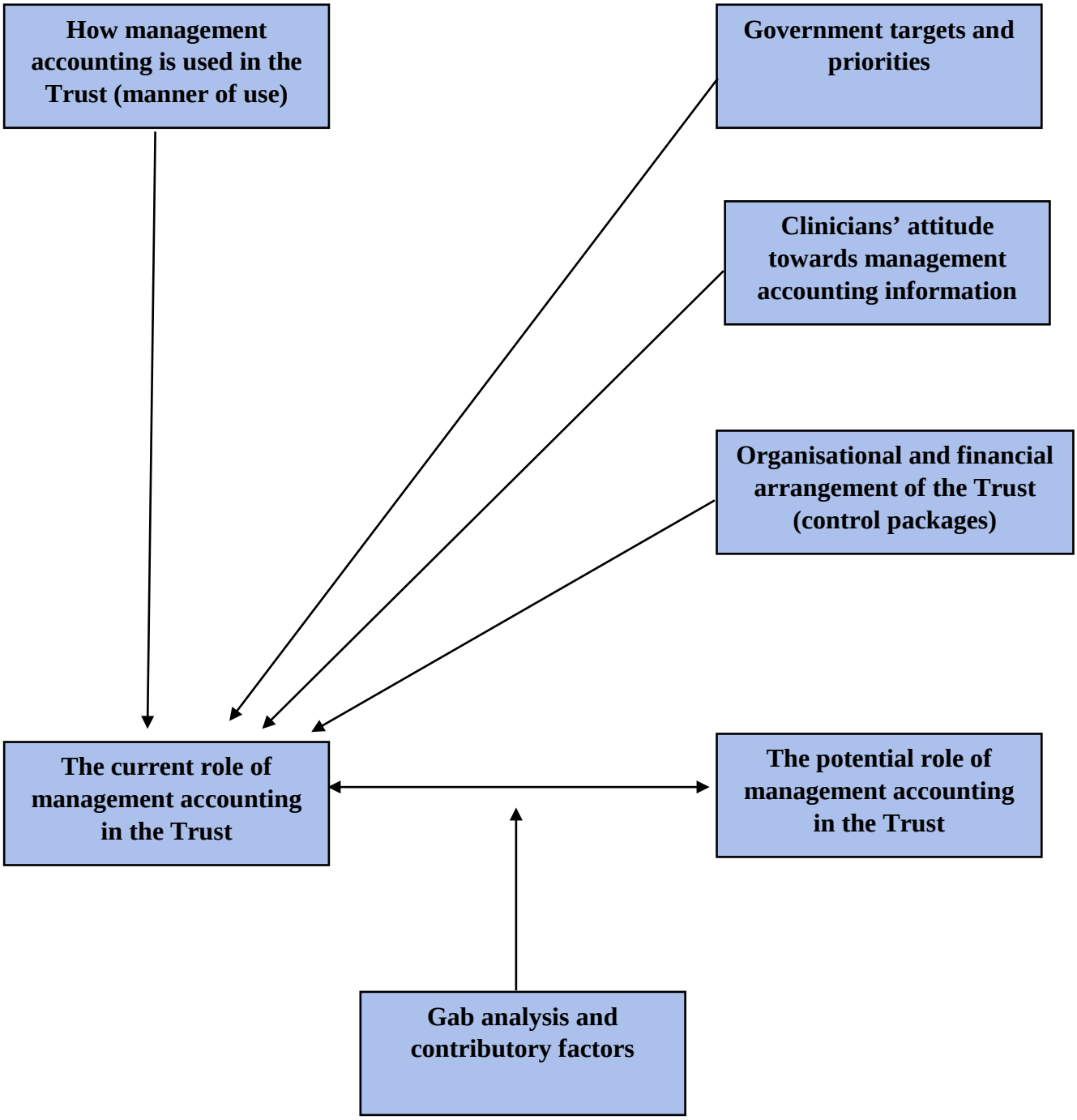

Figure 3.1 Diagram of the conceptual framework for the thesis

3.7 Conclusion

The chapter provides an overview of the contingency theory of MA which is used in this thesis as a theoretical lens to analyse and interpret the role of MA in community health services. The chapter discusses a number of criticisms of contingency-based studies in MA. It emphasises

the significance of adopting an interpretive case study in the community health services to eliminate the conceptual and methodological problems and bridge the literature gap in contingency-based studies in MA. The chapter ends with a discussion of the theoretical framework adopted in this study. Having presented the theoretical framework informing the study, the next chapter discusses the methodological stance and research method of the study.

Chapter 4. Research Methodology

4.1 Introduction

Previous chapter reviews the literature on MA's role in general and in NHS trusts in particular and outlines the theoretical framework of the research. This chapter explains and justifies the research methodology – that is, the systematic processes that were deployed to describe, explain and understand the phenomenon under investigation (Scapens, 1990). The chapter begins by discussing the role of research philosophy in influencing the choice of paradigm and justifies the selection of the interpretivist paradigm for the study. Section 4.3 discusses the methodological approach that was employed, explaining why this was qualitative rather than quantitative, while section 4.4 outlines the chosen research strategy (the single case study). Section 4.5 describes the details of the case study design, explaining how data was collected via semi-structured interviews, observation and documentary review and then subjected to qualitative content analysis (QCA). Section 4.6 concludes the chapter with a summary of the main points.

4.2 Research Philosophy and Paradigm

The first task in designing a piece of research is to select an appropriate research philosophy and paradigm. A research philosophy may be defined as a set of beliefs and assumptions concerning the nature of knowledge (epistemology), the nature of reality (ontology) and the nature of values (axiology) (Collis and Hussey, 2013). For a research philosophy to be credible, these assumptions must be well thought out and consistent with each other. Having determined their research philosophy, the researcher must choose the research paradigm or framework that best reflects their epistemological, ontological and axiological assumptions (Collis and Hussey, 2013). This paradigm will determine how they design the research (Pasian, 2015), including

the kind of evidence they will gather, and how it will be obtained and interpreted (Wilson, 2014).

The researcher's ontological assumptions reflect how they view the world and what they deem as real (Bisman, 2010). These assumptions would be broadly objectivist or subjectivist in orientation. Objectivists view reality as singular, external and independent of the researcher and other social actors. Most often associated with the natural sciences, objectivism treats social entities and physical entities in the same way. In contrast, subjectivism, which is most often associated with the social sciences, sees reality as socially constructed and personal to the actor experiencing it. To the subjectivist researcher, reality may only be understood by investigating how it is perceived by social actors, and the meanings they attach to it (Pasian 2015; Ritchie, et al.; 2013; Saunders, 2011). In other words, their ontological position drives their epistemological assumptions about how knowledge should be developed (Bisman, 2010).

Epistemology is generally concerned with the question of what is (or what should be) regarded as acceptable knowledge. For the social scientist, the main issue is whether or not social phenomena can or should be studied according to the same principles, procedures and ethos as the natural sciences (Bryman and Bell, 2015). The main choices from an epistemological point of view are positivism and interpretivism (Collis and Hussey, 2013). Researchers adopting the positivist paradigm seek to develop knowledge by investigating a set of variables and drawing causal links between them, while those adopting the interpretivist paradigm are more concerned with establishing a holistic picture of the phenomenon (Richardson, 2012). The two paradigms are discussed in detail in the following sections.

Finally, researchers must also be aware of the role that values play within the research process, whether these are their own rational values, developed on the basis of facts and reason, or the research subject's perceptual values, established on the basis of perception (Ryan, et al., 2002).

Axiology is generally concerned with how researchers deal with these values, which inform their judgment throughout the research process, from the choice of topic and philosophy to the selection of data collection method (Saunders, 2011). The question for researchers investigating social phenomena is how far their research can be independent of their values (value-free) or whether it can only be interdependent with their values (value-laden). While positivist researchers aim for value-free research, interpretivists assume that social research will inevitably be value-laden (Wilson, 2014; McNabb, 2002).

4.2.1 Positivism

The positivist paradigm regards social reality as objective and external to the researcher; it assumes that there is only one social reality, and that this has the same meaning for all social actors (Collis and Hussey, 2013). Epistemologically, it is opposed to metaphysical speculation without concrete evidence (Thomas, 2004), focusing instead on the exploration of observable, measurable phenomena to create credible and meaningful knowledge (Saunders, 2011). The central aim under this paradigm is to obtain knowledge which is independent of the researcher and uncontaminated by the act of investigation. According to Johnson and Clark (2006), the researcher may even delegate the task of data collection to someone else. The phenomenon under investigation is seen as being separate to and uninfluenced by the researcher and their activities, and the research process is supposed to be value-free (Saunders, 2011). Though most often associated with the natural sciences, positivism has also attracted some social science researchers, who have sought to treat organisations like physical objects or natural phenomena and to produce law-like generalisations like those created in the natural sciences (Saunders, 2011).

4.2.2 Interpretivism

The interpretivist paradigm is based on the assumption that reality is highly subjective and therefore varies from individual to individual. This means that the researcher may observe

multiple realities, the understanding of which requires in-depth analysis (Pasian, 2015). Indeed, the paradigm acknowledges that the act of investigation itself may affect social reality (Collis and Hussey, 2013), especially where there is a high level of interaction between the researcher and their participants (Wilson, 2014).

Epistemologically, interpretivism differs from positivism in that it seeks to empathetically understand rather than to explain human behaviour. Unlike positivists, interpretivists are not searching for causal relationships or seeking to make generalisations about social phenomena, nor are they interested in external factors that have no meaning for those engaged in social action (Bryman and Bell, 2015). Rather, they aim to understand the rules that people use by investigating how they structure knowledge (Sekaran, 2006). In line with its view of reality as socially constructed, interpretivism posits that developing an understanding of individuals' values and actions is the first step to understanding the structures and workings of the social system as a whole (Walliman, 2011). Axiologically speaking, it recognises the potential for bias, given that the researcher's own values are likely to affect how they perceive and consequently interpret their data (Collis and Hussey, 2013).Table 4.1 shows the main different between positivism and interpretivism.

Table 4.1 summarises the main differences between the two paradigms.

Philosophical assumptions	Positivism	Interpretivism
	-	-
	-	-
	-	-

Source: (Collis and Hussey, 2013, p. 46-47)

4.2.3 Rationale for Adopting the Interpretivist Paradigm

MA's role in the NHS as explained in the literature is shaped by the complex interplay of technical, behavioural, internal and external factors (Jones and Mellett, 2007). The aim of this

study is to move beyond the technical aspect of MA to consider its broader social and political aspects (e.g. the way in which the budget is used not just as an estimation instrument but as a tool for motivating managers to behave in a way that supports organisational aims). What is important is the desirability of behaviour that leads to this objective rather than the ability of estimation (Tinker, et al., 1982). Mainstream MA research has generally adopted the positivist paradigm (Malmi, 2010; Lukka, 2010; Modell, 2010), but this is of limited use when it comes to developing a meaningful narrative of the social, organisational and behavioural context of MA. Positivist MA research employs a fixed logic in which MA is used to put down human values, and it pays no attention to the social context of the organisation, or to organisational or individual behaviour (Covaleski, et al., 1996). This issue has been determined by Scapens (1990) as the limitation of neo-classical economic in MA research. The paradigm is employed to arrive at hypotheses or predictions, rather than to empirically interpret individual behaviour (Scapens,1990).

NHS trusts are in fact informed by two logics: one guided by accounting information (administrative logic) and one by clinical professional ethics and norms (professional logic) (Nyland and Pettersen 2004). As a result, different patterns of reality according to different context and variations can exist (Pettersen and Solstad 2014). So, by adopting interpretive paradigm this social world in which MA is socially constructed, with these multiple logics can be understood through explanations of the role of human interaction in producing this reality (Lukka, 2010). This thesis focused on the meaning and perceptions of those who act based on these logics such as clinicians and financial managers. The main objective was to understand the role of MA by emphasising on the individual underlying goals and a social structure of meanings (ter Bogt, et al., 2012). From an ontological aspect, the reality of MA, here, is socially constructed and produced by the mind and different social worlds, organisations, cultures and

experiences. Therefore, it is subjective, intangible, multiple and apt to change across and within individuals, groups and societies (Highfield and Bisman, 2012).

The experience and activities of individuals are crucial in providing insight into MA's role within the context of NHS trusts; it is important to learn from individuals what they do, and how and why they do it. Positivist methods are unsuitable for investigating the complex social implications of MA and may even yield a distorted abstraction of reality (Baker and Bettner, 1997). Close contact with the participants is necessary to understand how they construct and interpret meanings (Alvesson and Willmott, 1996); the research questions can only be answered by getting involved in organisations or societies in which MA is used, not by observing its use from a distance. This involves adopting an emic (insider) perspective (Lukka and Modell, 2010) and understanding things from the viewpoint of the research participants (Kakkuri-Knuuttila et al., 2008).

Exploring individual and collective experiences allowed the researcher to develop a holistic understanding of people's actions and interactions in the field (Modell, et al., 2008). It is important to note, however, that it was not the aim of this thesis to establish universal laws or generalisations. Rather, it aimed to understand and explain the dynamics of management accounting within one context (Ahrens, 2008). The interpretive paradigm was more likely than the positivist paradigm to yield rich knowledge about MA in practice, how it interacts with other organisational processes, and how it contributes to organisational effectiveness and adaptability (Hopper and Powell,1985). More broadly, it is more likely to give insight into the metaphorical dimensions of MA and how accounting works within the wider social context ((Baker and Bettner, 1997).

Having said that, it was decided that the interpretivist paradigm would be more suitable for this thesis. Rather than focusing solely on the technical-managerial view of MA, the choice was

made to adopt a pragmatic-interpretive view. The technical-managerial view represents the conventional wisdom of management accounting – that is, the theory showing practitioners how MA should be conducted (Scapen, 1994). In contrast, the pragmatic-interpretive view is more concerned with showing how MA is applied in practice and the organisational consequences of its application (contingency change). The literature indicates that MA in the NHS is the product of a complex fabrication process shaped by political, social and economic conditions (Jones and Mellett, 2007; Pettersen, 2001). The interpretivist approach allowed me to gather empirical evidence of actual practice to gain an insight into this complex mix of influences (Scapen, 2006) and to investigate the interplay between environmental and organisational factors that conceptualise MA in the Trust. By engaging personally with the organisational context, it was possible to gain rich, holistic insights from the views and actions of staff and to see how MA operates in practice.

4.3 Methodological Approach

The assumptions within a paradigm have important consequences for the way in which the researcher goes about obtaining knowledge about the social world. Different ontologies, epistemologies and axiologies are likely to incline researchers towards different methodologies (Burrell and Morgan, 1979); that is, they will influence their choice of tools, procedures and methods for carrying out their research (Myers, 2009; Wahyuni, 2012). The philosophical assumptions of positivism tend to be associated with quantitative research approaches, while those of interpretivism tend to be associated with qualitative approaches (Adams, et al., 2007). Quantitative methods, which are most commonly associated with the natural sciences, focus on the collection and analysis of numerical data. Numbers are used as scientific evidence of how phenomena work, with data being collected via surveys, laboratory experiments, mathematic models and econometrics (Myers, 2009; Saunders, 2011). Qualitative methods, on the other hand, are more usually adopted in the social sciences to study social phenomena.

These methods focus on the collection and analysis of non-numerical data, gathered using observations, interviews and documentary reviews, to understand people, their actions and the wider context in which they are embedded (Myers, 2009; Saunders, 2011). In line with its adoption of the interpretivist paradigm, this study employed the qualitative approach to achieve its objectives.

Qualitative research, as Bryman and Bell (2015) point out, usually relies on words rather than numbers – for example, where a survey instrument is used, this is unlikely to be a self-response questionnaire demanding highly structured and easily quantifiable responses, like its quantitative counterpart (Zikmund, et al., 2013). It is more likely to demand unstructured responses from which the researcher must then induce meaning (Parker, 2012). The focus of this kind of research is typically on sense making; it does not seek to arrive at universally valid constructs that are statistically generalisable from a sample to a wider population across a broad range of empirical contexts (Vaivio, 2008). The chief value of qualitative research lies in its ability to reveal the details of individual, social and organisational communication and experience (Parker, 2012). It is most appropriate when the researcher is looking to gain a deep understanding of the phenomenon under investigation and to understand how it happens in its natural context (Zikmund, et al., 2013).

The qualitative approach was therefore the most appropriate choice for this study, given that it aims to understand how MA phenomena are used and interpreted by individuals within a complex social environment and to provide a rich and deep description of MA's role in the context of community health trusts. This approach allowed the study to explore the role of MA in the NHS trust context beyond its functional role, which mainly serves rational management purposes, and to determine its actual role and how this is influenced by internal, external, technical and behavioural factors. According to Vaivio (2008), qualitative research can provide

a deeper perspective into MA research. It is used to discover the role of MA beyond its functional role and see MA as an imperfect practice applied in different ways to be de facto organisational reality.

4.4 Research Strategy

The research strategy is the researcher's plan for how they will go about answering the research question (Saunders, 2011). Punch (2013) describes the research strategy as being the core of the research design because it represents its logic or rationale. Like a road map, it sets out the systematic approach to be followed (Marshall and Rossman, 2011) in terms of data collection and analysis (Collis and Hussey, 2013; Myers, 2009; Remenyi and Williams, 1998). The link between the research philosophy and the selection of methodological techniques (Saunders, 2011), the research strategy ensures that the study design is cohesive and coherent (Creswell, 2013).

Potential research strategies for this qualitative MA research included the case study, field study and field experiments (Moll, et al., 2006). Case study research (the selected option) involves an empirical investigation of the phenomenon (the case) in depth and within its real-world context. This is especially important when the boundary between phenomenon and context is not clearly defined (Yin, 2013). The purpose of case study research is to develop an intensive understanding of the phenomenon (the case) or to explore a problem using the case as a particular illustration (Creswell, 2013). The strategy is particularly useful for investigating a complex situation in which the relationships between variables are not obvious but are important in the context of the research (Cooper and Morgan, 2008). The strategy is also valuable for gaining a wide understanding of the research context and addressing the "how" and "why" questions (Yin, 2013).

The field study strategy, although similar to the case study strategy, usually involves the less deep study of two or more organisations. Data collection is less intensive than in the single case study. One version of this approach is the comparative case method, in which the phenomenon is observed in different social contexts and the findings compared in order to improve generalisability (Moll, et al., 2006). The third type of research strategy is field experiments. This differs from the other two strategies in that the focus is on providing evidence of causal relationships between variables. As such, this method can offer a high degree of generalisability (Moll, et al., 2006).

4.4.1 Rationale for Adopting the Case Study Strategy

Scapens (1990) argues that case studies offer us the possibility of understanding the nature of MA in practice, both in terms of the techniques, procedures and systems which are used and the way in which they are used. The case study strategy can be deployed under either the quantitative or the qualitative approach; as a quantitative methodology, it can be used to generate statistical data for the purposes of testing and revising hypotheses in the real world (Eriksson and Kovalainen, 2015; Myers, 2009; Remenyi and Williams, 1998), while as a qualitative methodology, it allows the researcher to build a thorough understanding of phenomena by investigating how they are perceived by social actors in a specific context.

The qualitative case study strategy was chosen for this investigation for two main reasons. The first is that it facilitates understanding of the organisational role of MA by connecting it with the context in which it operates (Kaplan, 1986). MA's role in the Trust is affected by a set of complementary or even contradictory factors that reflect the interplay of the Trust's institutional, social and political contexts (Jones and Mellett, 2007). Understanding the complex relationships between these factors requires intensive description, interpretation of meaning and understanding of the context (Eriksson and Kovalainen, 2015). The main aim is to understand the factors that drive MA and how it becomes associated with organisational and

social action (Hopwood, 1987). This aim is more likely to be achieved by investigating MA in its real-world organisational context (Merchant, 2012) and recognising it as an imperfect system, used in different styles to become actual reality of the organisation. For example, budget and performance measurements might lead to an unintended effect if they are misunderstood, not reflect real intentions or are subject to game playing (Vaivio, 2008). Only then can researchers move beyond questions of what occurs in organisations to explore how it occurs, why observed cases happen in the ways they do and what drives minority behaviours (Parker, 2012).

The second reason for adopting a qualitative case study strategy was to gain a better dynamic understanding of the role and functions of MA in NHS trust. MA has traditionally been used in institutionally funded hospitals such as NHS trusts to control expenditure, allocate resources and measure performance (Robson, 2008). Top managers use it to implement strategic objectives, to inform the decision-making process, and to drive organisational performance, and it may also play a role in organisational dynamics and learning and dialogue (FlachÃ¨re, 2014). All of these aspects of MA's role – and how they relate to each other – need to be investigated to arrive at a holistic overview of its place within community health trusts. The case study strategy, as (Gummesson, 2000) points out, is better able to afford this holistic view than other strategies.

Otley and Berry (1994) argue that the role of MA cannot be fully understood without placing it in its wider context. This requires that the researcher be in direct contact with the organisational context and engage with actors in their natural setting. Drawing on this direct engagement, researchers can enter actors' socially constructed worlds, thinking, cultures, language and behaviours. Consequently, the researcher would be capable of distinguishing

between the manifest and the latent, understanding situations holistically and examining the actors' world (Parker, 2012).

4.5 Case Study Design

The case study design refers to the steps undertaken by the researcher to link the research questions with the data collection and analysis in a coherent way (O'Gorman and MacIntosh, 2014). Three main issues need to be taken into consideration in designing case study research: what kind of case study will be undertaken; how many cases will be included and what will be the unit of analysis (Yin, 2013)**.**

Depending on the aim of the study and the problem under investigation, the researchers may choose to conduct a case study that is descriptive, illustrative, experimental, exploratory or explanatory, though the categories are not clear cut and may be used in combination (Yin 2013; Scapens, 1990). Since the main purpose here is to understand the factors that affect MA's ability to support organisational performance and its role in one community health trust, an explanatory design was selected (Scapens, 1990). This involves offering an accurate interpretation of the facts of the case, searching for an alternative explanation of these facts, and arriving at a conclusion based on the interpretation that looks most congruent with these facts (Yin, 1981). The case study aims to provide an explanation of how MA can be used to support organisational performance in one trust, rather than to test theory.

The next question is how many cases will be covered in the study. This thesis is based on an intensive single case study that aims to give insight into the role of MA in supporting organisational performance in one NHS community health trust. According to Eriksson and Kovalainen, (2015), an intensive single case study emphasises the significance of case's interpretation and understanding in addition to the significance of sense-making process and elaboration of cultural meanings in a specific context. The main aim was to understand and

explore MA's role from the inside and develop an understanding from the perspective of people involved in the case.

The unit of analysis refers to the level at which data is collected; this may be an individual, a group, a division, an organisation, an industry, a process, a programme, or an organisational change (Bickman and Rog, 2008; Sekaran, 2006). It constitutes specific information regarding the phenomenon that the research wants to illuminate, and determine what the case study try to explain (what the case is) (Grünbaum, 2007). According to Yin (2013), a single case study may be holistic or embedded. If the whole organisation is chosen as the unit of analysis, the organisation is treated as a holistic case study. If, on the other hand, the researcher is concerned with sub-units within the organisation (e.g. divisions, processes or work groups), more than one unit of analysis will be required and the case study is referred to as embedded (Saunders 2011). The key criteria in selecting an appropriate unit of analysis are the nature of the phenomenon under investigation and the research questions (Yin 2013). As the main source of information, the unit of analysis must be capable of yielding sufficient data to answer the research questions.

The unit of analysis that was selected for this case study is a single organisation: A community health care trust in England. The Trust was established in 2002 in England to provide mental health and learning disability services and substance misuse services. In 2011, under the national Transforming Community Services agenda, the Trust merged with another community health organisation. It now serves people across a wide area in England with a £250 million budget and more than 5,500 staff. It provides three main services: adult mental health and adult learning disability services (AMH.LD); families, young people and children's services (FYPC); and community health services (CHS). These services are delivered through a range of units including community hospitals, specialist mental health inpatient units, longer term recovery

units, outpatient clinics, day services, GP surgeries, children's centres, schools, health centres, prisons and in patients' own homes. The Trust also provides training and education for medical, psychology, nursing and therapy students. It is managed by a Board of Directors, which is responsible for formulating strategy, ensuring accountability, and engaging with internal and external stakeholders to support delivery of the Trust's aims and objectives. The Board structure is shown in Figure 4.1.

Figure 4.1 Trust Board Structure

Source:(Integrated Governance Handbook of the Trust)

The role of MA was considered from three different perspectives (strategy, decision making and performance evaluation) in this study. Since this necessitates multiple levels of analysis within the Trust, the case study is embedded in nature (Yin, 2013). The aim in employing an embedded single case study is to provide an intensive description of the role of MA and reveal the structure of social behaviour in this particular context. The idea is that MA information can have different organisational influence due to its drawing upon systems of symbolic significance that rooted in different perspectives of organisation such as technologies; the values, beliefs and social relations of organisational members; and management strategies and formal controls (Ahrens and Mollona, 2007).

4.5.1 Sources of Evidence

The qualitative research methodology provides opportunities to draw on multiple sources of evidence such as interviews, observations and document analysis (Cooper and Morgan, 2008).

The process of data collection took nearly four months, from May 2017 to September 2017, during which time the researcher was able to immerse himself into the setting of the Trust by securing a part-time job as a trainee in the Trust's finance department. This gave him the opportunity to become familiar with the finance culture within the Trust and to see the world from the point of view of Trust staff. Data was collected from a variety of sources, including interviews, observations and document review. The use of multiple sources was designed to mitigate against the risk of bias associated with the single case study method, and to enhance the validity and reliability of the findings. The data collection methods are discussed below.

1. Interviews

Interviews are one of the most important techniques for collecting data in qualitative research. Not only do they allow researchers to collect rich data from a diverse range of social actors, they give an insight into the world of these actors by allowing them to express their views in their own words (Myers, 2009). Data can be collected by asking the interviewees questions to explore what they do, think or feel (Collis and Hussey, 2013), giving them the opportunity to share their experiences, stories and perspectives about the phenomenon being investigated. Through these conversations, the researcher is able to access the knowledge of interviewees who have practical experience in their field (Wahyuni, 2012). Interviews may be structured, semi-structured or unstructured in format; the key features of the three kinds of interview are summarised in Table 4.2.

Table 4.2 Key Features of Structured, Semi-Structured and Unstructured Interviews

Source:(Collis and Hussey, 2013)

Interviews conducted under the positivist paradigm tend to be structured, while those conducted under the interpretivist paradigm tend to be unstructured or semi-structured (Collis

and Hussey, 2013). This study employed semi-structured interviews with open-ended questions to explore the interviewees' experiences and opinions of the role of MA in the Trust[1].

2. Observation

Another source of evidence for the study was observation. One of the most effective data collection techniques (Saunders, 2011), this involves watching people, objects and events, rather than asking for information, to determine the essential facts of a situation. Data is gathered by the researcher recording their own observations in a natural setting (Shajahan, 2014). This is central within the interpretivist paradigm, which emphasises the importance of understanding context and the influence it has on phenomena (Collis and Hussey, 2013). By visiting the case study setting, the researchers are able to observe the environment and its behavioural and organisational conditions (Remenyi and Williams, 1998). Observation also has the clear advantage of making the researchers less reliant on participants' memories of what has happened, because he or she has recorded it himself (Eriksson and Kovalainen, 2015). The researchers may be fully involved in the context and culture being observed (participant observation) or detached and watching the action from a distance (non-participant observation). In non-participant observation, data is often collected via technological means (e.g. using videotape, photographs and audio recordings) (Saunders, 2011). Non-participant observation was adopted in this study.

3. Documentary Review

Documents can provide evidence that allows the researcher to build a broader and deeper picture than can be gained from interviews and observation alone (Myers, 2009). In general, documents are used as a source of secondary data to corroborate and augment the evidence

[1] The procedures followed to conduct the case study is explained under the fieldwork section.

gathered from interviews and observation; in other words, for the purposes of triangulation. The comparison of information collected using different methods helps mitigate against potential bias, a particular risk in a single case study (Bowen, 2009), and enhance the credibility and reliability of the findings. A large number of documents were reviewed for the study.

4.6 Fieldwork

The underlying purpose of the study is to explore the effectiveness of MA in supporting organisational performance at the operational and strategic levels of NHS trusts. The literature review indicates that this effectiveness is influenced by a complex set of complementary or contradictory contextual factors (Jones and Mellett, 2007). Accordingly, immersion in the context was necessary to acquire a holistic and deep understanding of the circumstances under which MA operates in the Trust. Access to the Trust was arranged on my behalf by the study's supervisors. Once the Trust had indicated its willingness to participate, applications for ethical approval were submitted to the University's College Research Ethics Committee (CREC) and the NHS's Health Research Authority. Granting of this approval was followed by a meeting with the Trust's deputy head of finance. I was attached to the finance and accounts department as a financial trainee and given a staff card, which granted access to all departments of the Trust, and a desk-top computer. I was also given permission to shadow one of the finance managers as they went about their routine tasks.

Prior to starting work at the Trust, an initial set of interview questions was prepared. The questions were tested in three pilot interviews to ensure that they would be able to achieve the study objectives and answer the research questions. These pilot interviewees all had extensive experience of working in finance and accountancy in the NHS; the first was a director of finance in a public hospital (30 years' experience), the second was a researcher in a public hospital, and the third had worked in the public sector for more than 30 years, 11 of which were

in the NHS. This interviewee was also on the board of a number of NHS trusts. Table 4.3 shows when the pilot interviews were conducted and how long they lasted.

Table 4.3 Pilot Interviews

Interviewee code	Date of interview	Length of interview
001	22/02/2017	35 minutes
002	22/02/2017	70 minutes
003	28/02/2017	50 minutes

Based on the comments and feedback received from the pilot interviewees and supervisors, a basic schedule was developed to guide the interviews in the main study (see Appendix 1), though this was modified according to the interviewee's function within the Trust. The schedule was also altered as the interview process progressed in order to further explore points raised in previous interviews.

Over the four months of fieldwork, I was able to engage closely with finance department staff and others and to conduct interviews with board members, finance managers, operational managers at various levels and some clinicians. Staff were observed at work and in discussion about numerous issues in the Trust, and meetings were attended where financial, operational and strategic issues were discussed. Finally, it was possible to review a number of documents related to financial and strategic performance.

Potential interviewees were approached either face-to-face (if they worked alongside me) or by email (if they worked in another setting). In both cases, they were given a participant information sheet explaining the aims and purpose of the study and how much time an interview would involve (see Appendix 2). Those who agreed to participate were asked to sign a consent form prior to their interview (see Appendix 3). All interviewees gave permission for their interview to be recorded. Interviewees were also reassured that their personal information would be kept confidential and that they could withdraw from the study at any time without giving any reason and without any implications for their legal rights. All the interviews were conducted at times convenient to the interviewees and on Trust premises.

To encourage interviewees to speak freely, open-ended questions were employed. The interview guide was left flexible, so that new questions could be asked in response to the unfolding conversation. The interview recordings were transcribed into Word document format and exported into Nvivo11 for the purpose of analysis. The interviews continued until no new information was being revealed and the gathered data was considered sufficient to answer the research questions. A total of 30 interviews were conducted (see Appendix 4), of which 13 were with clinician budget holders, three were with non-clinician budget holders, 11 were with financial managers and three were with non-financial managers. This number aligns with the average number of interviews for PhD theses in the UK, which is 28 (Bryman and Bell, 2015). A few problems were encountered during the interview process (e.g. some interviewees rescheduled their appointment, disrupting the interview plan), but the interviews were conducted successfully and yielded the information required for the purposes of the research.

The observation data was gathered by means of non-participant observation. This was conducted in three ways: by observing daily activity within the finance department, by sitting in on meetings and by shadowing staff members. As a financial trainee I was in the Trust's

finance department on a daily basis. This allowed me to immerse myself in the context and the day-to-day lives of the people in the department. I was able to collect data simply by working closely with the finance staff, observing their activities, listening to their conversations and discussing with them the issues covered in my study. Whenever possible, I asked for permission to attend any meeting that I felt might be useful to my research.

I observed many meetings during my fieldwork, including budget holder meetings, team meetings, one-to-one meetings between senior finance managers and non-financial managers at various levels in the Trust, turnaround meetings, financial position meetings and management meetings to discuss strategic and operational issues. The focus of the observation was always on how MA supports the Trust's organisational performance. In budget holder meetings, for example, this meant focusing on how MAs supported budget holders, the kind of language that was used, what problems budget holders faced in meeting their budget, how they addressed these problems, how they felt about the financial procedures, and how MAs responded to these feelings.

The third form of observation was accomplished by shadowing staff members as they went about their finance-related work. Interacting with them in their work setting allowed me to gain a better understanding of both their activities and their perceptions (Myers, 2009) and was helpful in developing contextual insights regarding the role of MA.

Field notes were written during or immediately after each observation, discussion and meeting. These notes highlighted anything interesting that had happened, recorded events, people and conversations, and, wherever possible, offered some initial ideas about how the data might be interpreted. The observations were stopped when it became evident that they were revealing nothing new. These above procedures were undertaken to reduce the risk of bias and reflexivity and to increase the reliability and validity of the research findings.

In terms of document review, I tried to collect and inspect a vast number of documents. When I collected and inspected the documents, I was drawing careful attention to how and for what reasons they are prepared and used. In this thesis, the documentary sources were used for triangulation purpose and as a supplementary information to support the data collected from other sources. The document reviewed included strategic plans, operational plans, service transformation plans, annual budget statements, job descriptions, codes of practice, financial regulations, agendas and minutes of meetings, monthly budgets for several cost centres, service line reports, cost improvement programmes (CIP) for each service, CIP planning, CIP performance, service finance reports, reference cost guidance, integrated governance handbooks, income comparisons, staff costs, statements of financial position, statements of cash flow, and turnaround reports.

4.7 Ethical considerations in the study

Ethical considerations and confidentiality were adhered to throughout the research process. Careful consideration was given to the ethical research guidance of both Nottingham Trent University and the NHS. As a result, ethical approval was secured from both. The steps taken to comply with accepted practice in terms of consent, confidentiality and the use of results are described below.

1. **Informed Consent**

Potential interviewees were given the basic information they needed to decide whether to participate and offered further information should they want it. This included the purpose of the study and its basic procedures, the role and identity of the researcher, why they were selected for the study, possible future use of the data, possible risks associated with taking part, and who was responsible if anything went wrong. A participant information sheet was given to interviewees before each interview (see Appendix 2) along with an informed consent letter

explaining that their participation was voluntary and that they had the right to withdraw at any stage before the writing up of the study (see Appendix 3).

2. Anonymity, Privacy and Confidentiality

All the data was kept securely in a password-protected file and handled only by the researcher. The anonymity of those participating in the research was respected by giving interviewees a unique code in the writing up stage, ensuring that it was not possible to link any of the interview data to any one individual.

3. Use of Results

The findings that emerged from the study were used only for the specific purposes mentioned in the study. The participants were informed that the findings and results would not be used in any circumstances to make external conclusions in regard to their individual performance, ability or trustworthiness.

4.8 Data Analysis

The purpose of qualitative data analysis is to understand, gain insight into and provide explanations for the collected data rather than to arrive at statistically valid conclusions (Ghauri and Grønhaug, 2005). A dynamic and creative process, qualitative data analysis involves inductive reasoning, thinking and theorising. In determining the themes, relationships and assumptions that best reflect the respondents' view of the phenomenon, the researchers may have to continually revise their interpretation of the data. They rely upon their actual experience with setting, informants and documents to do this (Basit, 2003).

Techniques for analysing qualitative data include thematic analysis, template analysis, discourse analysis, content analysis, narrative analysis, hermeneutic analysis and grounded theory analysis (Collis and Hussey, 2013). The range of techniques underlines the point that there is no single best way to analyse qualitative data; a technique used in one research situation

may not be appropriate to another. Some of the techniques are mutually exclusive, but many are interconnected, overlapping or complementary (Punch, 2013). Each has a different focus; in discourse analysis and hermeneutic analysis, for example, this is on the participants' use of language. Researchers applying these techniques give more attention to how texts develop over time rather than searching for particular content within the data set (Flick, 2009). In content and thematic analysis, on the other hand, the focus is on identifying themes or patterns within the content that convey specific meanings and understandings, while in grounded theory analysis, the emphasis is on explaining what is central in the data to producing an abstract theory (Punch, 2013; Flick, 2009). It is up to the researcher to choose the technique that best suits their research objectives. Whichever they choose, there are basic principles of analysis that are common to all techniques; the data must be prepared and organised, reduced into categories or themes by coding, and presented in figures, tables or a discussion (Creswell, 2013; Schreier, 2012).

4.8.1 Qualitative Content Analysis

In this thesis, content analysis focusing on the themes or categories as a unit of analysis was used to analyse the data collected. The aim was to categorise the content of the texts under analysis through allocating words, sentences or statements to a frame of themes or categories that provide a holistic description of the role of MA in the Trust (Drisko and Maschi, 2015). However, the content analysis in this thesis did not focus on quantification or statistics to infer meaning, instead it focused on the interpretation in logic manner to understand the data collected. So, it is qualitative content analysis that provide a good description of the material (Drisko and Maschi, 2015). According to Schreier (2012), qualitative content analysis is a method for systematically describing the meaning of qualitative material. It is done by classifying material as instances of the categories of a coding frame. So, in this thesis, QCA refers to the systematic procedures followed to analyse the texts of different kinds of data

collected, emphasising not only the manifest content but also on the latent content of the texts (Drisko and Maschi, 2015; Eriksson and Kovalainen, 2015). Three characteristics distinguish QCA from other analysis. First, QCA allows the researcher to concentrate on data that relates specifically to the research question rather than focusing on the comprehensive and full meaning of a text in each and every issue. The second characteristic is the systematic nature of QCA in that all appropriate material is taken into consideration to decided which part is fitted with the coding frame that relevant to the research questions; in that it requires a series of steps regardless of the research questions and materials and in that it requires conducting double coding process to provide more reliability of the coding frame. A third characteristic is that QCA is highly flexible as it combines varying aspects of categories, that are concept-driven and data-driven, within one coding frame (Schreier, 2012).

The data analysis process in this thesis started with the transcription of the interview recordings into Microsoft Word. These transcripts and the field notes from the observation were then reviewed thoroughly to allow the researcher to become familiar with the data. Data collection and data analysis were conducted simultaneously in an iterative way (the collect-analyse-collect approach); this saved time and reduced the feeling of being overwhelmed with too much data (Liamputtong, 2009), but more importantly, it meant that categories could be developed gradually in response to the field material (Miles and Huberman, 1994).

The data collection process produced a large amount of data that needed to be reduced and managed. All of the textual data was exported into NVivo11, where it was coded and reduced. The initial coding process began with the rereading of the texts, so that segments containing potential units of meaning could be defined and labelled. The objective of this step, which is called unitising or segmenting, was to determine the units of data that needed to be addressed in the subsequent analysis. An index of 99 codes was generated for interpreting the data (see

Appendix 5), some of which were drawn from the literature and others from data collected from the interviews with Trust staff. The index was compiled using both inductive and deductive reasoning, as recommended by Schreier (2014).

In the next step – what Schreier (2014) calls the structuring and generating step – these codes were grouped into overarching categories. In this step, main and sub-categories were created by aggregating codes with similar attributes into broad groupings. Each category incorporated a number of apparently related codes that linked to the research questions (Saunders, 2011). The categories and sub-categories in this study were initially based on the interview questions and the literature but were continuously revised as the findings were analysed. Ahrens and Chapman (2006) argue that throughout the research process, problem, theory and data influence each other. This process was useful in terms of comparing the data with the literature as it generated a reasonable consensus between the problem, theory and data. Attempts were made to minimise overlapping (i.e. codes falling under more than one category) by checking the consistency and validity of the coding process and rereading transcripts. The development of categories continued until the point of saturation, when no further categories could be identified. Each category was clearly defined and described in order to fully elucidate the concept it captured and how it was differentiated from other categories. The codes were then sorted into 15 final categories (see Appendix 6).

In the final step, the data was conceptualised. This is an important precursor to the development of theory as it entails understanding how the individual components of the data connect together into a broader conceptual framework (Daymon and Holloway, 2010). The main categories emerging from the second step of analysis were studied carefully to determine patterns and develop a holistic explanation of the case study. A pattern-matching technique was used to conceptualise the data. This involved gradually building an explanation by

comparing the initial theoretical framework and predictions with the identified empirical patterns and revising the theoretical framework accordingly (Mollona, 2010). The explanation was thus formulated by connecting the findings of the study with the conceptual framework.

4.9 Credibility of the Research

One of the main challenges when conducting qualitative research is ensuring its credibility. Both validity and reliability are important components in evaluating research credibility (Bickman and Rog, 2008); validity refers to the degree to which the research conclusions provide an accurate description or illustration of what happened, while reliability refers to the extent to which another researcher would detect similar findings if they repeated the study (Eriksson and Kovalainen, 2015).

A number of strategies were employed to ensure the credibility of the study. For example, the interview schedule was shown to interviewing experts who are in the similar situation for those in the real case study. This helped ensure that the interview questions were clear and unambiguous, and that they were properly targeted to achieve the study objectives (Cassell, 2015). At the same time, the fact that the interview schedule was designed to be flexible meant that questions could be changed as necessary to respond to new insights as they emerged (Eriksson and Kovalainen, 2015). The credibility of the findings were also enhanced by the fact that the researcher spent a considerable time working in the Trust and studying the context at close quarters (Lapan, et al., 2011), and by the use of multiple sources of evidence. This allowed for the triangulation of the findings and reduced the chances of systematic bias (Aurini, et al., 2016). Finally, the results are reported alongside relevant extracts from the interview transcripts, allowing readers of the thesis to develop their own ideas and feelings about the aspect of the people who were studied (Bryman and Bell, 2003; Flick, 2009).

The third criterion of credibility, after validity and reliability, is the generalisability of the findings; that is, the extent to which they may be extrapolated to a wider context (Eriksson and Kovalainen, 2015). Critics of the case study strategy, particularly the single case study, argue that the results cannot be generalised beyond the specific case because they rely upon relationships, circumstances and processes that are unique to that particular context. However, scholars advocate the significance of evaluation of the case study research based on its fundamental tenets rather than the tenets of some other methods (Myers, 2009; Yin, 2018; Lee, et al, 2007). For example, it would be inappropriate to evaluate the case study research by criteria used in evaluating survey research. In this vein, Yin, (2018) distinguishes between two types of generalisation, statistical generalisation and analytical generalisation, while Lukka and Kasanen, (1995) categorise generalisation in MA research into Statistical generalization, Contextual generalization and Constructive generalization. The main notion of this debate is that the statistical (universal) generalisation from sample to population does not fit with a case study research when the emphasis is on studying a phenomenon within a particular context. Accordingly, the logic of replication should be applied to justify a case study research instead of the logic of sampling that fit with survey research. The logic of replication refers to the situation where significant findings are made in a case and there is a need arises to replicate the research in further experiments so that findings can be duplicated and hence considered robust (Yin, 2009). This means generalise one or more cases to theory instead of population. Therefore, considering statistical generalisation to be the way of generalising the findings from the case study is a fatal flaw in doing a case study (Yin, 2018; Myer, 2009). However, the authenticity of research findings and the plausibility of associated explanations of the case study research should be achieved as Lukka and Modell, (2010) discuss through thorough and thick explanations that reflect the real-life world of actors being studied and through abduction whereby the researcher develops theoretically informed explanations drawing upon available

theoretical and empirical knowledge. This may offer important insights of value to specific organisational and institutional context. These may either better explain the processes that produce the macro-relationships already identified in the literature, or call into question the foundations of behaviours and relationships that previously have been taken for granted(Parker,2012).

Since this thesis is qualitative and seeks rich contextual understanding and critiques of the MA process and outcome through the engagement of the researcher with its institutional and organisational context in a single community health trust, it aims at theoretical generalisation which means building a theory that can be generalised to other contexts rather than to population. The objective is to provide a rich understanding of how MA interacts with, shapes and is shaped by the organisational activities, events and changes. This agenda of research as Parker (2012) discusses inconsistent with the agenda that focus on building generalizable, predictive law of behaviour. It presents a more micro-organisational perspective emphasising the understanding and critique of process and context. Within this perspective, the real-life situations are never as neat and tidy as the theories. Therefore, the power of doing a case study research is that it enables the researcher to explore and test theories within the context of messy real-life situations by allowing them to be close to the action (Myers,2009). In summary, the aim of this study is to illustrate and generalise to a theory. While the results are intended to provide a deeper understanding of the role of MA in one trust, they might also provide evidence of the applicability of the selected framework in a different context. This thesis uses previously developed theory as a comparing model with its result. The aim is to make some form of connection with previous results (Eriksson and Kovalainen, 2015). The findings, therefore, will explicitly be connected to prior theory but the power of the study will be in its context of a community health trust and the depth of the analysis that present MA as a contextualized practice within a unique case study setting.

4.10 Conclusion

This chapter discusses the methodology that was followed to conduct the research, from the choice of research philosophy and paradigm to the design of the study and the collection and analysis of the data. The chapter justifies the choice of the interpretivist paradigm and qualitative approach as being the most appropriate for investigating the various contextual factors and multiple logics that impact on MA's role within the Trust and for providing a deeper understanding of this role. It explains the rationale for conducting a single case study, which was to provide a holistic overview of MA's role in the Trust and to enable the researcher to gain sufficient organisational understanding of this role by connecting it with the context in which it operates (Kaplan, 1986).

The chapter outlines details of the case study organisation, the Community health Trust, and the services it provides, before describing the main data collection methods (semi-structured interviews, non-participant observation and document review) and the qualitative content analysis that was employed to analyse the gathered information. Finally, the chapter describes the steps that were taken to ensure the credibility of the research, discussing its validity, reliability and generalisability. The findings from the case study are presented in the next three chapters.

Chapter 5. Findings:

The relevance and role of cost accounting in the Trust

5.1 Introduction

The aim of this chapter is to discuss the operational role of MA, as represented in the cost accounting system of one community health service in England, and the factors that affect the

implementation of MA initiatives such as PLICS. Also, the chapter is set to provide explanation to the roles and attitudes of clinicians towards the operation of management accounting in the Trust. According to New Public Management (NPM) principles, the final phase of functionalist MA (after strategic planning and budget preparation) should be based on quantitative measures derived during the operation and activity phase (Pettersen and Solstad, 2014). The behavioural and organisational literatures suggests MA within healthcare organisations as mainly purposive; it is designed and implemented to control behaviour and/or to facilitate decision making by providing information to reduce ex ante uncertainty (Abernethy, et al., 2006). However, some scholars have criticised MA for focusing more on cost control than on providing information to evaluate and improve operational performance (Johnson and Kaplan, 1991).

In the healthcare setting, MA has long been seen as having the potential to reconcile cost containment, quality and accountability, but in practice, it has too often fallen short because it has failed to adapt to clinical needs (Fiondella, et al., 2016). For decades, NHS managers, aware of MA's potential usefulness in improving operational performance, have sought MA approaches that will provide costing information that is relevant to clinicians' work (Harradine and Prowle, 2012). However, the complex nature of healthcare delivery makes accurate cost measurement a major challenge. The treatment of just one patient, from first contact through to clinical consultation and treatment, may require the deployment of a range of clinical and administrative resources, from equipment to personnel and space, each of which carries its own costs. Furthermore, each individual patient will follow their own unique treatment path (Kaplan and Porter, 2011).

The discussion is structured as follows. Section 5.2 considers the appropriateness of the Trust's current cost accounting system, after which section 5.3 discusses the need for robustness in this

system. Sections 5.4 and 5.5 focus specifically on PLICS, discussing respectively the organisational/human and contextual/technical factors that affect the implementation of patient-level costing systems. Finally, section 5.6 reviews the main points in the chapter.

5.2 Appropriateness of the Cost Accounting System in the Trust

The costing of, reporting on and management of services is the cornerstone of MA in all organisations (CIMA, 2009). The literature points to the usefulness of cost accounting in enhancing both financial and operational performance (Pizzini, 2006), whether this is by reducing costs, improving efficiency and resource allocation, supporting decision making or helping managers evaluate the viability and coherence of activities (Verbeeten, 2011). In the NHS, the role of the finance function has traditionally been to control overheads. However, if this role were rebalanced to encompass both control and empowerment, it is more likely that it would be seen as adding value – through the provision of high-quality, relevant information to support decision making nearer the point of action (i.e. the patient) (CIMA, 2009).

It should be noted that calculating cost is a highly complicated process, the understanding of which is generally limited to those staff with direct responsibility for it. In discussions of cost system design, the MA literature has mainly focused on the level of complexity or sophistication involved, especially in terms of the applied overhead absorption procedures (Schoute and Budding, 2017; Drury and Tayles, 2005). It emerged from the discussions with the Trust's finance staff that the Trust uses NHSI guidelines to calculate costs. In this top-down method, costs are divided into direct, indirect and overhead costs and allocated based on full absorption (i.e. all the costs of health treatment and support services are absorbed into the appropriate specialty, service or programme) (HFMA, 2016). The method involves breaking down the total budgeted expenditure to as great a level of detail as possible by direct assignment to cost heading or apportionment to specialty (Howes, 1994). However, the majority of interviewees (finance managers and clinicians) criticised this method as providing insufficient

detail and inaccurate cost information. The head of finance in the FYPC F06 agreed that "*In terms of overheads it is quite crude at the moment. We do need a more sophisticated system to apportion more accurately*".

The observation indicates that the Trust cost structure is dominated by fixed labour overheads that are allocated by depending on the top-down method as an average allocation (flat percentage based on the actual cost) to each service line. The crudeness of the system thus lies in the fact that it uses service lines (diagnoses) as cost objects instead of patients (Llewellyn, et al., 2016). While none of the interviewees saw a problem in the cost information provided at the level of the Trust, several argued that this information is unlikely to accurately reflect resource consumption by patients. One cost accountant (F09) explained that "*The costing system of the Trust at the moment gives information at an aggregate and summary level"*, adding "*We are unable to fully understand the cost that makes up these elements"*. The comments indicate that under the current system, cost information for individual patients is based on the average cost, and that it is not possible to link this cost data with specific clinical activities (Scarparo, 2006).

The Trust's cost accounting system has received considerable criticism from most of the Trust's clinicians, the majority of whom see it as not sophisticated enough to add value or facilitate decision making near the point of action (the patient). The medical director of the Trust (C05) acknowledged that

> *"We do not have a good system to let people know the impact of their clinical decisions. For example, what is the cost of the patient's pattern and what's the actual cost of certain duration stays in the inpatient unit? I think our cost system currently is not sophisticated enough to input all those types of information and give it to the clinicians in a way they understand"*.

Consequently, clinicians are unable to see the cause-and-effect relationships between their decisions, resource consumption and clinical results. The Trust's current approach to analysing cost behaviour may highlight problems, such as the costs of a certain HRG being above reference costs, but it offers no guidance on how to fix these problems (Chapman and Kern, 2010). Having a precise figure for overheads offers no more than a general understanding that reducing length of stay is beneficial (longer stays spread overheads more thinly across more patients) (Chapman and Kern, 2010). Meanwhile, a detailed analysis of overhead spending in relation to clinicians' activities and choices remains beyond reach.

Generally speaking, a cost accounting system should produce information that is detailed and flexible enough to be used for several purposes. The expected payoff from decisions based on more detailed information is generally greater than that from decisions based on more aggregated information (Pizzini, 2006). The information provided by the Trust's cost system meets the Trust's requirements in terms of contracts, payments and external reports and allows it to determine costs at Trust level reasonably accurately. However, most clinicians believed that it is not the kind of information that can be easily used by front line staff to improve performance and drive value for money since it gives little indication of the resource consequences of any given action. A clinical director in the mental health service C02 summed up clinicians' negative perceptions of the current cost system.

The design of the Trust's costing system has been determined by the financial reporting regulations and the demands of external regulators for more detailed financial information (Schoute and Budding, 2017), with the result that less emphasis has been placed on providing information that meets the needs of clinicians. The findings indicate a lack of cost information relevant to clinicians' needs and decision making; there is nothing, for example, that allows clinicians to see the costs incurred during an individual patient's progress along the path of

diagnosis and treatment. The finding is consistent with the literature, which shows that not only is access to such information often inadequate, but that this information is often perceived as irrelevant by cost systems designed to respond to corporate and regulatory organisational requirements rather than to support clinical performance (Maiga, et al., 2014).

5.3 The Need for a Robust Cost Accounting System in the Trust

The observation indicates that concerns about how best to provide services within budget have led to an increased emphasis on efficiency in the Trust. The Trust relies heavily upon clinicians to use resources wisely, making it vital that they are aware of the cost implications of their decisions (Cardinaels and Soderstrom, 2013). However, this is made more difficult by a lack of relevant information (Jacobs, et al., 2004). It is arguably how individuals use cost information which determines the value of any cost system; a system that is incapable of generating accurate and relevant information that enables individuals to improve their decision performance cannot be said to create value (Michael, 2011). In the Trust's case, the majority of clinicians argued for better cost information to help them become more aware of how they are using the Trust's resources; the clinical director C05, for example, commented that *"We need a costing system that provides information and gives it to clinicians in a way they understand"*. Interviewees on the finance side also called for a more sophisticated costing system.

The need for greater sophistication has long been recognised; as far back as 1995, the Audit Commission, (1995 cited in Jacobs, et al., 2004) argued the importance of providing information that is clinically useful. Accordingly, the NHSI is now recommending NHS providers across the UK to move to patient-level information and costing systems (PLICS). These are "IT systems which combine activity, financial and operational data to cost individual episodes of patient care" (Ellwood, et al., 2015). The literature emphasises the crucial role of PLICS in providing information at the individual patient level and how this can serve trusts in

various ways (Vogl, 2013). Unlike the top-down approach, in which costs are collected into departments or cost centres, in PLICS, the patient is the basic cost-collection unit (Ellwood, et al., 2015). Utilisation data is linked to cost data which can then be aggregated into activities that contribute to the final outcome: patient care. This allows the cost of activities to be determined even when they extend across multiple departments (Blunt and Bardsley, 2012). PLICS allow trusts to capture costs at the level of individual patient activities, enabling them to determine the costs incurred by individual patients throughout their care in a way that reflects the complexities of each case (CIMA, 2008).

The NHSI is emphasising the importance of PLICS for the whole NHS economy, not just individual trusts (Llewellyn, et al., 2016). In a series of healthcare costing standards, it has set out the steps NHS providers in England should take to change to PLICS. The aim is to guide NHS providers to improve their costing process and in particular build up costs from the service user (patient) level, though the development of this guidance and its implementation across the NHS will take a number of years (NHS Improvement, 2018b). Acute health services are already making good progress towards the full implementation of PLICS. Community health services are still in the pilot stage, though from 2020 it may be mandatory for them to submit costs in line with prescribed patient-level costing collection guidance (NHS Improvement, 2018a).

Various attempts have been made to find MA approaches that support clinical performance, with varying degrees of success. Some, such as management budgeting, have failed and been withdrawn, while others have been gradually modified over the years (Harradine and Prowle, 2012). It is unclear at the moment whether PLICS will succeed, have little impact or fail, especially in community health services, which differ from acute health services. Although none of the interviewees said that PLICS will fail, most saw several major challenges that need to be tackled if the new systems are to have significant impact. The clinical director of mental

health services (C07), for example, commented that "*The PLICS is reasonable in the acute services, so we can't use the same model in exactly the same way in mental health*". The comment suggests that the success of any PLICS is seen as depending upon its ability to provide a correct diagnosis of the situation (Malmi, 1997). This means that those involved in the development of the system must have a deep knowledge of the operational context and working environment if the model is to accurately represent organisational reality. Other factors that might influence the results of the model (Cinquini, et al., 2009) can be broadly divided into organisational/human (e.g. the level of non-accounting ownership and the level of training provided) and contextual/technical (i.e. the level of IT sophistication). The influence of these factors is discussed in the following sections.

5.4 Organisational (Human) Factors

It is observed that the main feature of the PLICS in the Trust is that its implementation is the result of external, non-negotiable pressure from the NHSI rather than an internal demand to understand and manage costs. The need for a new costing system is acknowledged by those in the Trust, but there is a danger that any attempt from outside to impose MA initiatives may only alienate staff, especially if they do not comprehend the objectives of the new system (Fiondella, et al., 2016). The involvement of clinicians in the process is therefore vital, since their resistance can significantly reduce the chances of the new system succeeding (Jones, 1999a). However, while the majority of interviewees support that PLICS will transform the use of accounting information by clinicians, reducing resource usage and overall patient costs, a minority expressed concern regarding the level of engagement clinicians are having in the implementation process. A family service manager within the FYPC (C06) acknowledged that "*I think clinicians on the front line are probably disconnected from the finance and we need to connect them more*".

It may be that the strong professional autonomy of these clinicians in general makes them distrustful of managerial tools aimed at controlling and driving clinical decisions (Jacobs, 2004). This influences the way in which clinical staff perceive cost information which, in turn, creates a gap between clinicians and finance managers. The majority of clinicians did in fact see MA initiatives as rationing tools. According to the interim head of learning and development (C01), "*Clinicians see MA as an administrative tool to control expenditure because they are passionate about delivering the quality of care and for them and for us, the MA shouldn't be a barrier to doing that*". Clinicians have their own cultural references and clinical (professional) logics, and many may view accounting practices as intrusive and not connected with their beliefs and values (Pettersen and Solstad, 2014). If this leads to PLICS being complied with formally but not used for clinical decision making, the system will fail in its aim. True change requires not just the introduction of a new initiative (or modifications to an existing system) but the internalisation of new practices by individuals within the organisation (Padovani, et al., 2014). For the introduction of new initiatives to be successful, an environment must be created that fosters receptivity to change (Abernethy, et al., 2006). The NHSI anticipates that adopting PLICS will lead to a significant improvement in clinicians' engagement with cost data (Llewellyn, et al., 2016), but this will require a considerable cultural shift, and this is unlikely to occur quickly (Harradine, et al., 2011). Without a clear strategy from the Trust, it will be even more difficult (Llewellyn, et al., 2016).

Most clinicians believed that their engagement would be encouraged with appropriate training programmes. A clinical director of mental health (C02) commented: "*The new leadership training is about not only quality but sustainability as well, and this is something historically as clinicians we have not been trained in*". This interviewee's suggestion that clinicians need to be educated on how to take advantage of the potential of PLICS was supported by the interview findings generally, which revealed that none of the clinicians (apart from some senior

staff) knew much about the proposed system. The AMDH service manager's (C08) admission that "*I do not know this system, I do not know that I have ever heard about that*" indicates that clinicians have not received sufficient training about PLICS and that the concept has not yet become integrated into the organisational culture. To do this will require a significant amount of resources (financial, human and organisational) and its acceptance as a strategic issue across the organisation (Arnaboldi and Lapsley, 2005).

There was also strong support among clinicians for improving dialogue and collaboration between clinicians and finance staff. The medical director (C05) explained that

> "*I think clinicians are not always able to understand the financial impact of some clinical decisions. It could be because actually the clinicians have never thought about finance and they have never understood finance, so we need to have more dialogue between finance and the clinicians to close the communication gap between them*".

Creating a collaborative environment is seen in the literature as key to overcoming the cultural barriers between clinicians and finance managers and bringing the expertise of the two groups together to solve problems (Llewellyn, 2001). Both clinicians and financial managers in the Trust emphasised the need for better understanding of each other's professional knowledge and better communication. It has been suggested that such dialogue and collaboration might lead to the differences in meaning between medicine and finance becoming less marked and hence to greater mutual understanding (Llewellyn, 2001). Even if deep-rooted professional rivalry remains strong within the organisational culture, the development of closer working relationships is vital to mitigate any potential conflicts between the two groups (Uslu and Conrad 2011).

The main problem in this relationship is that clinicians and finance managers work with very different sets of ideas and act according to different logics, making it difficult for them to decode and make sense of each other's messages (Pettersen and Solstad, 2014). Messages from clinicians tend only to make sense to other clinicians, and the same for finance managers. When finance managers do try to communicate with clinicians (or vice versa), their messages frequently encounter one-way windows and are reflected back to the domain where they were encoded. The messages tend to lack communicational transparency because the senders and receivers have different experiential backgrounds and thus different frames for sense making (Llewellyn, 2001).

Most of the clinician interviewees strongly believed that senior clinicians holding managerial positions (e.g. clinical directors) can play a vital role in closing the communication gap between clinicians and finance managers and in helping clinicians on the front line to engage with cost information. The clinical director of the FYPC (C07) commented:

> "*It is the job of people like myself in the management leadership positions to make sure clinicians understand the value of several things. The first priority for clinicians is to make sure they are providing good care, but good care does not mean to be expensive. So, if clinicians say, 'This is the best care I can give to my patient,' then the job of people in the leader position is to say, 'Excellent, you should do that, but let's do that in a way that is not going to be expensive'*".

The comment indicates that clinical directors are crucial for closing the gap between clinicians and finance because, as the holders of both clinical knowledge and management responsibility, they can work with both sets of ideas (Nyland and Pettersen, 2004). However, as Llewellyn, (2001) notes, the domain of clinical director represents much more than just a site for collaborative working; it is also the location of a new form of organisational expertise. Another

benefit of having clinicians in management roles, as was highlighted by several clinician interviewees, is that it helps maintain the balance between quality and cost. One clinical director of mental health (C02) explained that

> "*There are two things for me in my role: one is quality and the second thing is financial sustainability. There is a relation between them. It has to be seen together; financial sustainability, the health of the finances, is crucial to the quality of services we deliver. I think as a clinical leader you need to keep your eye on quality as well as the sustainability of the service you provide*".

This implies that clinical directors seek to find the right balance between quality and efficiency using both their accounting and clinical knowledge.

From the financial perspective, the overwhelming majority of interviewees highlighted that PLICS will be welcomed by clinicians rather than resisted because they will see the cost information the system generates as relevant to their clinical decision making; in other words, they will see it as serving the patient's needs rather than those of the organisation. According to F07 (clinical director of mental health),

> "*The clinicians are interested in the PLICS system so this will help them get more involved in the finance. PLICS gives us a more accurate picture. At the moment, we use spreadsheets to work out the cost of service line reporting and that is not very accurate. The PLIC system is more up-to-date as well, and we can track the cost better; we can follow the patient through their journey in our Trust, so it's more accurate*".

Any cost accounting system with this kind of potential may be considered beneficial to clinicians and therefore more likely to engage them, but the finance managers in the interview

sample were optimistic that it would also engage clinicians by giving them a clear insight into the limitations of the available financial resources and the importance of maintaining sustainability. Almost all interviewees noted that cost awareness among clinicians has grown over the years, and that this will continue under PLICS because it highlights the cost consequences of their clinical decision making. A finance manager F05 commented: "*I think clinicians are far more aware of the financial environment, far more aware of business opportunities within particular services and far more aware of the changing in the finance at the moment*". The comment suggests that although MA has not previously provided clinicians with data relevant to patient care, it has succeeded in raising their cost awareness (Jacobs, et al., 2004). Through PLICS, it is suggested that it will be able to provide relevant and accurate cost information at the level of individual patient activities, which will not just sustain this awareness but encourage clinicians to engage more with costing information.

5.5 Contextual (Technical) Factors

Advanced IT systems are crucial to the implementation of sophisticated costing systems such as PLICS (Krumwiede, 1998). However, most interviewees (clinicians and cost accountants) were concerned about the level of IT currently available in the Trust, with many arguing that it is unable to generate the robust data required by PLICS. As the Trust's financial director (F11) explained:

> "*We can only be as good as what has been put into the system. If the activity is not recorded correctly, then what comes out is incorrect. But it is the only data we've got, so we quite often have this debate about the quality of the data put into the system*".

The comment highlights the importance of data quality; no matter how detailed and accurate a methodology is, if the activity data is inaccurate, it will produce poor outcomes (HFMA, 2016).

However, it is not just the availability of good quality data that determines an organisation's ability to develop its costing and reporting (CIMA, 2009); the format of this data is also crucial. The Trust captures a lot of clinical data, but primarily for clinical rather than costing purposes. It, like all other NHS trusts, faces the challenge of improving both the quality and format of its activity data so that it can produce the information it needs to implement an accurate costing system (Manoy 2014). Recognising this, the NHSI has identified raising the standard of clinical activity data as its first priority in its efforts to improve the accuracy, consistency and relevance of costing (NHS Improvement, 2018b).

The main strength of PLICS is their ability to combine activity, financial and operational data into one system to cost individual episodes of patient care (Ellwood, et al., 2015). However, this is made more difficult if these different sets of data are held in disparate IT systems. This was acknowledged by the interviewees, most of whom emphasised that the current lack of integration[2] between the finance and clinical systems in the Trust must be tackled before PLICS can be implemented. The project's cost accountant F09 commented that

> "*The activity data is got from the information department. In our Trust there are about three or four systems storing the activity data. It is quite difficult to gather all the activity data. We have to ask the information department to give us the activity data because we do not have access to the data. Until we make progress with that, we can't make progress in applying the PLICS*".

The integration of clinical data into the financial system and communication between the two systems are key to the success of PLICS, which relies on being able to consolidate these different kinds of data for costing purposes (CIMA, 2009).

[2] This lack of integration means there is no clear process for sharing data between the financial and clinical systems (Juhnke 2012).

Improving the IT so that it can bring all the data together and provide it in the format and quality required is therefore vital (Llewellyn, et al., 2016), but the majority of interviewees felt that notwithstanding recent improvements, the Trust's IT system is still insufficiently advanced to provide the data required for PLICS. One clinical director (C05) observed that

> "*I do not think there is much interrelation between the finance and clinical systems, but we are trying to improve it. The technology has improved. For the finance system it is absolutely essential that they get all the data on clinical activity accurately. At the moment, we have a problem getting all the data accurately. It is not easy for clinicians to record – they are recorded, but the system is not given the right report, so we have a problem*".

The comment is positive in that it suggests that clinicians are aware of and support the need for better communication between the finance and clinical systems. At the moment, however, their efforts to record, collect and report clinical data are being frustrated by the limitations of the IT system.

To conclude, the success or failure of the PLICS implementation will be contingent on both organisational/human and contextual factors. If the Trust's PLICS is to effect real transformational change in how costing information is produced and used in the Trust, it will require not only good information and communication systems but also clinicians' engagement and organisational cost consciousness.

5.6 Conclusion

This chapter presents and discusses the findings with regard to the operational role of MA in the Trust, as represented in its cost accounting system. The discussion reveals that the Trust's current cost system is not sophisticated enough to provide detailed, accurate and relevant information to clinical decision makers, having been designed to meet corporate and regulatory

requirements rather than to support clinical performance. The system is dominated by the external information needs of the regulator (NHSI). The findings highlight the importance of designing and implementing a costing system that underpins the operational role of MA and enhances the effectiveness of accounting information in Trust. This system should also encourage clinicians to become more aware of the cost consequences of their clinical decisions, in addition to the assessment of the economic effect of processes and activities (Cannavacciuolo, et al., 2015; Pizzini 2006; Jacobs, et al., 2004).

PLICS have been recommended by the NHSI as a way of effecting radical transformational change and providing costing information that has greater relevance to clinical decision making. However, it is unclear whether PLICS will have the anticipated impact or prove ultimately as ineffectual as previous cost initiatives; though implementation is still in the pilot stage, the findings indicate that several big challenges need to be addressed if PLICS are to have significant impact. The discussion identifies a range of factors that affect the ability of PLICS to achieve positive results. These factors are categorised into organisational/human (e.g. the level of clinician ownership and the level of training provided) and contextual/technical (primarily the level of sophistication of the available IT).

In terms of organisational factors, it emerged that the success of PLICS depends mainly on reducing clinicians' resistance to their implementation. This requires a clear strategy from trusts. Appropriate training programmes and the development of dialogue and a collaborative environment are also likely to have a major impact on clinicians' involvement in PLICS. These two factors are important to overcome the cultural barriers between clinicians and finance managers and to promote mutual understanding.

While the findings indicate a communication gap between finance staff and clinicians, they also reveal that clinical directors, as senior clinicians who also hold managerial positions, can

play a role in closing this gap. Clinical directors have access to managerial thinking, have some control over how these ideas are presented to other clinicians and are able to disseminate information from management. In this way, they are able to channel ideas from management to other clinicians (Llewellyn, 2001). The findings suggest that the relationship between those in managerial and clinical/professional roles will be problematic until the behaviours associated with financial awareness and cost control become normalised and accepted within the medical profession (Kuhlmann, et al., 2013; Kurunmäki, 2004).

In terms of the contextual/technical factors, the findings reveal the significance of IT in facilitating the implementation of PLICS. The lack of software packages, data requirements and integration between clinical and finance systems were seen by interviewees as impediments to the successful implementation of PLICS in the Trust. This finding suggests that organisations with more advanced IT and shared databases, that track the detailed operational data needed for resource and activity analysis, could have an easier time implementing advanced costing systems such PLICS (Krumwiede, 1998). IT is essential for the complete, timely and accurate computation of costs (Jiménez Carabalí, 2018); the challenge facing the Trust is to develop its IT so that it is able to provide the quality of data required by these advanced costing systems.

Chapter 6. Findings:

The Role of the Budgetary Control System in the Trust

6.1 Introduction

The focus of this chapter is on budgetary control systems, an integral part of MA. These systems can help NHS trusts deal with the many challenges they face (Harradine, et al., 2011). The chapter is set to provide explanation to the managerial role of budgetary system. The central question addressed in this chapter is whether the budgetary control system being used in the Trust is fostering or hampering clinicians' ability to maximise the Trust's public value and how can improvements be made.

Budgetary systems act as a vital integrative mechanism which combine the impact of the many varied factors concerned into a measure of organisational effectiveness (Otley 1987). The sole

formal integrative control at senior management level, they are used to ensure probity, control total expenditure and provide data to government (Goddard, 2005; Otley, 1987). Budgetary control systems are frequently criticised for being slow to adapt to changing environmental or organisational demands, for making people feel undervalued, for strengthening command and control relationships and for creating relatively little value for the time they take to prepare (Hope and Fraser, 2003). Despite these criticisms, however, they remain important for planning and performance evaluation (Derfuss, 2009). Otley (1978) suggests that their effectiveness depends not only on their technical suitability to the particular organisational and environmental circumstances, but also on the way in which organisational participants make use of the information they provide.

The chapter is organised into six sections. Section 6.2 discusses the budget setting in the Trust, after which section 6.3 considers the role of the budgetary control system. Section 6.4 discusses the strategic focus of the system, while section 6.5 addresses its control and empowerment role and section 6.6 its role in facilitating performance improvement. Finally, section 6.7 reviews the main findings of the chapter.

6.2 Budget Setting in the Trust

The observations indicate that the Trust relies on its budgetary control system to regulate and direct its performance towards the attainment of its objectives. The Trust's budget is determined largely by the contract negotiation with CCGs, who commission about 80% of the Trust's business. In the absence of national tariffs for community health services, the budget is based on the block contract, under which it receives a set sum, regardless of the number of patients treated or the actual volume of activities undertaken. The Trust thus carries much of the risk of increased demand and cost. The budget is set mainly using historical cost data,

adjusted to take into consideration the saving/efficiency requirement and inflation (Chalkley and McVicar, 2008).

Observations and discussions with interviewees reveal that Once the contract with the CCGs has been agreed, the Trust's chief executive submits a business plan which takes into account the Trust's financial targets and forecast resource availability. Prior to the start of the financial year, the director of finance prepares the budget, against which he monitors the Trust's financial performance. At the directorate level, the budget is divided into twelve months and delegated to budget holders (managers), who are authorised to spend a given amount of money on specific activities. Budget holders may incur expenditure up to the budget level without referring to a higher authority. This authorisation function is closely tied to the formal distribution of responsibility and authority within the Trust and with the ideas of responsibility accounting (Prowle, 2014; Emmanuel and Otley, 1990). Each of the Trust's four divisions contains both medical and non-medical cost centres, each of which has its own budget holder who is responsible for pay, non-pay and income. In this way, the budget is passed down from one level to the next through the formal chain of command.

The Trust's approach, which is what the literature describes as the conventional approach to budgeting (McCarthy and Lane, 2009; Hope and Fraser, 2003; Macintosh, 1985), is essentially incremental; that is, the budget remains broadly the same from one year to the next. The starting point for preparing the following year's budget is the Trust's existing operations and current allowance for existing activities. This base is then adjusted for any changes which are expected to occur during the new budget period. The major disadvantage of this approach is that most of the expenditure associated with the base level of activity remains unchanged (Perrin, 1988).

6.3 The Role of the Budgetary Control System in the Trust

The review of the MA literature revealed that budgetary control systems can play a number of organisational roles. According to Sponem and Lambert (2016), these include motivating managers to make plans, informing managers about what they are expected to do and accomplish, fostering manager commitment, coordinating the organisation's various activities, and providing a standard by which to judge actual performance. They may also assist the organisation in its strategy formation and implementation, communication with shareholders and external interested parties (via the annual report), resource allocation, spending decisions and risk management. Hansen and Van der Stede, (2004) categorise these various roles into short-term operational (operational planning and performance evaluation) and long-term strategic (communication of goals and strategy formation), while Prowle, (2014) divides them into traditional (planning, controlling and resource allocation) and modern (delegation, strategy implementation, performance improvement, prioritisation of activities and services, and motivation). In terms of the NHS specifically, Harradine, et al., (2011) see budgetary control systems as playing three main roles: strategy implementation, control and empowerment and performance improvement. These are therefore the focus of the discussion in this chapter.

According to contingency theory, there is no universal (best design) for budgetary control systems. No single system will be relevant to all organisations, so it is up to organisations to design a system that best suits their own circumstances (Otley, 1987) and addresses their most important problems. Some, for example, may choose to focus more on operational planning while others may focus more on performance evaluation (Hansen, 2011). The role budgetary control plays within the organisation may be influenced by budgetary characteristics such as choice of target difficulty, the number of individuals involved in the budgeting process, and the degree of emphasis placed on meeting budget targets (Hansen and Van der Stede, 2004). The following sections discuss the effect these and other (contextual) characteristics have on

the Trust's budgetary control system and its strategic, control and empowerment and performance improvement roles within the Trust (Harradine, et al., 2011).

6.4 Strategic Focus of the Trust's Budgetary Control System

The first criterion for evaluating the role played by the budgetary system in the Trust is its strategic focus. It is important to ensure that the budget-setting process is informed by the organisation's strategic priorities and that it takes into account proposed changes (Prowle, 2014), but the incremental nature of the Trust's budget-setting process (see section 6.2) means that resources are allocated using historical cost data that does not reflect the future strategic direction of the organisation. The majority of interviewees (clinicians and finance managers) strongly believed that the budget-setting process should facilitate the achievement of longer-term strategic objectives and were critical of the lack of strategic direction; the deputy director of finance (F10), for example, argued that "There should be a connection between the strategic objectives and the budget, but the reality is that the budget does not get tied to our strategic objectives".

One factor that has an adverse impact on the budget's strategic focus is the lack of flexibility around revisions and the reallocation of resources. The Trust faces intense pressure from the centre to reduce costs, which it is forced to pass on to budget holders. It stipulates that "All budget holders will be expected to formally agree their allocated budgets at the commencement of each financial year and be accountable for maintaining income and expenditure within budget". It imposes restrictions on the behaviour of budget holders, even reviewing their performance every month in order to highlight any deviation from the budget. If they are unable to meet targets, they are required to "explain and give a rationale or a reason why we could not achieve the target" (Mental Health Services manager/C08) and to describe the action that will be taken to correct the deviation. Intolerance of interim budget deviations and routine

inspections of performance are characteristic of tight budgetary control (Van der Stede, 2001). The vast majority of interviewees (clinicians and finance managers) felt that the annual budget trap discourages strategically focused behaviour; as the Trust's financial director (F11) put it: "*We shouldn't be working on the annual cycle, we should work on the five-year plan*". The finding implies that the budgetary control system in the Trust introduces rigidity rather than flexibility into the management process, diverting attention away from the Trust's long-term strategic focus. It supports the argument that budgetary control systems whose primary focus is the accomplishment of short-term budgetary targets are unlikely to foster long-term strategic viability (Wood and Wood, 2005).

Another factor contributing to the lack of strategic focus in the Trust's budgetary control is environmental uncertainty. This was noted by a few interviewees, who described the difficulty of thinking long-term in the current NHS context. Changes in the budget (and thus the available resources) over the years, the rise in demand and shifts in political policy were all seen by interviewees as creating a high degree of uncertainty in the environment around the Trust. The interim head of learning and development (C01) commented that "*By the nature of the NHS we are absolutely at the mercy of politicians; so, you could have a great budget, but you have to shift to pay for other things because the politicians tell you to do so"*. Such uncertainty makes long-term strategic focus more problematic; future events become highly unpredictable, making it difficult to know whether budget goals will still be appropriate (Ezzamel, 1990) or even rendered obsolete (Ekholm and Wallin, 2000). The findings indicate that the Trust's budgetary control system is budget- rather than strategy-focused. It is out of alignment both with the Trust's strategy and with its rapidly changing environment – an environment that demands flexibility and initiative rather than rigidity and compliance.

As noted above, one of the main consequences of the budgetary control system in the Trust is the concentration on short-term performance at the expense of long-term performance. Almost all of the interviewees were primarily concerned about the immediate pressure to meet the budgetary objective; one service manager in the Mental Health Services (C08) commented that "*My performance is mainly focused on the financial year*. *A lot of talk in meetings is around this financial year rather than any sort of further long-term performance*". The comment reflects the fact that the budgetary system in the Trust drives managers to focus on attaining annual objectives. However, the course of action that is best in the short term may not be the best over the long term; for example, a manager might decide against pursuing long-term strategic opportunities if the required action incurs immediate cost and the benefit is still uncertain (Sternad, 2014). The overwhelming majority of interviewees saw the necessity of balancing long-term sustainability with short-term profitability, but even more highlighted the difficulty of long-term thinking in an austerity environment. The medical director of the Trust (C05) acknowledged that "*There is a significant deficit in the NHS budget. So, when we have that kind of pressure, there is always actually pressure from the centre saying that you have to balance the books"*. This pressure significantly reduces the level of financial flexibility available to the Trust with regard to the budget.

The Trust might be less short-term-oriented if a more flexible mode of management was introduced. This is necessary to reconcile the tension between the need to meet annual financial objectives as expressed in the budget and the need for flexibility to ensure long-term sustainability. Continuous budgeting (using a three- or five-year cycle) might help avoid the inherently restrictive nature of budgetary control by enabling managers confronted by unexpected events to revise plans and reallocate resources in pursuit of strategic organisational objectives. This does not mean abandoning the budgeting system but integrating it with other control processes to allow managers to respond to unexpected events (Frow, et al., 2010).

6.5 Control and Empowerment

One of the main roles of a budgetary system is to control and contain overall expenditure within the agreed budget. The aim is to encourage, enable and force managers to act in the best interest of the organisation (Johansson and Siverbo, 2014). Budgetary control is used to guard against the possibility that people will do something the organisation does not want them to do or fail to do something they should do. It should induce the desired behaviour and limit dysfunctional behaviour, though this is not always an easy task (Morris, et al., 2006). The main challenge is to choose a control system that strikes the right balance between empowerment and accountability and between top-down direction and bottom-up creativity (Morris, et al., 2006); in the Trust's case, this means being both an effective instrument of managerial control and a tool for empowering staff and managers (Harradine, et al., 2011). However, the findings suggest that in practice, the Trust's budgetary control system currently serves to control rather than to empower staff.

It was observed that the budgetary control system in the Trust is top-down- and command and control-oriented. Budget limits are set by top management and imposed throughout the organisation, with tasks, responsibilities and functions being cascaded down to achieve national and local[3] objectives and targets. A national inspection and monitoring regime (see section 7.2) ensures that the Trust is carrying out its function in a way that meets NHS targets. A few interviewees attributed the top-down orientation of the budget to the pressure from central government to make progressive efficiency savings; the head of corporate finance (F01) explained that "*In the last few years, budget preparation has been top-down, simply because of the external pressure we face*". This pressure has led the Trust to adopt cost improvement

[3] The local requirements are those set by the Better Care Together (BCT) programme, a collaborative partnership of key health and social care organisations.

programmes (CIPs) focusing on key line items within the budget, with the aim of driving down costs and holding managers accountable. The literature describes this focus on certain line items as characteristic of rigid budgetary control systems (Van der Stede, 2001). In such systems, budgetary targets are normally passed down from the top executive team to the operational front-line staff who will deliver the services and functions (Latham and Prowle, 2011). The annual budgetary targets and rigidly delineated responsibilities associated with such systems are seen in the literature as limiting the scope of managers to operate flexibly (Frow, et al., 2010); in other words, they may be seen as inhibiting empowerment.

Another factor inhibiting the empowerment of staff in the Trust is its organisational structure. Staff empowerment is facilitated by a decentralised organisational structure in which power and authority are transferred to operating managers, who can use their judgement and initiative to achieve their goals (Frow, et al., 2010). However, austerity has led to strict spending limits being enforced across the NHS (Prowle and Harradine, 2014) and, the Trust has forced to take tight control of its finances, and much of its financial decision making. The result is that budget holders in the Trust have been largely disempowered as their authority to spend has been significantly curtailed. Where they were once able to spend £50,000 before needing to get authorisation from senior directors, their upper limit is now just £250. This erosion of authority indicates a lack of trust and real delegation and highlights the way in which financial decision making is now chiefly in the hands of senior level staff.

Despite this, however, there was evidence that the budget is used interactively through face-to-face meetings between managers in different functions and at different levels to discuss budgeting issues regardless of actual performance. While most clinician budget holders considered the dialogue between senior and business unit managers to be important in breaking down hierarchal barriers, few of them were keen to do more of it. As the Trust's medical

director (C05) explained: "*It is important to have that kind of conversation, but I think we need to have more dialogue between managers in different levels of the Trust"*. Such dialogue about the budget, which is an important aspect interactive use of budget, is important in encouraging information sharing and enabling employees to search for opportunities to improvement and solve problems (Linder and Torp, 2017).

The findings suggest that the Trust's accounting-based budgetary control system strengthens vertical command and control and is thus incompatible with staff empowerment. Johnson (2002) argues that bottom-up empowerment is virtually inconceivable in organisations that are dominated by top-down control systems, which give ownership of information and decision making to top managers. The majority of clinical managers were strongly of the opinion that there is no balance between empowerment and control in the Trust because the strong emphasis on budget allows little or no room for flexibility. This balance is more likely to be struck with a more bottom-up, decentralised structure that enable staff to influence their results and the freedom to take action (De Waal, 2013). At the moment, the Trust's budgetary system disempowers staff by denying them the resources they need to act.

6.6 Performance Improvement

The budgetary control system, and particularly the budget-setting process, can provide an opportunity to improve operational performance in NHS trusts by motivating managers to improve their performance against the budget target (Harradine, et al., 2011). In this way, the budgeting system becomes a key driver of performance improvement though success depends on the interest and willingness of staff to engage with the process (Frow, et al., 2010). When the budgeting process is complete, each manager ends up with a specific target for which to aim (Barrett and Fraser, 1977). This budget target may range from very loose and easily attainable to very tight and unattainable(Van der Stede, 2001). Easily attainable goals fail to

present a challenge to participants and therefore have little motivational effect. Very tight and unattainable goals, on the other hand, lead to feelings of failure, frustration and lower aspiration levels (Kenis, 1979). Dysfunctional behaviour is more likely to occur in a rigid budgetary control system in which managers are evaluated primarily on whether or not they have achieved their budget target (Van der Stede, 2000).

The findings from the interviews and observation revealed that the Trust's reduction of cost centre budgets has created major challenges for budget holders now obliged to comply with significantly reduced spending levels. The vast majority of budget holders believed their budget target would be extremely difficult to meet, and none thought it would be easy. One paediatric consultant (C04) explained that "*The budgetary target has become much harder to achieve because our paid get down and there is no capacity to absorb anything extra*". The literature generally supports the case for having a small number of motivational targets that are challenging but not impossible (Merchant and Otley, 2006), but for some interviewees, the perceived difficulty of their targets has proved demotivating. The majority, however, considered it as the main problem need to be addressed in the future to tackle the rise of demand. A service manager in the mental health service C08 admitted: "We are not going to meet our target this year; we are already looking at overspending". The comment reveals the frustration of many budget holders (especially in the Mental Health Services, where demand has increased significantly) faced with targets they see as unachievable.

The more staff participate in the process of setting the budget, the more committed they are likely to be to achieve its targets (Buckley and McKenna, 1972). In the case of budget holders, this means having the opportunity to influence the budget for which they are accountable (Collins, 1978). Most of those interviewees who were budget holders considered this participation important in motivating them to improve performance, but very few said they had

any influence over the setting of the budget target. One ward matron (C09) in the mental health service explained that

> "*As a budget holder, my budget is set out for me. I would imagine as a budget holder I should be able to say this is my money and I want to break up it like this, whereas that decision is taken out of my hands*".

The comment indicates that managers are not given the opportunity to negotiate their targets; instead, these are imposed by the Board in accordance with the Trust's overall efficiency target. One clinical director budget holder (C07) noted that "*The money is taken off anyway; so, it is not an option*". As with unachievable targets, lack of participation in setting targets was demotivating for some budget holders. Some interviewees argued that such participation would make them feel greater commitment to the budget and therefore more motivated to achieve its goals. This is not to imply that middle managers should be able to determine the content of their own budget, but rather that the content should be discussed with them and the budget set in a way that takes their views into account (Otley, 1987).

The main consequence of rigid budgetary control in the Trust is the overwhelming focus on cost reduction rather than the maximisation of public value. However, as a public-sector organisation, the NHS's efforts to maximise public value should be driven not just by cost efficiency (that is, the need to continually reduce costs and provide good stewardship of public funds) but also by effectiveness (that is, the need to understand what services or health outcomes users value and to enhance these services). Together, these two drivers provide the motivation and rationale for cost efficiency and the delivery of enhanced value to service users (Radnor and Osborne, 2013). The majority of interviewees argued that the pressure to reduce costs has led to a focus on increased efficiency at the expense of quality or health outcomes. A service manager (C10) in the Mental Health Services commented that "*We provide the service*

in the way that fits with the budget rather than in the way that is best for the patient, and that affects the quality of services provided".

In the 2017/2018 financial year, the Trust managed to deliver a £3.1 million surplus, as a result of which it was awarded sustainability and transformation funding of £1.556 million from the NHSI (included in the final out-turn of £4.675 million surplus). Budget constraints have thus had a positive influence on resource consumption in the sense that they have led to the budgetary objective being achieved, but this should arguably be seen as a hollow victory. Balancing the books does not mean the Trust has met all its service demands, nor does it mean the organisation has operated efficiently (Arnaboldi, et al., 2015); the adverse impact on service quality is clear in the CQC's overall rating of the Trust as requiring improvement. In fact, the observation revealed that the cost saving was mostly due to staff cuts rather than more efficient use of resources.

As a public-sector organisation, efficiency in the NHS is not just about maximising output quantity and minimising input costs. It is also about the quality of outputs, whether some citizens should receive more or better-quality outputs on grounds of need, whether current output should be reduced to support investment in future service production, and the fit between the types of output produced and the outputs citizens want (Andrews and Entwistle, 2014). In the Trust, there is already conflict between the need for efficiency savings and the need to meet increasing demand with an acceptable level of healthcare; this conflict is only expected to get worse. Most interviewees strongly believed that the big challenge for the Trust at the moment is to improve quality within the funding constraints. As one paediatric consultant (C04) put it: "*Efficiency saving is getting more and more difficult because the easier efficiency has been done"*.

Managing the tension between these different dimensions of performance remains one of the most important tasks in public sector organisations (Andrews and Entwistle 2014). The Trust's financial director (F11) explained the importance of maintaining the balance between quality and finance:

> "*We can set a nice financial outcome or target, but it will have a quality impact. On the other hand, if we just focus on the quality then we will end up putting our budget into overspend. What we are trying to do is get the right balance consistently and that is not an easy task*".

The concern over how best to provide services within the budget has increased the emphasis on efficiency in the Trust. However, given that the tension between efficiency and quality is created by clinical activities, the best chance of resolving this tension is to allow clinicians to have an input into the budgetary control process. At the very least, this will encourage them to think about the balance between quality and finance in their everyday practice.

The findings of this study appear to support some of the main criticisms that have been levelled at traditional budgeting: first, that it is time consuming and expensive and adds little value for users; second, that its emphasis on rigidity and compliance leaves it ill-equipped to support either strategic alignment or environmental change; third, that it undervalues employees and encourages dysfunctional behaviour; and fourth, that it tends to reinforce departmental barriers rather than foster knowledge sharing (McCarthy and Lane, 2009; Clarke, 2004; Hope and Fraser, 2003).

Researchers have offered a range of suggestions for resolving these issues, from ideas for maintaining and improving the budgeting process (Libby and Lindsay, 2010) to arguments for abandoning it completely (Hope and Fraser, 2003). The empirical findings from the Trust reveal that although most clinical managers were dissatisfied with the current budgeting

process, there was very little support for abandoning the budget altogether; just one ward matron in the mental health service (C09) believed that the budget adds no value to the Trust, while the vast majority of interviewees saw it as adding value. The empirical results thus support the argument that despite its shortcomings, the traditional budgeting process is still generally regarded as robust and as playing a vital role and that, while many believe it needs improvement, there is little appetite to see it replaced (McCarthy and Lane, 2009; Ekholm and Wallin, 2000; Libby and Lindsay, 2007)

6.7 Conclusion

This chapter examines the effectiveness of the Trust's budgetary control system, focusing specifically on its role in supporting the organisation's strategic focus, its controlling and empowering role and its performance improvement role. The chapter addresses two of the study's research objectives by (1) examine the managerial role of budgetary control systems in the Trust and (2) analysing the factors that impact its effectiveness.

The empirical results illustrate that management processes in the Trust are built around a budgetary system that is concerned with setting efficiency targets and monitoring and evaluating the performance of managers and their units (Otley 1987). MA supports the traditional system of accountability to influence managerial behaviour. It is used to centralise control and underpin a structure built around a rigid hierarchy of relationships (Jermias and Setiawan, 2008). It focuses on hierarchical accountability for inputs (administrative rules guide routine tasks and budgetary allocations) and reinforces legal accountability for process which focuses on audit site visits and other monitoring tasks (Heinrich, 2002). MA serves as a formal means of communicating rules for expected behaviour, norms and values, which managers and staff are expected to follow (Collins, 1978). This reliance on detailed standard operating procedures to control inputs and processes effectively disempowers staff because it prevents

them from responding creatively to customer needs or devising better ways of operating (Simons, 1995).

With regard to the second objective, the effectiveness of the Trust's budgetary control system appears to be influenced by a mix of contextual (e.g. organisational structure, external pressure and uncertainty) and budgetary factors (e.g. budget priorities, staff participation and intended use). The interaction between these two sets of factors determines the role played by the budgetary control system, ensuring that it is driven by accountability rather than empowerment, top-down direction rather than bottom-up creativity, and efficiency rather than flexibility. Spending limits under fiscal austerity have led the Trust to adopt a rigid system to meet the efficiency requirement, resulting in two main dysfunctional behaviours: short-term performance orientation at the expense of long-term orientation; and emphasis on cost reduction rather than on maximising public value.

Chapter 7. Findings:

The role and contribution of management accounting to strategic management in the Trust

7.1 Introduction

The main objective of this chapter is to explore the contribution of management accounting to strategic management in the Trust. This chapter is set to provide explanation about the effectiveness of MA's strategic role in the Trust and how can improvements be made. It discusses the three main aspects of MA's strategic role: that is, the effectiveness of strategic

performance management (SPM) in the Trust; the role of MA in supporting the strategic orientation or focus of the Trust, using the balanced scorecard (BSc)[4] ; and the strategic role of management accountants (MAs) in strategic decision making and the factors that affect this role.

The relationship between strategy and management accounting (MA) is one of the most debated concerns in the MA literature. Strategy has been defined in many ways; for example, it has been described as a pattern of decisions about an organisation's future which take on meaning when implemented through the organisation's structure and processes (Miles, et al., 1978), and as a long-term, future direction through which organisations seek to maintain and improve their performance (Andrews, et al., 2009). All organisations need to have a clear strategic orientation, identifying long-term goals and objectives and adopting the courses of action and allocating the resources they need to achieve these goals (Prowle, et al., 2013). However, public sector organisations such as the NHS differ from those in the private sector in terms of what drives this strategy. In the private sector, strategy is normally driven by the need to find ways of outperforming rivals in a competitive market (Genc, and Şengul, 2015). In the public sector, however, competition rarely extends beyond the development of quasi-markets, and strategy is instead driven by a desire to improve public value rather than to attract customers (in this case, patients) away from similar providers (in the NHS there is an excess demand rather than a demand deficit). Accordingly, this is how the term "strategy" is understood in this thesis. This pursuit of public value is relatively durable and unlikely to change significantly in the short-term (Prowle, 2014; Cuganesan, et al., 2012).

MA can play a significant role in ensuring that performance is in line to achieve organisational strategies and goals (Langfield-Smith, 2006). In accordance with the main objective of the

[4] BSc is a strategic performance management system that translates an organisation's mission and strategy into a comprehensive set of performance measures (Kaplan and Norton 1996a, 1996b).

thesis – to explore the contingent nature of MA in the NHS – this chapter examines the relationship between MA and organisational strategy in one community health trust in England.

The chapter is organised into eight sections. Section 7.2 discusses the external pressure that the Trust faces from regulatory and inspection agencies (i.e. its regulatory context). This is followed by section 7.3, which addresses SPM (including vision, values, strategic objectives and strategic priorities), section 7.4, which evaluates the effectiveness of the Trust's strategic planning, and section 7.5, which considers the factors that affect its ability to execute this strategic plan. Section 7.6 discusses the Trust's mechanism for strategy control – that is, its performance measurement framework – while section 7.7 discusses the strategic role MA plays within this performance measurement framework. The involvement of MAs in the strategic process is explored in section 7.8. The chapter concludes, in section 7.9, with a brief summary of the main findings.

7.2 External Pressure Posed by Regulatory and Inspection Agencies

It is the job of independent regulatory agencies to monitor and direct the performance of regulatees to ensure it is in line with government targets and priorities. To aid them in this task, regulators have a wide range of instruments at their disposal, including performance indicators, planning systems, inspection, auditing, budgetary controls and annual reports (Ashworth, et al., 2002). Figure 7.1 shows that the Trust is embedded in a highly complex network of relationships with external regulatory agencies. The observations reveal that it is subject to significant pressure from three main sources: two regulators (NHS Improvement (NHSI) and the Care Quality Commission (CQC)) and clinical commissioning groups of GPs (CCGs). These agencies exercise sustained and focused control over the quality and financial aspects of the Trust's performance to ensure it delivers community health services efficiently and effectively.

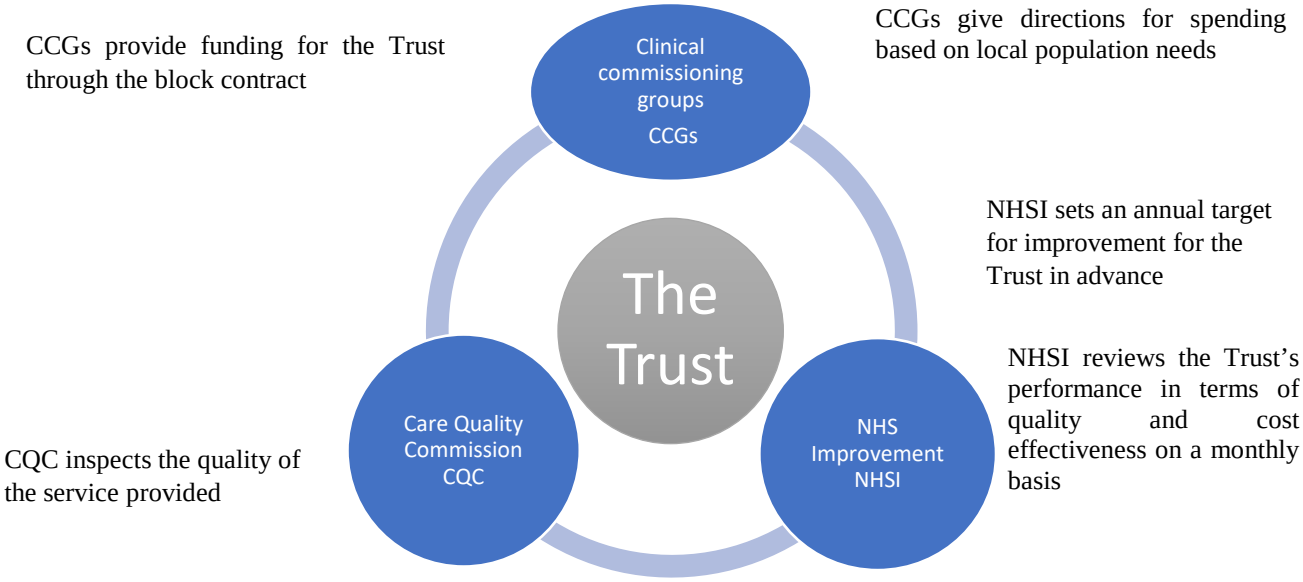

Figure 7.1 Regulatory Context of the Trust

The Trust's financial performance is regulated by the NHSI. This organisation is responsible for inspecting the performance of foundation trusts, NHS trusts and independent providers supplying NHS-funded care. It was established in April 2016 with the merger of Monitor; the NHS Trust Development Authority; Patient Safety, including the National Reporting and Learning System; the Advancing Change Team; and Intensive Support. The NHSI's main role is to ensure that public money is spent economically, efficiently and effectively (NHS Improvement ,2018)[5]. The Trust's head of corporate finance (F01) explained that the Trust is required not only to break-even but also to meet an annual financial target (called the control target) set by the NHSI. This target may be a surplus control or a deficit control, depending on the financial position of the Trust (deficit or surplus); in either case, the Trust is required to show how the target has been met. The interviewee went on to explain that the NHSI monitors the Trust's performance on a monthly basis and that if it misses its financial target, a turnaround

[5] https://improvement.nhs.uk/about-us/how-we-work/

team will be brought in to support it in resolving the problem. In the 2016/2017 financial year, however, the Trust succeeded in meeting its surplus control target of £2.3 million.

The second key aspect of performance to be monitored by regulators is the safety and quality of the services provided. The Trust is subject to annual inspections by the CQC, the key agency charged with inspecting the safety and quality of both NHS and privately funded services (www.cqc.org.uk). This independent regulator is also responsible, along with the NHSI, for issuing healthcare providers with a joint licence of safety and quality and for ensuring the continuity of services[6]. In its 2017 inspection report for the Trust, the CQC assessed the Trust's performance in fifteen core services across community and mental health. The services were evaluated on the extent to which they were deemed safe, effective, caring, responsive and well led. The Trust was rated "good" for caring but as "requiring improvement" in the other dimensions. The overall result was "requires improvement".

The block contract with CCGs (clinically led statutory NHS bodies) forms the third plank in the Trust's regulatory context. About 80% of the Trust's business is commissioned by CCGs; this involves determining which services are required to meet the needs of local stakeholders and ensuring that these services are provided to the required standard. CCGs place pressure on the Trust in terms of both finance and quality[7]. They fund the Trust for those services they consider are needed to meet local requirements, with the incentive of a bonus if it also delivers on that year's CQUIN (commissioning for quality and innovation) plan. This national scheme for improving services involves NHS England each year choosing an aspect of the service that it wants providers to improve. This is then incorporated into the CCG contract with the provision that the Trust can take 2.5% of the contract value as a return if it achieves the desired

[6] https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are
[7] https://www.england.nhs.uk/ccgs/

improvement. The Trust is therefore under pressure to deliver on the CQUIN if it wants that extra money. CCGs also place pressure on the Trust to meet the standards set out in the National Institute for Health and Care Excellence (NICE) guidelines and the CQC's service guidelines.

The Trust is thus under pressure to achieve outcomes and targets set by regulators who want to devolve some responsibility for services to the local level. This pressure is exacerbated by current financial constraints, which make good outcomes even more difficult to achieve. The majority of interviewees strongly believed that this pressure affects the way the Trust provides health services; the Trust's financial director (F11) explained that

> "*The contractual arrangement between commissioners and provider comes under scrutiny and pressure, and therefore we end up with this standoff between commissioners and providers. When you have this distraction in the middle, it can affect the way you provide services*".

This suggests that the Trust is not a sovereign power but executing government functions under delegated authority by way of legal obligation (Johanson, 2009). The criteria that the CQC and NHSI use to evaluate trusts are nationally driven, and numerous interviewees asserted that they are rigidly applied, primarily to ensure that government policies are being implemented. However, the fact that "*The commissioners do get involved in the discussion of improvement and changing, and they want to know what we are going to do and how we are going to change things*" (deputy director of finance/F10) suggests that CCGs may have a broader interest in improving performance. The Trust thus faces the challenge of achieving a diverse range of targets and performance standards that reflect the varied interests of its regulatory stakeholders.

This sustained and focused control over the different aspects of trust performance may be interpreted as a response to an organisational context that is characterised by a relatively weak internal hierarchical structure, the presence of strong professional groups (clinicians) and a

culture that resists managerialism in favour of individualism and professionalism. In such an organisational context, regulation is the mechanism that gives those who manage the trust greater internal power (Nunes, et al., 2009). It also provides a mechanism for managing performance; rather than using a traditional bureaucratic hierarchy to oversee the implementation of strategy across the massive, complex enterprise that is the NHS, the institution is treated as a network of smaller organisations (trusts, foundation trusts and commissioners) and the job given to regulatory agencies (Walshe, 2003).

The overwhelming majority of interviewees saw the prioritisation of the near term over the longer term as a direct consequence of the regulatory environment. None of the interviewees were concerned with long-term performance. Current government policy is oriented towards the NHS as a whole achieving a budget surplus, and this puts pressure on trusts in the short term. One clinical director (C02) commented that *"At the moment, the way we're working is really about the balance, the sustainability through the year"*. The comment highlights the drive to achieve short-term earnings to meet the regulatory requirement. As highlighted in the literature of MA (Otley and Emmanuel, 1992), this is characteristic of the harvest strategy, in which organisations focus on short-term efficiency at the expense of long-term sustainability. This is in contrast to the build strategy, which recognises that short-term earnings may need to be sacrificed in order to attain long-term sustainability.

To ensure that the Trust meets its targets, it is required to produce very detailed financial information. This demand is the focus of significant attention by the Trust, which produces a monthly "financial monitoring return" that the NHSI can use to evaluate the Trust's actual performance against the plan. The report is a major task for management accountants MAs, who are expected to deliver it regularly each month. As in trusts across the UK, the Trust's monthly financial report serves as a formal vehicle to serve the information needs of regulators.

The head of corporate finance (F01) explained that "*All our internal reporting is tailored to a similar format because the financial performance is evaluated based on this report; so, there is no point in doing something else"*. The finding confirms that the design of MA in the Trust is generally determined by the information needs of regulators rather than internal information needs. In terms of MA's strategic role, the report is oriented towards short-term financial information. This focus is in line with and supportive of (even beneficial to) the Trust's portfolio management strategy combined with harvest orientation.

7.3 Strategic Performance Management in the Trust

In discussing the effectiveness of the Trust's strategy, this thesis aims to provide insights into the strategic context in which MA works in the Trust, and how it is influenced by this context. The following sections start this discussion by exploring the procedures followed by the Trust in its SPM process. De Waal, et al., (2009, p.1243) define SPM as

> "*The process where steering of the organization takes place through the systematic definition of mission, strategy and objectives of the organization, making these measurable through key performance indicators, in order to be able to take corrective actions to keep the organization on track*".

SPM is seen in the literature as a significant mechanism for translating strategy into communicable objectives and measures, facilitating strategy implementation, aligning management actions with strategic objectives and improving organisational performance (Abdel-Maksoud, et al., 2015). This discussion of the effectiveness of SPM in the Trust draws on the model proposed by Prowle, et al. (2013) (see Figure 7.2). The model identifies three dimensions of SPM – strategic planning, executional ability and strategic control – and comprises five main themes: financially grounded, sustainable, public value, executional ability and strategic control.

Figure 7.2 The SPM Model

Source: Prowle, et al. (2013, p. 23)

The first step in the Trust's SPM was the development of a strategic management framework containing a clear vision, values and strategic objectives. The Trust describes its vision as being "*To improve the health and wellbeing of the people of its area by providing high quality, integrated physical and mental health care pathways*". In line with this vision, the Trust has four main strategic objectives. These objectives are: delivering safe and effective patient-centred care (quality); partnering with other organisations to deliver the right care at the right time in the right place (partnership); attracting and maintaining a high-quality staff (staffing) and ensuring sustainability (finance). The Trust focuses on these high-level strategic objectives across the board. Underneath these objectives are many sub-objectives; for example, to achieve its sustainability objective, the Trust needs to deliver a surplus each year (requiring it to set its budget accordingly). The main and sub-objectives of the Trust are shown in Figure 7.3.

Figure 7.3 Strategic Objectives of the Trust

Source: Integrated Governance Handbook of the Trust

7.4 Effectiveness of the Trust's Strategic Planning

A whole picture of strategy is completed by programming the strategies and making them operational. This involves breaking down intentions and objectives into a series of formal steps to be implemented over a period of three to five years (Mintzberg, 1994). This process can assist organisations in clarifying their vision and priorities, allocating resources and ensuring that staff performance is in line with their strategic priorities (Allison and Kaye, 2011). In the case of the Trust, a five-year strategic plan has been developed setting out the Trust's targets and milestones to ensure that it achieves its strategic objectives and meets its obligation to deliver all national and local standards and targets to the highest level. The Trust has embarked on a major transformational change strategy aimed at improving the effectiveness and efficiency of its services and aligning it with both the National Strategic Context (NHS Five Year Forward View) and Local Strategic Context (the LLR Sustainability and Transformation Partnership). A core aim of the Five Year Forward View is to undertake radical action to transform the way NHS care, including community care, is provided (Lords, 2017). The effectiveness of the Trust's strategic planning, and whether it reflects long-term steps towards the strategic objectives and its transformational change strategy, is one of the themes addressed in this thesis.

For strategic planning to be effective, it must satisfy three main criteria: it must be financially grounded, it must be sustainable, and it must maximise public value (Prowle, et al., 2013). Prowle, et al., (2013) consider an appropriate financial strategy to be central to effective strategic planning. This strategy must, they emphasise, take into account specific risk factors and the views of stakeholders. The importance of sound financial grounding is highlighted repeatedly in the MA literature; Nelson (1996), for example, argues that the most successful organisations only develop an overall strategic plan when they have thoroughly understood the financial challenges they are likely to face and identified how best to use the available financial resources to implement their aims. However, planning processes in public sector health organisations such as the Trust vary widely; some organisations have disconnected processes with limited analysis, while others have highly integrated processes with sophisticated tools and analysis (Grube, 2006).

The interviewees underlined the importance of consistency between long-term financial planning and strategy, with most arguing strongly that long-term financial planning is vital if the Trust's transformation strategy is to be successful. The Trust's clinical director C05 explained that "*The only way we can do the transformational change is actually to see the financial challenges as a three-year or five-year cycle"*. The finding indicates that the Trust had a multi-year financial plan and budget to support its strategic plan. The deputy director of finance (F10) gave more detail:

> "*The financial strategy is set for five years. So, we set out every surplus we want to generate each year, how much cash balancing we want to have each year and then we make the plan for each year fit to our objectives and strategy*".

However, the majority of interviewees (clinicians and finance managers alike) strongly agreed on the difficulty of longer-term planning and thinking in the current business environment,

which many thoughts put the sustainability of the Trust's strategy in doubt. Sustainability is measured as the ability of an organisation to achieve its objectives and increase long-term stockholder value while fulfilling its economic, environmental and social responsibilities (Prowle, et al., 2013). According to one service manager (C08) in the mental health service,

> "*I don't think we are looking ahead. There are many things that I know won't happen this financial year because of the cost pressures. And that is about as far as my forecast goes – it is mainly focused on the financial year. A lot of the talk in the meeting is around this financial year rather than any sort of further planning*".

Similar opinions were strongly expressed by both clinicians and finance managers, who recognised that if the financial and operational pressures are not addressed, the sustainability of the Trust's strategic planning will be put at risk. Their comments support Prowle, et al.'s (2013) conclusion that while the Trust's strategy might seem sustainable in the short term, it may not be sustainable in the longer term.

The final criterion in the model is the ability of strategy to maximise public value. Multi-agency planning and working with other public organisations to be key here, along with focusing on outcomes for individuals and communities (Alderwick, et al., 2016; Prowle, et al, 2013). The national health strategy supports the concept of multi-agency cooperation as central to delivering health improvement, integrating services and reducing health inequalities (Alderwick, et al., 2016). It is clear from the previous discussion that the Trust works within a complex multi-agency context; if it is to maximise public value, it must align its own strategy with the requirements of this context. This issue was given more attention by senior level interviewees, who were more concerned with strategy than those at the lower levels. Some claimed not to know much about the Trust's multi-agency strategy, but the majority of senior

level interviewees emphasised the importance of multi-agency working in enabling the Trust to achieve transformational change; according to the financial director (F11),

> "*If you are to get real transformation, you need to work together across systems rather than individual organisations having that pressure. It has to be whole system changes that we need to see. So, it is multiple organisations, local authority, NHS organisations, all work together to try to achieve the same thing. When we say it like that, it's questionable why we have not done this before*".

The multi-agency strategy requires the Trust to find a way to make collective decisions about the use of resources and how services should be delivered, but this is made more difficult when the NHS context does not support collaboration between organisations (Alderwick, et al., 2016). Indeed, some interviewees saw the current CCG contractual mechanism as a major impediment to the multi-agency strategy. The operational director of FYPC and AMH.LD (C13) explained that

> "*The ambition of the transformational partnership is to remove some of the market-based language and economics from the system and to work more in collaboration, but we are not there yet. We spend a lot of time in contractual discussion around variance from a plan*".

The comment highlights the concern of some senior level staff about the strategy. Although the Trust has entered into a local strategic partnership, there is no evidence that the multi-agency strategy has improved public value. Furthermore, unless the challenges are addressed, it is unlikely to achieve its objectives.

The findings appear to support Prowle, et al.'s (2013) conclusion that the strategy developed by the Trust, although financially grounded, lacks longer-term sustainability and is unlikely to

maximise public value. This suggests that if the Trust's strategic planning is to be effective in bringing about transformational change, public policy outcomes should be pursued and judged based on the coordination mechanism rather than market and contractual mechanisms.

7.5 Executional Ability

The next step after strategic planning is the execution of this strategy. This is "the process of indirectly manipulating the pattern of interactions an organization has with its environment in order to achieve its overall objective" (MacLennan, 2010). There is clearly a direct connection between the strategic planning process and the subsequent implementation of the decisions emerging from that process. However, this connection cannot be taken for granted, nor can it be regarded as something that is easily cultivated or maintained, especially in organisations that are attempting to change strategic direction (Elbanna, et al., 2016). In fact, while developing an effective strategy is a major task, implementing that strategy is perhaps even more difficult. Even with a superb strategic vision and the formulation of a robust strategy, the best-laid plans can go astray for several reasons (Prowle, et al., 2013). Most of the Trust interviewees believed that the Trust's aims are likely to have diverged from the strategic plan by the end of the plan period – only the associate director of strategic planning (NF02) argued that the Trust has a realistic strategy that reflects its strategic objectives and what it wants to achieve. Furthermore, the interviews and observation revealed a number of challenges that threaten the Trust's ability to execute its strategy.

First and foremost is the pressure to make large-scale efficiency savings on an annual basis. Under the NHS Five Year Forward View, efficiency savings of 2-3% per year up to 2020/21 are required if the scope and quality of services are to be maintained within the planned budget (Lafond, et al., 2016). As a result, the Trust, like other trusts, is under significant pressure to reduce costs and improve its use of resources. Almost all interviewees from different staff groups saw this pressure to make efficiency savings as undermining the Trust's ability to

execute the transformational strategic change. The Trust's medical director (C05) summed up the dilemma thus:

> "*There is a lot of short-term pressure, so our challenge actually is to address that, we need to work with that, but at the same time step back and look at actually long term how we can solve the problem, and it is difficult when you have such an amount of pressure*".

The problem is that operational pressures consume the Trust's resources in a way that affects its ability to execute the strategic transformational change. This finding agrees with Lords (2017), who conclude that a real risk to transformational change is that the funds made available for strategy will be swallowed up by efforts to sustain local services instead of transforming them.

The big challenge for the Trust is thus to remain focused on long-term planning while simultaneously responding to the pressure to achieve the required surplus at the end of each year. This saving, which is then shifted from the budget to close the gap between costs and income at the macro (NHS) level, impacts on the Trust's ability to execute its own strategic plan.

Numerous interviewees also blamed the funding model for the difficulties the Trust has when trying to execute strategy. About 80% of the Trust's business is commissioned by CCGs through a block contract. Typically, this involves a lump sum payment for the delivery of services during the contract period (Gruen and Howarth, 2005). As the Trust's head of corporate finance (F01) explained, the fact that this contract period is only two years seems inconsistent with the long-term thinking necessary to implement the strategic plan.

> "*Our contract with the commissioner each year is key really, and that determines a lot of how we are going to provide the service for the following year. So, it is very difficult to plan for the next period because you really don't know what they are going to put in the contract. It makes it very difficult to have a long-term view really*".

Under this block contract, the Trust lacks the clarity it needs in terms of long-term financing; only ever sure of what financial resources it will have for the next two years, the Trust finds it very difficult to plan any further ahead.

Increasing demand is another challenge facing the Trust in its efforts to execute its strategic plan. The NHS in general faces growing demand for healthcare, which it attributes to an ageing population, advances in drugs and technology and rising public expectations (Prowle, et al., 2013). The majority of interviewees, especially in the mental health service, attributed this growing pressure to inadequate budgets; the clinical director of mental health (C07), for example, commented that "The challenge we've got is increasing demand, we know more and more patients are coming in, but we've got the same time a reduction in the resources". The problem is that the government puts pressure on the Trust to meet the growing demand without offering a real increase in the budget. Several interviewees expressed their frustration at the pressure this puts on the Trust's resources.

The empirical evidence highlights the practical challenges the Trust faces as it attempts to execute the strategic plan within the proposed time scale (see Figure 7.4). These interrelated challenges, explained the Trust's financial director (F11), absorb the available resources, triggering delays in the five-year plan as resources are diverted to offset short-term pressures. This has significant implications for the long-term strategy. The result is short termism, where the focus is on meeting the cost reduction target and capital investment is reduced, to the

detriment of future results and long-term strategy (Demartini, 2014). This finding can be interpreted by the fact that there is no sufficient focus on correct action to achieve the strategy because its link to the short-term performance is unclear. Managers have difficulty distancing themselves from day-to-day operations and, as a result, strategy gets too little attention (De Waal, 2013). The main challenge facing the Trust is to create organisational environments and structures that are capable of executing the strategies developed through the strategic planning process and supplying the missing link between short-term action and strategy. In other words, it is to align operational performance with strategy – seen in the literature as essential for effective strategy execution (Voelker, et al., 2001; Atkinson, 2006).

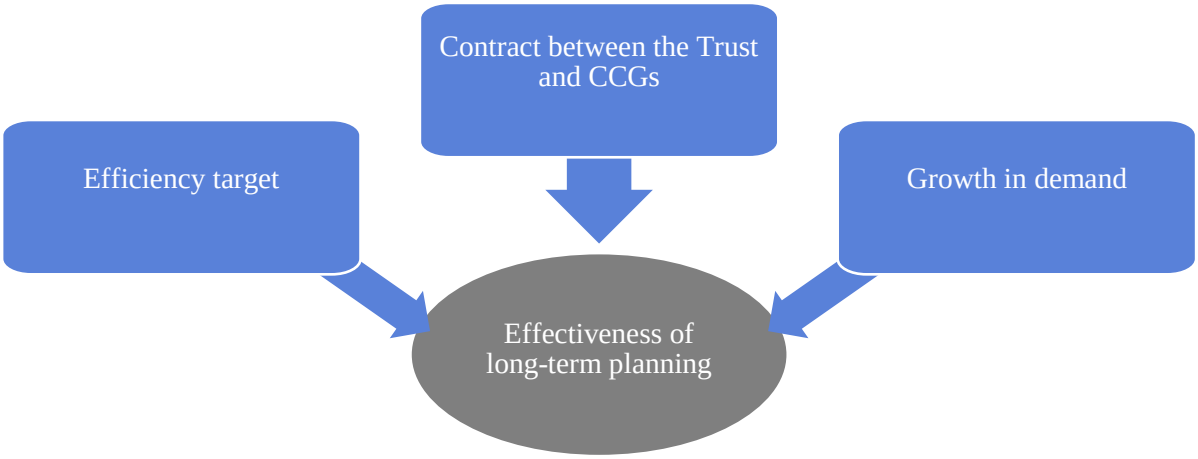

Figure 7.4 Challenges to Strategy Execution in the Trust

MA, as a performance measurement system, has the potential to serve as this missing link between strategy and operations and to support the Trust's strategic focus. However, MA's strategic role relies upon its integration into organisational strategic processes (Bhimani and Langfield-Smith, 2007), and this requires the adoption of a performance measurement system

that is strategically oriented and goes beyond the traditional system of MA (Voelker, et al., 2001). Traditional MA has concentrated on the development of indicators largely relating to economy (inputs) and efficiency (costs) due to the limited ability to measure effectiveness or outcomes in government organisations. This traditional performance measurement has been much criticised because it excludes non-financial dimensions of performance from many sets of measures (Kloot and Martin, 2000).

A more recent contribution to the MA literature, which emphasises the role of MA in supporting organisations' strategic focus, is the balanced scorecard (BSc). The BSc is seen as one of the most significant developments in MA (Hoque, 2014). The BSc is a SPM system that comprises financial and non-financial measures. It is used in this thesis as a basis to explore the effectiveness of the Trust's SPM. Academic research in MA emphasises the distinguishing features of BSC as a performance management framework. These features enable organisations to be strategically oriented by linking all operational activities with strategic objectives and integrating both financial and non-financial measures. It is thus seen as a mechanism for translating strategy into objectives and measures which can be clearly communicated, facilitating strategy implementation (Nuhu, et al., 2017; Abdel-Maksoud, et al., 2015). The next section will discuss the framework of the performance measurement system applied by the Trust to control strategy

7.6 Strategy Control

Strategy control refers to the use of formal mechanisms to evaluate an organisation's strategic progress from a critical, long-term perspective (Prowle, et al., 2013). This involves selecting a performance measurement system to make sure that the strategy is being implemented as planned and producing the intended results. Performance measurement thus translates the strategy into measurable results (Drury, 2013). The Trust's performance measurement framework comprises a wide set of measures divided into five key perspectives: quality of care;

finance and use of resources; operational performance; strategic change; and leadership and improvement capability. The key purposes of the framework are to:

"1- Ensure that the organisation has effective systems and processes in place to provide assurance to the Trust Board and stakeholders that the organisation is performing to the highest statutory and regulatory standards.

2- Develop the business intelligence capability of the Trust and thus inform service delivery; improve activity planning, productivity and efficiency; and deliver cost reduction and transformation programmes.

3- Support the delivery of strategic objectives.

4- Provide assurance that the Trust is achieving best value for money in its use of resources".

The framework forms a key deliverable project within the Trust's Five-Year Plan (Strategic Initiative Plan 8.4, project ref. 174), underpinning the strategic sub-objective "Ensure that we meet all national and local standards and targets". Its format and perspectives comply with the Single Oversight Framework set by the NHSI

Performance is reviewed monthly by the Trust Board and executive committee against all corporate KPIs, and an Integrated Quality and Performance Report (IQPR) is produced to show how the Trust is performing against the strategic plan. Performance is scored between one and four on four different scales and the results combined into an overall score. A top score (one) indicates that the Trust is at low risk of not being able to deliver the targets, while a bottom score of four means that it needs to be put in special measures.

The document analysis and interviews revealed that the Trust's performance measurement framework is multi-dimensional, comprising financial and non-financial measures and employing qualitative signs (red, yellow and green indicators) to compare actual results with target levels. However, they also confirmed that the government plays in important role in shaping performance measurement practices (Chang, 2006). The Trust's performance framework has been dictated by external pressures rather than the Trust's own strategy, with the majority of performance indicators (60%) being developed externally and incorporated by the Trust primarily to meet regulatory requirements. The framework serves mainly as an accountability mechanism to demonstrate 1) the Trust's compliance with the NHSI Single Oversight Framework and the CQC's registration requirements, and 2) that it is delivering both on national standards for quality, performance and finance and local contractual targets agreed with commissioners.

7.7 The Strategic Role of MA as a Performance Measurement System

MA has been identified as central to the process of measuring performance, but its ability to play a strategic role relies upon its integration into organisational strategic processes (Bhimani and Langfield-Smith, 2007). This requires the adoption of a strategically oriented performance measurement system that goes beyond traditional MA (Voelker, et al., 2001), which has concentrated mainly on the development of economic (inputs) and efficiency (cost) indicators. This traditional approach to performance measurement has been much criticised because it excludes many non-financial dimensions of performance (Kloot and Martin, 2000). One recent development within MA that emphasises its role in supporting strategic focus is the balanced scorecard (BSC). This technique, seen as one of the most significant developments in MA (Hoque, 2014), is used in this thesis to explore the effectiveness of the Trust's SPM. BSc allows organisations to become more strategically oriented by linking their operational activities with their strategic objectives and integrating financial and non-financial measures; strategy can be

translated into objectives and measures which can then be clearly communicated, facilitating implementation (Nuhu, et al, 2017; Abdel-Maksoud, et al., 2015).

The potential of MA to support strategic management depends on its ability to encourage behaviour that is consistent with the organisation's strategy (Hoque, 2005). To do this, it employs an integrated performance measurement framework to clarify and communicate strategy and manage its implementation (Drury, 2013).This section evaluates the strategic role of MA in the Trust based on its ability to create a high level of strategic focus and alignment within the Trust context; provide a wider set of performance measures; the use of performance measures that are linked to strategy; and the use of performance measures that have cause-and-effect relationships(Baird, 2017; Atkinson, 2006; Voelker, et al., 2001).

As pointed out in section 7.6, the Trust has adopted a multi-dimensional approach to performance measurement that encompasses both financial and non-financial measures. However, effective SPM demands more than a collection of generic measures grouped into four or five categories; it needs to be customised to the organisation and to describe strategy in operational terms (Voelker, et al., 2001). The core of SPM is the translation of strategy into a group of hypotheses of cause-and-effect relationships. This is one of the most important assumptions of the BSC. The measurement system should make the relationships (hypotheses) among objectives (and measures) in the various perspectives explicit so that they can be managed and validated (Kaplan and Norton, 1996). However, the reality in the Trust is that the chain of cause-and-effect relationships is not fully integrated into the performance framework. As a result, performance measures were seen by many interviewees as stand-alone basis measures; according to the interim head of learning and development (C01), "*Financial and non-financial measures tend to be separate"*. The literature emphasises that it is not enough simply to structure the measures in the scorecard perspectives; measures within and between

perspectives should be explicitly linked (Baird, 2017). Each performance measure should be understood as part of a cause-and-effect relationship linking strategy formulation to financial outcomes. Collectively, the chain of cause-and-effect relationships allows the non-financial measures (lead measures) to be used to predict future financial performance (lag measures). This chain should permeate all perspectives of the SPM (Drury, 2013).

One of the criteria used to evaluate the effectiveness of a measurement system is the level to which it integrates financial and non-financial measures (Hoque and James, 2000). This is crucial, as the relationships between measures are as important as the measures themselves. However, many of the clinicians and finance managers who were interviewed described a lack of integration between measures across functional areas of the Trust, with financial and quality measures, for example, being disconnected from each other. One administrative service manager (NC01) in the FYPC commented that "*finance and non-finance issues are not integrated enough within our organisation. You find that perhaps they are not on the same page*". The weaknesses in the Trust's SPM are mainly attributable to the fact that there is no clear model showing how the measures fit together logically.

Another issue affecting the effectiveness of SPM in the Trust is the lack of alignment between its strategic objectives and operational performance measures. This alignment is generally regarded as a cornerstone of SPM (Baird, 2017). It is key to upgrading a performance framework from a simple measuring device to an integrated SPM tool in which strategic goals in key performance areas are defined and communicated to all employees (Kaplan and Norton, 2006). If it is to facilitate strategy execution effectively, SPM must create a hard-wired spiral between strategy and daily activities (Burton, 2003), but as discussed in section 7.5, the link between short-term action and strategy in the Trust seems unclear to many. Some interviewees

saw this as a key barrier to the Trust's execution of the strategic plan. C07 (clinical director of mental health) commented:

> "*I do not think there is a very strong link between the strategic objectives and performance measures. For example, the strategic priority of the Trust is to deliver high-quality care to be the top of all organisations. But underneath, we've got this massive efficiency target to attain. So, it is a big challenge*".

This view was common among interviewees, who saw the misalignment between strategy and short-term measures and action as major challenges that the Trust needs to address. Unless performance measures are routinely linked to the achievement of specific strategic objectives, managers are unlikely to align their interests with the interests of the organisation (Decoene and Bruggeman, 2006).

The literature argues that effective communication throughout the organisation is crucial to execute strategy successfully (Malina and Selto, 2001). In fact, communication is crucial to every aspect of strategy implementation, as it relates in a complex way to the organising of processes, the organisational context and implementation objectives, all of which impact on the process of execution (Obeidat, et al., 2017). However, the poor alignment between measures and strategy in the Trust undermines efforts to communicate this strategy to managers throughout the Trust. Many interviewees appeared to lack strategic awareness or to feel that they had any active role to play in its development. When asked about strategy, clinician managers tended to say that it was not their area; C09 (a ward matron), for example, admitted: "*For me, I do not have any sort of future strategy*". Interviews with finance staff produced a similar finding. Strategy was generally seen as a high-level management practice that has little connection to managers. Consequently, it is unclear how much of a contribution staff at this level make to the overall strategic aims of the Trust.

This failure of communication has also had an adverse impact on managers' involvement in strategy execution. Managers act according to their own perceptions and if these are inconsistent with the strategy, they are likely to behave in ways that are inconsistent with effective strategy execution (Collier, et al., 2004). However, rather than directing managers' attention and motivating them to behave in strategically desirable ways, emphasis is instead placed on short-term targets, with the result that managers continue to concentrate on short-term financial performance at the expense of the Trust's strategic objectives. This was evident in the majority of interviewees. C02 (clinical director of mental health services), for example, explained that "*At the moment, the way we're working is the financially forecasting. So, it is really about the balance the sustainability through the year*". They were more concerned with achieving short-term results and meeting budget demands because this was the prime focus of their performance evaluation (and what they were rewarded for). This is the main dysfunctional behaviour created by the Trust's current SPM approach.

Several interviewees argued that commitment to strategy execution would be greater throughout the Trust if measures and objectives were integrated and presented in a format that would be clear to all staff. The medical director (C05) emphasised that "*Very few reports are prepared for individual clinicians or other team members to help them understand how they manage their strategy*". A strategy map (see Kaplan and Norton, 2004) would be invaluable in helping staff throughout the Trust understand the strategic plan and see how it links in with what everyone does on a day-to-day basis. Such a map would show how a range of potentially disparate activities link together to enable the organisation to achieve its vision. Strategic maps are intended to capture the key drivers that affect successive perspectives (bottom to top) (Irwin, 2002). By allowing the Trust to communicate strategy to managers holistically rather than via a cascade of objectives passed down through the chain of command, such a map would enable

these managers to better understand their role within the broader picture (Kaplan and Norton, 2004).

In summary, SPM within the Trust appears to be more of a performance measurement system than a strategic management system. The Trust's performance measurement framework comprises a set of performance indicators which allow for the financial and non-financial assessment of various aspects of performance; however, these assessments, while sufficient to meet external and internal information demands, are only stand-alone basis measures. They do nothing to clarify the cause-effect linkages that describe the way operations are related to strategy. SPM is seen as a mere reporting tool, the main focus of which is the Trust's operational performance; it plays no part in creating a clear strategic direction or facilitating strategy execution. Indeed, the findings indicate a low level of strategic focus and alignment in the Trust, with greater emphasis being placed on strategy formulation than on strategy execution, and the strategic plan being produced primarily to meet external requirements.

In this context, it can be said that MA contributes little in terms of strategy execution. MA neither supports the alignment of operational performance with strategy nor assists the Trust to be more strategy-focused. However, as discussed before, MA works within a context that is operationally oriented, and this influences its strategic role. This influence is difficult to avoid and has a negative impact on the long-term strategic role of MA. It is important to note that clinicians and finance managers share a common understanding about many aspects of strategy in the Trust. This is probably because there is little focus on strategy in the Trust.

7.8 The Role of Management Accountants in the Strategic Process

Another facet of MA's role in supporting strategy is the strategic role played by management accountants (MAs). Traditionally, the role of MAs has been limited to providing managers with useful information for decision making, but a number of authors (e.g. El-Sayed and Youssef,

2015; Aver, et al., 2009) have suggested that this role has evolved and that more MAs are now acting as proactive internal advisors and "business partners" to management (Wolf, et al., 2015). The term "strategic accountant" has been coined to differentiate these accountants, who tend to be proactive in analysing broader business issues, from their traditional, financial/operational-oriented counterparts (Aver, et al., 2009), but there is as yet little empirical evidence regarding the strategic role they play, especially in the context of community health services (Cadez and Guilding, 2008; Wolf, et al., 2015; Prowle, et al., 2013). This section goes some way towards addressing this lack of evidence with a discussion of the strategic role MAs play in the Trust.

Almost all interviewees agreed that MAs are an integral part of the strategic management process and important strategic partners in the management team; according to one operational manager (C012), "*The management accountant is very crucial in our strategic team, helping shape collectively the strategic decisions we make*". Strategic decisions in the Trust are made by a management team made up of managers from varying backgrounds and different functional fields, including MAs. The financial director (F11) explained that at the corporate level, decision-making processes are based on coordination between the members of Board who are seen as health directors with different background. The Trust Board works in coordination way and MAs within the Board are seen as health directors with finance expertise. This means that MAs (i.e. chief financial director) are considered business specialists with strategy-oriented role and partnership with other functional areas of the organisation (Joseph, 2006). MAs participate in discussions about strategic issues, make recommendations and advise on the best course of action. For example, at the time of this study (2017), when the Trust encountered problems in its contract to provide healthcare to a local prison, MAs were party to the Board's strategic decision to withdraw from this market.

Most interviewees, especially clinician managers, felt that as MAs work closely with other areas within the Trust, they understand what information these areas need. One clinical director for mental health (C02) felt that "*MAs have a very crucial role in my work.* They educate me and advise me about the financial situation. I see them more as partners". The partnership with non-financial managers is strengthened by MAs in the Trust spending much of their time in other departments rather than at their desk. This gives them greater insight into the nature of the healthcare business, the real nature of the challenges being faced and the organisation's strategic responses to these challenges (Prowle, et al., 2013). F01 (head of corporate finance) explained:

> "*MAs are quite embedded in the service; they've got a lot of service knowledge. I think the knowledge of the finance staff can help service development. So, they get involved in every aspect of performance. For instance, they are part of the monthly service board"*.

This mode of working, the literature notes, is at the heart of MAs' shift to a more strategic- and partnership-oriented role (Prowle, et al., 2013; Joseph, 2006; Emsley, 2005).

However, as discussed in section 7.2, the Trust is subject to strong pressure from regulatory agencies to control its expenditure, and in this context, MA is the main tool for ensuring the Trust's efficiency and accountability. The prime responsibility of MAs, therefore, remains to make sure that performance at the lower levels aligns with the efficiency requirements and to produce financial reports that show whether and how the Trust is meeting these targets. This requires them to use traditional accounting and financial control models. This emphasis on operational financial issues was seen by many interviewees as a major challenge to the forging of relationships between MAs and non-financial managers. The Trust's head of insurance and delivery (NC02), for example, commented that "*The main problem between me and finance is*

the financial pressure because I'm very tight with my budget". Several interviewees argued that MAs in the Trust need to move away from these traditional models and towards a more business partner-oriented model if they are to play a more strategic role. The associate director of strategic planning (NF02) acknowledged that "*We are less good in analysis cost for strategic decisions*". To provide more support for the decision-making process, issues such as cost analysis, performance analysis, and financial forecasting must relied upon by MAs to improve their role.

Another factor that limits the strategic role of MAs in the Trust is the narrow scope of the information they provide. Chenhall and Morris (1986) define scope in terms of focus, quantity and time horizon. Narrow scope information, which is concerned with events internal to the organisation, is likely to be financial and historic. In contrast, broad scope information may be external, non-financial and future-oriented; it is likely to be proactive, strategy-oriented and directed at improving the business, increasing efficiency and creating value. Strategically oriented MAs must be able to provide broad scope information that is (1) mostly non-financial; (2) focused on the future; (3) both internal and external to the organisation; and (4) based on realistic projections of the future, not simple extrapolations of the past (Chenhall and Morris, 1986). However, the information provided by MAs in the Trust was considered by almost all interviewees to be too narrow in scope to be useful for strategic purposes. This information was predominantly financial, historical and internal; that is, it was operationally rather than strategically oriented.

The problem, as many interviewees indicated, is that the Trust lacks the MA techniques it needs to provide broad scope information. The Trust's medical director C05 explained that

> "*We do not have a good system to let people know the impact of their decisions. For example, what is the cost of the patient's pattern and what's the actual cost of*

certain duration stays in the inpatient unit? I think our finance system currently is actually not sophisticated enough to input all of those types of information".

Accordingly, there was wide agreement among interviewees on the need to adopt more advanced techniques and to shift the focus of MA from simply cost determination and financial control to the creation of value through the improved deployment of resources. This requires the urgent development of improved costing systems and costing methods. Most interviewees recognised patient-level information and costing systems (PLICS), which are able to link cost with clinical activity, as one of the most important techniques in this area; indeed, the move to adopt PLICS has already begun as part of a government-led project for community health services. The value of the system was acknowledged by the head of finance for community health services (F06), who called it "*crucial for the Trust as it gives a variety of information and gives us more accurate information as well, which is more help rather than just a budget*". The Trust as a whole will be required to apply PLICS from 2020.

To conclude, the findings reveal that MAs make a significant contribution, as business partners, to the Trust's strategic decision making, which in turn adds value to and fosters the strategic role of MA in the Trust. This contribution is seen by clinicians as significant in underpinning the strategic decision-making process. Through their business partner role, MAs substantially improve clinicians' cost awareness and use of resources and improve internal processes and decision making. However, the work carried out by MAs is simultaneously both influenced by and influential upon the context through their links to others in the organisation (Lambert and Sponem 2011). The pressure to meet efficiency targets makes reconciling MAs' functional accounting orientation (required for operational control) and business partner orientation very difficult in practice. This, along with the narrow scope of information provided by MA, are seen as the main challenges facing MAs' business partner role in the Trust

7.9 Conclusion

This chapter aims to present and discuss the findings with regard to the strategic role of MA in the Trust. The analysis reveals that the Trust faces the challenge of achieving a set of targets and performance standards that reflect the diverse interests of its regulators. It is subject to sustained and focused control in three main areas: financial performance (by the NHSI); safety and quality (by the CQC); and its delivery of the block contract with CCGs.

The analysis draws on Prowle, et al.'s (2013) model of SPM to explore the effectiveness of the Trust's strategic planning, executional ability and strategic control. In terms of its strategic planning, the findings suggest that while the Trust's strategy is financially grounded, its long-term sustainability and its ability to maximise public value are less certain. The discussion goes on to show that the Trust's ability to execute its strategy is hampered by three main factors: the emphasis on meeting the efficiency target, the CCG contract funding model and the growth in demand. Finally, the analysis shows that the strategic control function is carried out by means of a multi-dimensional performance measurement framework which, while encompassing both financial and non-financial measures, is designed primarily to satisfy the requirements of external regulatory bodies rather than to monitor the achievement of the Trust's strategic objectives.

The findings suggest that MA in the Trust plays little role in fostering or supporting strategic behaviour. Although a set of balanced measures appear in the performance measurement framework, these are not tightly connected to the strategic plan. Furthermore, no attempt has been made to create a clear visual representation of this plan to help staff understand and engage with the strategy. On the whole, the Trust appears to place more emphasis on strategy development and formulation than on strategy execution. MAs, although widely considered an integral part of the strategic decision-making process, often find their ability to adopt a broader

business role restricted firstly, by the external pressure to focus on financial control and secondly, by unsophisticated MA techniques that limit the scope of information they can provide.

The two main aspects of MA's strategic role – that is, its potential to support an organisation's strategic focus and the role of MAs in strategic decision-making process – are thus contingent upon a number of factors, including the availability of sophisticated techniques and take into consideration some characteristics that seem important to be more strategic focused. The regulatory environment has a major influence on the context in which MA works. In the case of the Trust, this context is characterised by a harvest strategy, in which the focus is on short-term efficiency at the expense of long-term sustainability. The findings also show that three main challenges affect the ability of the Trust to execute its strategy. These factors include the efficiency target, the contract between the Trust and the commissioners and the growth of demand.

MA can help in addressing the problem of strategy execution by helping the Trust to keep focus on the strategy and maintain the balance between short- and long-term objectives, financial and non-financial measures, lagging and leading indicators, and internal and external performance perspectives. However, this role is contingent upon the Trust adopting a performance measurement system that is strategically oriented and more comprehensive than traditional MA (Voelker, et al., 2001). The BSC can provide a more holistic understanding of organisational strategy, and a clearer link between the elements of the strategy and the organisational processes that will be central to its execution (de Salas and Huxley, 2014).

Chapter 8. Conclusion

8.1 Introduction

This study set out to develop a deep understanding of MA and its role in supporting organisational performance in England's community health service. Specifically, it sought to investigate the effectiveness of MA in one community health trust and how this is shaped by a set of internal, external, technical and behavioural factors. Following the presentation and discussion of the findings in Chapters five, six and seven, this chapter presents the overall conclusions of the study and considers their implications. Section 8.2 presents a summary of

the major findings by research theme, while section 8.3 discusses the theoretical and practical contributions of the study. Finally, section 8.4 considers the limitations of the study and suggests areas for future research.

8.2 Major Findings

The main purpose of the study is to assess the role of MA in providing information that helps managers to perform their job and organisations to develop and maintain viable patterns of behaviour, so that they can achieve their desired outcomes (Malmi and Brown, 2008). The study analyses the process and outcomes of MA in the context of healthcare organisations (NHS community trusts) in order to provide an understanding of how MA is shaped by a set of environmental and organisational factors. It therefore assesses MA's role in terms of its ability to promote strategic, managerial and operational behaviour that is aligned with organisational objectives. Its main conclusion is that while MA is generally successful in meeting external demands for information, it is less so in giving clinicians information that is relevant to their clinical decision making. As the core of the Trust's performance management system, MA is conceptualised by both environmental and organisational factors. Its role is thus affected by multiple contingencies that require it to meet varying, sometimes conflicting, demands and leave it unable to achieve optimal performance. Its influence is most strongly felt at the departmental level in the deployment of a budgetary control system to ensure the efficient use of resources; in other words, its role is mainly managerial rather than strategic or operational in nature. The analysis shows that the Trust uses MA to encourage behaviour that is aligned with the desired organisational outcomes, but that MA's ability to support the Trust is inhibited by a number of factors. This section summarises the major findings of the study, as they relate to the research questions (see section 1.4).

1- **What role does management accounting play in improving operational performance in the Trust, and how can this role be enhanced?**

The question aimed to analyse the relevance and role of cost information in decision making in the Trust. The findings discussed in section 5.2 reveal that the effectiveness of a costing system depends on the extent to which its design takes into account the information needs of both internal and external users. Since the effectiveness of the cost accounting system in healthcare organisations arises from its ability to balance the information produced for internal and external use (Finkler and Ward, 1999), this study focuses on the ability of the Trust's cost system to strike this balance. It argues that creating a cost-conscious culture among clinicians depends on collecting information that is detailed, accurate and relevant to their clinical decision making, but the findings show that the Trust's costing system is not sophisticated enough to be able to provide such information. Instead, it is primarily oriented towards collecting the external information needed for contractual reporting and to meet regulatory requirements. The finding that there is no costing information on clinical activity supports the argument put forward by previous researchers that costing systems, especially in public sector organisations, tend to be driven by financial reporting regulations (Lapsley and Wright, 2004; Johnson and Kaplan, 1991). In the Trust, costing information is used as a means for non-clinical managers within the trust to justify a political agenda of restricting the financial resources available for community healthcare. However, the practical impact of having no clear link between cost and clinical activity is that clinicians do not understand the cause-and-effect relationships between their clinical decisions, resource utilisation and clinical results.

Contingency theory posits that the usefulness of a costing system, and thus MA's capacity to improve operational performance, are determined by their appropriateness to the context (Chenhall, 2003). In the trust context, the first level of decision making occurs in the meeting between clinician and patient. The findings reveal that the costing system is important for its ability to provide information that can help clinicians make better decisions, but prioritising the information needs of external users may make it more difficult to design a system that is

user-friendly for clinicians; that is, one that produces information that can be readily understood by those with a relatively limited knowledge of financial-economic instruments. The findings suggest that there is a strong association between this inability to produce understandable information and clinician dissatisfaction.

The findings discussed in section 5.3 suggest that PLICS are the best way of raising the quality of cost information, and hence its ability to play a useful role in trusts. PLICS are better able to provide clinically useful information than less sophisticated cost systems because they can provide a clear link between cost and clinical activities, allowing clinicians to see the cause-and-effect relationships between their clinical decisions, resource utilisation and clinical results. The findings suggest that the ability of PLICS to provide relevant and accurate cost information at the level of individual patient activities will not just raise awareness among clinicians but encourage them to engage more with costing information. They confirm the importance of a good MA system in providing managers with the high-quality, relevant information they need to make effective decisions and achieve organisational goals (Hoque, 2005).

2- **What role do clinicians play in, and what is their attitude towards, the operation of management accounting in the Trust?**

The question aimed to analyse what role clinicians play in MA effectiveness, and their attitudes towards its use in the Trust. The evidence presented in section 5.4 shows the central role clinicians play in the development and implementation of MA initiatives such as PLICS, highlighting that their commitment is vital for success. In the case of PLICS, securing this commitment will require the provision of appropriate training, but more than this, attention should also be given to improving dialogue and collaboration between clinicians and finance

staff. Both tactics are key to overcoming the cultural barriers between clinicians and finance managers and bringing the expertise of the two groups together.

The evidence also highlights the significance of the role that clinical directors play in closing the communication gap between clinicians and finance managers. Attuned to both administrative and clinical logics, they are able to underpin clinicians' engagement with costing information and maintain the balance between quality and cost. As an integral part of MA, the budgetary control system constitutes an important part of their managerial work. Appropriate budget procedures are essential in guiding managers in the right direction to achieve the organisation's goals and objectives (Finkler and Ward, 1999), though according to contingency theory, the question of what is appropriate will vary from one organisation to the next.

The findings presented in section 6.6 reveal a low level of motivation among managers towards meeting the budget targets in the Trust. The tightness of the budget, the rise in demand and the lack of participation in setting the budget targets were all seen as inhibiting managers' motivation in this regard. A greater degree of participation was seen as the best way of raising managers' commitment to the budget and motivating them to achieve its goals, but at the time of writing (2018), the budgetary system does not adequately support the empowerment of managers. The findings highlight a number of factors that disrupt the balance between controlling and empowering in the Trust. One is the fact that the budget, with its constraints and limits, is imposed from the top down in order to monitor how managers use resources and their resource allocation decisions. Another problem is the Trust's highly centralised organisational structure, within which budget decisions are made at a fairly high level. Bottom-up empowerment is incompatible with this kind of top-down control system (Johnson, 2002). The evidence suggests that bottom-up empowerment is fostered by adopting a more decentralised approach and transferring power and authority from the centre to managers. Dialogue about the budget across the managerial levels should also be encouraged to overcome

the hierarchical barriers created by top-down control and to foster an environment in which information sharing is routine and managers are empowered to search for opportunities and solve problems.

Notwithstanding the criticisms levelled at the system by the clinicians, the findings support the literature in showing that the budget is seen as central to upholding internal effectiveness, especially in public organisations, by providing a roadmap explaining where the organisation is, where it wants to go and how it will get there (Johansson and Siverbo, 2014; Colman, 2004). The case study therefore does not support the argument for abandoning the budget altogether; rather, the evidence points to the importance of openness and flexibility as the cornerstones of the budgetary system's effectiveness.

3- **What contribution does management accounting make to strategic management in the Trust, and how can this contribution be enhanced?**

This question aimed to describe and evaluate the process of strategic management in the Trust, how MA contributes to this process and how this contribution can be improved. Section 7.3 reveals that the Trust's strategic management framework sets out a clear vision, along with the Trust's values and strategic objectives. A five-year strategic plan has been set, in line with these objectives. The Trust has embarked on a major transformational change strategy aimed at improving the public value it provides. In terms of the effectiveness of the Trust's strategic plan (strategy formulation) and whether it maps out a long-term path for meeting the strategic objectives and realising its transformational change strategy, the findings show that while the plan clearly defines the Trust's organisational mission and strategic objectives (i.e. the foundations of its strategy), it lacks the detailed direction that would ensure the implementation of these objectives (see section 7.4). They also highlight a number of challenges that need to be addressed if the strategic planning for the transformational change policy is to be effective.

Most importantly, they indicate that public policy outcomes should be attained and judged using the coordination mechanism rather than the market and contractual mechanism.

The second aspect of strategic performance – execution – appears even more difficult than strategy formulation. The findings indicate that the Trust is unable to achieve its short-term goals without sacrificing its ability to meet its mission obligations in the long-term strategy. Several factors that are outside the Trust's control are adversely affecting its ability to implement the transformational change strategy within the designated timescale, including the efficiency targets, its contract with commissioners, and the growth in demand. These factors appear to be distracting managers' attention away from strategy execution and forcing them instead to focus on short-term performance, making it much more difficult for them to take an overview. The findings highlight the need for a performance management system that is able to bridge the gap between operational performance and strategy. More broadly, they highlight the significance of the alignment between operational performance and strategy in ensuring that the latter is executed effectively.

As noted above, the case study findings indicate that the Trust is not on the whole strategy-focused, being concerned with strategy formulation but paying little attention to strategy execution. Within this context, MA appears to do little or nothing to encourage strategic behaviour. As discussed in section 6.4, the budgetary control system draws manager attention away from long-term performance – the opposite of what is required to encourage strategic focus. The Trust responds to the high degree of uncertainty in the surrounding environment by placing strong emphasis on meeting budget targets, effectively restricting managers' attention to those matters that will influence their performance within the current budgeting period (i.e. encouraging short-term orientation). The findings (see section 7.7) also reveal that although the Trust's performance measurement system comprises a diverse set of financial and non-financial measures, it does not link the Trust's operations to various perspectives of measures

or to strategy and is therefore unable to offer a clear strategic direction or guide employees' behaviour towards strategy implementation.

However, while MA makes little contribution to strategic management in the Trust, the evidence presented in section 7.8 reveals that MAs in the Trust are increasingly assuming a partnership role in the strategic decision-making process, which is in turn adding value to and fostering the strategic role of MA in the Trust. Clinicians and managers alike saw this contribution as significant, with the findings indicating that it has substantially improved clinicians' cost awareness, use of resources, internal processes and decisions. However, the work carried out by MAs simultaneously influences and is influenced by the context and their relationships with others in the organisation (Lambert and Sponem, 2011), and the pressure to meet efficiency targets makes reconciling the functional accounting orientation (required for operational control) and the business partner orientation very difficult in practice. This, and the narrow scope of information provided by MA, were seen as the main challenges facing MAs trying to play a business partner role.

As pointed out in section 7.7, particular attention should be given to performance-driven behaviour; unless performance measures are associated with the achievement of specific strategic objectives, managers are unlikely to align their interests with those of the organisation. The findings suggest that a full application of the balanced scorecard (BSC) may be useful in addressing this issue as it offers a mechanism for making explicit the link between strategic objectives and operational goals, identifying clear performance targets at all levels in the organisation, and engaging employees at all levels in the discussion of the strategic priorities (Atkinson, 2006). The adoption of the BSC needs to be underpinned by a strategy map linking the strategy to what everyone does on a day-to-day basis. This will foster greater understanding among managers of their role within the broader strategic picture (Kaplan and Norton, 2004).

Finally, as highlighted in section 6.4, a more flexible mode of budgetary control would be better able to accommodate the longer-term resource trends identified within the strategy, which would in turn help managers to respond more effectively to environmental change and to align their behaviour with the organisation's strategic goals.

4- **What are the contingencies that shape management accounting's role in the Trust?**

This question aimed specifically to analyse the contingencies that affect MA's role in the Trust. The findings discussed over chapters Five, Six, and Seven show that MA's role is shaped by a complex fabrication process that is highly contingent on political, social and economic conditions. These factors inform the context in which MA works, influencing its design, use and development. Consequently, it needs to be customised to suit this context.

The findings presented in Chapter five reveal that both technical and behavioural factors need to be considered if trusts are to fully realise the potential benefits of new MA initiatives. In terms of the behavioural factors, as discussed above, the findings indicate that clinician engagement is crucial, and that without a clear strategy to encourage this engagement, a new system is unlikely to obtain the desired results. Section 5.5, meanwhile, shows that the level of IT employed also has a major impact on the success of MA initiatives. The findings show that the integration of clinical activities data into the financial system and communication between the clinical and financial systems are key to successful implementation. Drawing on contingency theory, this result suggests that previous MA initiatives in the NHS may have failed because they did not match the requirements of the trust context (Hoque, 2018), being insufficiently sophisticated to respond to a range of sometimes conflicting information needs (Finkler and Ward, 1999).

The findings discussed in Chapter six support contingency theory's assumption that MA systems and the behaviours they encourage are influenced by the context in which the organisation operates (Otley, 1978). In the Trust, for example, the role of the budgetary system is context-dependent, with budget characteristics such as target difficulty and target participation, being driven by organisational characteristics such as environmental uncertainty and organisational structure. The finding supports the argument that what role MA should play depends mainly on the circumstances surrounding the organisation. It also implies that MA's influence on manager behaviour is contingent upon the congruence between organisational context and budgetary context, underlining the importance of organisational context when studying MA's role.

Finally, the findings discussed in Chapter seven reveal that the strategic role of MA in the Trust is influenced by both external pressure from regulatory organisations and internal inhibiting factors such as the rise in demand. This is in line with contingency theory's assumption that regulatory requirements play a key role in the process of strategy formation in public sector organisations (Modell, 2012). In the case of the Trust, the focus is mainly on short-term efficiency at the expense of long-term sustainability (i.e. a harvest strategy), with MA being tailored to provide information showing how the Trust is meeting the targets set by regulators. The finding confirms that MA in the Trust is shaped and driven by factors at the macro level, at which various and significant pressure of convergence is currently at work (Ma and Tayles 2009).

8.3 Theoretical, Empirical and Practical Contributions

The theoretical and practical contributions of the study are discussed in the following sub-sections.

8.3.1 Theoretical and Empirical Contribution

The study contributes to the relevance lost debate (Hope and Fraser, 2003; Johnson and Kaplan, 1991) by providing empirical evidence of MA's role in supporting organisational performance in community healthcare in England, using the Trust as a case study. In so doing, it responds to a gap in the MA literature, most of which focuses on acute care rather than community care. This study explores MA in the context of a range of community-based healthcare services including families, young people and children's services; adult mental health services; and adult learning disability services. To the best of the researcher's knowledge, it is the first academic study to provide evidence-based insights into the relevance of MA and its determinants in the community health context.

By discussing MA's role and determinants from different angles, the study is able to offer a broad and holistic view of MA. Otley, (1999) argues that taking a holistic view of MA rather than concentrating on a single aspect of the phenomenon (e.g. the BSC) is more likely to produce reliable results, as an organisation may make heavy use of one system and largely ignore others. Accordingly, the study considers MA as a system for addressing strategic, managerial and operational issues (Prowle and Lucas, 2016) in community healthcare. It is thus able to contribute to both the relevance lost (Johnson and Kaplan, 1991) and beyond budgeting (Hope and Fraser, 2003) literature. The findings support some of the key arguments within the relevance lost debate; for example, that MA does not support the communication and implementation of strategy, that it does not give clinicians the information they need for clinical decision making, and that it is driven mainly by external financial reporting requirements (Hoque, 2018; Bjørnenak, 2013; Otley, 2008; Roslender, 1996). However, they do not support all of the claims made in the beyond budgeting debate; while it is true that the findings confirm the short-term orientation of MA, its rigid and hierarchical nature and its emphasis on control

rather than empowerment, they also highlight the central importance of the budgetary system within trusts (Francesco, 2016; Harradine, et al., 2011; Ekholm and Wallin, 2000). This suggests that better budgeting, not beyond budgeting, is a more appropriate option for trusts such as the Trust.

The study provides a clear understanding of the complexity of the processes which shape MA practices in the community health service. It offers empirical evidence that MA in the case study trust is influenced by a complex network of political, social and economic factors, some of which work in opposition to each other. These factors appear to be key to understanding and explaining the processes and outcomes of MA in the Trust. This is in line with previous suggestions (e.g. Hopwood, 1974; Chapman, et al., 2009) that MA is subject to pressures from its wider social and economic environment, and that it is shaped by and shapes wider social processes. Most importantly, the study identifies a set of internal and external environmental pressures that explain why MA fails to fully realise its potential role.

The MA literature has long advocated the importance of studying the role of MA within its organisational context (Hopwood, 1974; Chapman, et al., 2009). According to Roberts and Scapens (1985), the only way to understand MA practices is by understanding the organisational reality in which they operate and for which the accounting systems are designed. Accordingly, the study contributes to the literature by locating and conceptualising MA within its organisational context (i.e. community healthcare). It draws on the literature review and contingency theory to construct a conceptual framework, which is used as a theoretical model to provide understanding of the contextual and environmental factors shaping MA's role in NHS community trusts. The framework shows how MA's processes and outcomes are embedded in the organisational and environmental contexts and identifies the gaps between its actual and potential roles.

The literature review revealed a lack of empirical evidence regarding the business partner role played by MAs in community health services. The study goes some way towards addressing this lack of evidence by demonstrating that MAs in the Trust have a business-oriented role and are seen as integral to managerial decision making. However, the findings are consistent with the literature in showing that the work carried out by MAs is influenced by the context (Lambert and Sponem, 2011); that is to say, their ability to play the business partner role is hindered by the narrow scope of MA information, the crudeness of the costing system and the pressure to meet efficiency targets.

The study adds to the literature addressing the interaction of front-line clinicians with MA information in community healthcare. Its findings are consistent with those of previous studies (Lapsley, 2007; Abernethy and Vagnoni, 2004; Jacobs, et al., 2004) citing the lack of access to accounting information and the perceived irrelevance of costing information as the main factors contributing to clinicians' lack of engagement with MA information.

The study provides a rich empirical description of how a change in MA systems, as represented by PLICS, can encourage clinicians to become more involved with MA. It supports Hopwood, (1974) in arguing that MA is not an autonomous phenomenon and that social, behavioural and technical factors can all provide bases for MA change. This implies that MA change is context-specific, and that MA should be seen as a social practice rather than merely as a technical tool (Fiondella, et al., 2016). However, these technical and behavioural factors may also act as barriers to change. These barriers must be surmounted if cost accounting is to develop.

Finally, the study makes a significant contribution to the literature of contingency theory of MA by adopting post-contingency theory as its theoretical basis. It explores the relationship between contingencies and MA using the single case study approach rather than the questionnaires used in most contingency studies of MA. By adopting a case study approach,

the research responds to the call for a detailed and in-depth contingency explanation of MA's role (Chenhall, 2003). The study adds to the literature of MA in community healthcare by providing a deeper understanding of how MA reacts to contingencies or conditions in this environment and giving insights into how MA systems are shaped within NHS community trusts. As such, it provides interpretive focus to the context of MA (i.e. NHS community trusts) and shows how MA is implicated within the potential conflicts between groups or individuals (Chenhall, 2003). One of the main findings of the study is that MA plays a significant regulatory role within trusts, with the NHSI relying upon it to ensure that community health services are meeting health needs within the NHS budget. Since acute care services are expected to satisfy the same requirements, the findings may also be applicable to this context.

8.3.2 Practical Contribution

The theoretical and empirical insights offered by this thesis expand our understanding of MA and its determinants in community health services, but they also have practical implications for managers in the NHS. In particular, the findings draw attention to the practical challenges associated with strategy execution in these services. They highlight the importance of linking operational activities with the strategic objectives and integrating both financial and non-financial measures. In the first of these, creating a link between strategy and the organisation's daily operational activities (Burton, 2003) will improve how strategy is communicated and give managers a greater understanding of their role within the broader strategic picture (Kaplan and Norton, 2004).

The study also sheds light on the factors that inhibit the ability of MAs to play a partnership role. This has an adverse impact on the strategic role of MA in the community health service. The pressure to meet efficiency targets and the narrow scope of MA information were considered by interviewees to be the main barriers preventing MAs from becoming effective

business partners, but the study also highlights the importance of multi-agency collaboration at the strategic level, central to which is collective decision making on matters of resource use and service delivery.

Some of the insights offered by the study could be useful in managing the tension between competing demands within trusts. The findings suggest that the success of the budgetary control system relies upon its ability to keep the balance between freedom and constraint, empowerment and accountability, top-down direction and bottom-up creativity and flexibility (Kominis and Dudau, 2012). They suggest that budgetary information needs to be used in a more flexible manner and seen as just one indicator of a longer-term concern with quality and efficiency. This implies firstly, that manager performance can still be evaluated positively even where budget targets are not met, if there is a reasonable explanation for this outcome (Otley and Fakiolas, 2000), and secondly, that it should be possible to strike a balance between acting in a way that is congruent with the organisation's goals and giving employees the autonomy to make decisions (Mundy, 2010).

Finally, the study highlights the importance of closing the gap between clinicians and finance managers by creating a cooperative environment to overcome the cultural barrier between the two groups and foster mutual understanding (Llewellyn, 2001). It also provides insights into some of the factors that need to be taken into account if PLICS are to be implemented successfully in community health services.

8.4 Limitations of the Study and Suggestions for Further Research

As with any piece of research, the study has a number of limitations, the first of which is its reliance on a qualitative case study conducted in a single organisation within a particular context. The results of the study cannot therefore be statistically generalised to a wider context,

but as the aim is theoretical generalisation rather than statistical generalisation, this is not a major concern.

The second limitation of the study arises from the lack of strategy awareness identified among managers. This made collecting data about strategy difficult, as interviewees tended to say that it was not their area, and as a result, it was necessary to rely on a relatively narrow range of responses from interviewees with some sort of strategic involvement, usually at board level. Another problem in terms of data collection was finding cost project managers who were willing to participate in the research and to provide all the requested information. Any deficiencies in the information provided by interviewees, whether through their reluctance to participate or their lack of knowledge, were offset by the observation and document review. The researcher spent more than four months as a financial trainee, during which time he was able to gather the required information by observing and talking to other staff members. Any potential impact was minimised by the deployment of multiple data collection methods, which allowed for triangulation of the findings.

There are four areas in which current knowledge of MA might be expanded by future research. First of all, more research is needed to fill the literature gap surrounding MA in community health services. Future studies should focus on the specific characteristics of this context, how these differ from the primary and secondary health contexts, and whether MA's role is also different. Investigations might perhaps take the form of comparative studies of the nature and role of MA in community services and other services (i.e. acute health services).

Secondly, further research is needed to provide a greater understanding of MA's role in strategy formulation and implementation in the public sector in general and in community health services in particular. This could be undertaken by considering MA within the context of a control package. Greater attention should be paid to how MA might supports the achievement

of long-term, sustained organisational improvement, with particular emphasis on the business partner role of MAs and the determinants of this role.

Thirdly, the findings confirm that managing the tension between the different dimensions of performance remains one of the most important tasks in public sector organisations (Andrews and Entwistle, 2014). A greater understanding of how this balance can be achieved is therefore urgently needed (Mundy, 2010).

Finally, future research needs to focus on the implementation of PLCS in the NHS in general and in community health services in particular. This is especially urgent, given that implementation is still in the early stages and the success of the programme is by no means secure. Longitudinal case studies could be particularly useful here as they would allow the gathering of qualitative and quantitative data to capture a detailed picture of the fine-grained behaviour associated with PLICS implementation over time (Rainer, 2011).

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Appendix 1.
Interview questions

- **The Relevance and Role of Cost Information in Decision Making in the Trust**

1. What approach is used to assign costs to health research groups? Do you think this is an appropriate approach?
2. Is the cost calculation method followed by the Trust top-down or bottom-up?
3. Has the Trust adopted the patient-level information and costing system (PLICS)?
4. Why do you need PLICS?

5. Are you under pressure from the NHSI to introduce PLICS?
6. Who are the main users of MA information in the Trust?
7. Do you think that MA provides the right accounting information for your work or decisions?
8. Does the MA information identify the resource consequences of clinical decisions?
9. In your opinion, are clinicians cost-conscious?
10. In your view, is the information provided to clinicians relevant to their work?
11. What are the main characteristics of MA information in the Trust (qualitative or quantitative, internal or external, financial or non-financial, historic or futuristic)?

- **The Managerial Role of Budgetary Control Systems in the Trust**

1. How important is the budget for the Trust and what is its aim?
2. As a budget holder, how is your performance evaluated?
3. Do you think there is more concentration on financial efficiency than on quality?
4. Do you think the budgeting procedure helps in achieving a balance between flexibility and control?
5. Do you see the budget as an administrative tool that limits your ability to improve quality?
6. Is the budget the most effective way to control expenditure?
7. How do you manage your budget?
8. Do you participate in setting the budget?
9. Does the rationing in the budget affect service/care quality?
10. How is the budget set?
11. How do you use the budget to evaluate performance?
12. Do you think the budget procedures are too rigid?

13. What is the quality impact of cost improvement programmes (CIPs)?
14. Is there pressure to change to CIPs from outside the Trust?
15. Do you think there is a connection between the budget and strategy?

- **The Contribution of Management Accounting to Strategic Management in the Trust**

1. Is your focus on short-term financial performance rather than the long term? In other words, is your performance evaluated on your ability to meet the budget? Do you think this affects your work? If so, in what way?
2. Is there any cooperation or integration between the Trust and external regulators in terms of performance measurement?
3. Do you think there is more concentration on short-term efficiency than the long term?
4. Do you have a long-term plan?
5. Do you think the strategy has changed over the years?
6. Do you think that the Trust's MA systems provide a relevant set of measures?
7. Are there any differences between the information prepared for external reports and that prepared for management (internal)? If so, how does it differ?
8. Are financial measures complemented by non-financial ones?
9. Have the performance measures emerged from the strategy of the organisation?
10. What is the strategy of the Trust?
11. Are there links between long-term and short-term performance?
12. Are there linkages between strategic objectives on the one hand and the performance measures on the other hand?
13. Do you think that your planning and controlling procedures help or hinder the implementation of the strategy? If so, how?

14. Do you see management accountants as business partners, especially in strategic decision making?

- **The Influence of Clinician Attitudes on the Effectiveness of Management Accounting in the Trust**

    1. Is it true that clinicians often see the budgeting system as a tool of administrative control aimed at constraining NHS expenditure and their ambitions to improve health services?
    2. How does financial management support your work?
    3. Are you satisfied with the information provided by MA?
    4. Is MA providing you with accurate and timely information regarding clinical activities?
    5. Is there any systematic dialogue between managers and clinicians?
    6. What potential influence does costing information have on clinicians' decision making?
    7. Is there any cooperation between managers and clinicians to determine best practice and decrease variations in cost and efficiency?
    8. Are clinicians held responsible for financial performance?
    9. Do you think you provide the information clinicians need to get involved?

- **The Contingencies That Affect the Role of Management Accounting and its Development in the Trust**

    1. How does government policy affect the Trust?

2. Is MA used as a control to meet the targets and objectives of external regulators? If so, can you tell me how this influences the information and reports provided by MA?
3. How do regulators and commissioners affect your work as a financial manager?
4. What are the challenges facing your Trust?
5. Do you think the pressure to reduce costs is bringing new thinking to the organisation?
6. Do you think that the technology provided in the Trust helps your MA system or is it inadequate?
7. To what you prefer the block contract?
8. Do you provide financial training for clinicians?
9. Do you think the financial system is sufficiently integrated with the clinician system?

Appendix 2

Participant Information Sheet

An examination of the influential contingencies on the role of management accounting, to support organisational performance, The case of an NHS Community Trust

Thank you for agreeing to consider participating in this research project. Before you decide to grant an interview, it is important that you understand the reason why this research is being carried out and what your participation will involve. We shall be grateful if you will take time

to read the following information carefully and discuss it with colleagues if you wish. Please feel free to get back to me if anything is unclear and to take as much time as you need to decide whether or not to take part.

What is the purpose of the study?

This project is a partial fulfilment for the degree of Doctor of Philosophy (PhD) in Nottingham Trent University. The following determine the context of the project.

This thesis is motivated by the debate over the relevance of MA in the NHS and questions about what determines its role in this context. The study seeks to provide a deep and holistic understanding of management accounting's (MA) role in supporting organisational performance in England's community health service. Its main purposes are to illustrate the effectiveness of MA in one community health trust and how this is shaped by a set of internal, external, technical and behavioural factors. In fact, a number of aspects will be investigated to determine the potential role of management accounting such as the clinicians' attitude toward the use of MA information, the managerial role of the budgetary control system and the strategic role of MA in the Trust.

The key research question, therefore, will be:

How the NHS community trust's MA roles were conceptualised by a number of contextual and environmental contingencies.

The study has the following aims:

- To examine the relevance and role of cost information in decision making in the Trust.
- To examine the managerial role of budgetary control systems in the Trust.

- To explore the contribution of management accounting to strategic management in the Trust.
- To explore the influence and impact of clinician attitudes on the effectiveness of management accounting in the Trust
- To explore the contingencies that affect the role of management accounting and its development in the Trust.

The whole project commenced on 2nd February 2015 and is due to complete at the end of January 2019.

Who is running this study?

The study is being run by Mr Ali Alyamoor (PhD) student at *Nottingham Business School, Nottingham Trent University*.

Who is funding this study?

This study is funded by the Ministry of Higher Education and Scientific Research (Iraq)

Why have I been chosen to take part?

I am asking you to give us an interview because of you either a member of the finance department or budget manager in the Trust.

Do I have to take part?

Your participation is entirely voluntary and, you, therefore, are free to take part or not: as you choose.

If you do decide to take part, you will be given an information sheet to keep, and you will also be asked to sign a consent form. You will still be free to withdraw at any time and at any stage of the research: This includes the right to withdraw their interview from the study after it has taken place. You can withdraw at any stage up to write- up the project. No questions will be asked if you decide to withdraw at any time or at any stage.

If you decide not to take part, or to withdraw at any stage, you will not be asked to give us any reasons.

What do you want me to do?

We would like you to take part in a semi-structured interview lasting approximately an hour. It will take place in your workplace, if appropriate, or another location designated by yourself or the research team and will be arranged at a time convenient to yourself. The topics to be covered are identified in the above section of this document: *What is the purpose of the study?*

The interview will be carried out by the researcher, following a pre-set schedule. We will ask for your written permission to record the interview to ensure that the information you give us is accurately recorded.

What will happen to the information I give in my interview?

The recording of your interview will be transcribed. I will then analyse the information and feed it into my results. At the end of the study all the transcripts, digital recordings and notes will be destroyed.

How will you protect my confidentiality and anonymity?

The recording and transcript will be handled only by the researcher. Hard copies of research notes are kept in locked filing cabinets, and electronic files are kept on password protected computers which are not accessible to any other university staff.

You will not be named in any publication arising from this project unless your role forms part of a narrative that is already in the public domain: for example if you were the named author of a published document or gave evidence to a public inquiry relevant to the study. No unpublished opinions or information will be attributed to you, either by name or position without your express consent.

We will, unless consent is given, exercise all possible care to ensure that you cannot be identified by the way we write up our findings.

What are the possible disadvantages and risks in taking part?

The main cost to you will be the time needed to be interviewed. The main risk is that you might give us information that is detrimental to you or your organisation, or that runs counter to data protection laws.

I am confident that the arrangements described above will prevent any of your information being shared with anyone apart from the research team. For this reason, I believe that the risk of detriment is very low.

What are the possible benefits?

I hope that you will find the interview interesting and will take satisfaction from helping to develop knowledge of this important topic. I also hope that you will find the results of the project helpful to your work.

What will happen to the results?

The result will be summarised and reported in a PhD thesis at Nottingham Trent University. The results will also be published in scientific journals. all data will be completely anonymised. No individual will be identifiable from the published results. The findings from the study can be discussed with You as a participant and the results will be at the participants' disposal at the end.

How can I find out more about this project and its results?

I will send a copy, if requested, of the executive summary to all our interviewees, so you will be able to read about our findings. The researcher will be happy to discuss any aspect of the study with potential participants prior to or post their involvement.

Has anyone reviewed the study?

The study has been reviewed by the supervisory team, and independently reviewed by the practitioners and academic reviewers within the University. The study has been accepted by the College Research Degrees Committee at Nottingham Trent University, and it has been registered for MPhil with the possibility of a transfer to PhD.

Who is responsible if anything goes wrong?

This project is being administered by Nottingham Trent University. Nottingham Trent University is therefore responsible for the conduct of the project.

Contacts for further information

Please feel very welcome to contact the researcher for further information, at the following addresses:

ali.alyamoor2014@my.ntu.ac.uk

Also, the supervisory team can also be contacted at the following address:

Professor Malcolm Prowle
Professor of Accounting
Nottingham Business School
Division of Accounting and Finance
Email: malcolm.prowle@ntu.ac.uk

Dr Donald Harradine
Principal Lecturer of Accounting
Nottingham Business School
Division of Accounting and Finance
Email: donald.harradine@ntu.ac.uk

Dr Roy Stratton
Reader in Operations and Supply Chain Management
Nottingham Business School
Division of Management
Email: roy.stratton@ntu.ac.uk

We thank you for your consideration

Mr Ali Alyamoor
The researcher

Appendix 3

The consent form

"An examination of the influential contingencies on the role of management accounting, to support organisational performance, :

The case of an NHS Community Trust.".

CONSENT FORM

Please read and confirm your consent to being interviewed for this project by initialling the appropriate box(es) and signing and dating this form:

1- I confirm that the purpose of the project has been explained to me, that I have been given information about it in writing, and that I have had the opportunity to ask questions about the research .

☐

2- I understand that my participation is voluntary, and that I am free to withdraw at any time and any stage up to write up the project without giving any reason and without any implications for my legal rights

☐

3- I give permission for the interview to be recorded by research staff, on the understanding that the recording will be destroyed at the end of the project

☐

4- I agree to take part in this project

☐

_____	_____	_____
Name of respondent	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature

PROJECT ADDRESS:

Mr Ali Alyamoor, Nottingham Business School; Nottingham Trent University, Burton Street, Nottingham NG1 4BU. Email: ali.younus2013@my.ntu.ac.u

Appendix 4

Demographic Details of Interviewees

	Code	Position	Date	Duration/ Minute	Place	Qualification	Year of experience
1	F01	Head of corporate finance	17/05/2017	27	The Trust location	Accounting CIMA	24
2	F02	Senior financial management assistant	17/05/2017	15	The Trust location	Accounting CIMA	23
3	F03	Head of Adult mental health(AMH) finance	17/05/2017	24	The Trust location	Accounting CIMA	26
4	F04	Financial controller	17/05/2017	28	The Trust location	Accounting CIMA	12
5	F05	Finance Manager	19/05/2017	26	The Trust location	Accounting CIMA	18

6	F06	Head of families, young people &Children (FYPC) Finance	24/05/2017	49	The Trust location	Accounting CIMA	27
7	F07	Head of Community Health Services(CHS) finance	24/05/2017	29	The Trust location	Accounting CIMA	25
8	NF01	Associated director of strategic planning	31 /05/2017	24	The Trust location	MBA	30
9	C01	Interim head of learning and development	01/06/2017	39	The Trust location	Registered Nurse, and master's in leadership for health and social care	24
10	C02	Clinical Director of Mental Health services	08/06/2017	21	The Trust location	Consultant Psychiatric	12
11	C03	Physical therapist	09/06/ 2017	40	The Trust location	Master in management.	30
12	C04	Pediatrician consultant	09/06/2017	25	The Trust location	MSc pediatric	20
13	C05	The medical director of the Trust and consultant psychiatrist	17/06/2017	31	The Trust location	Fellow royal college of psychiatrists	22
14	F08	A finance manager	29/06/2017	35	The Trust location	A Level	34
14	C06	Family service manager within FYPC	11/07/2017	27	The Trust location	Nurse and health visitor	25
15	NC01	Administrative service manager FYPC	11/07/2017	47	The Trust location	A postgraduate diploma in business and management	37
16	NC02	Head of assurance and delivery	12/07/2017	46	The Trust location	Master's degree in health care management and governors	12
17	C07	Clinical director for the learning disability services and family, young people and children	17/07/2017	34	The Trust location	MRC psychiatry	18
18	C08	Service Manager AMH Acute & Forensic Services	18/07/2017	31	The Trust location	Master in the community mental health	25
19	C09	Ward matron	18/07/2017	21	The Trust location	Diploma of higher education	10
20	C10	Service Manager Crisis, Liaison and Triage Services	19/07/2017	35	The Trust location	Master of leadership	20
21	C11	Team manager in the mental health services	20/07/2017	33	The Trust location		
22	NC03	Service Group Manager- Group 1-FYPC	24/07/2017		The Trust location	Master's degree in health and social care management	16
24	NF02	Contracts Manager, Business Development & Contracting	31/07/2017	35	The Trust location	Level A	30
25	F09	Project cost manager	30/07/2017	26	The Trust location	Accounting CIMA	14
26	C12	Head of Service ICL	31/07/2017		The Trust location		
27	F10	Deputy indicator of finance and procurement	01/08/2017	31	The Trust location	Accounting CIPFA	18

28	NF03	Contract manager of the Trust	02/08/2017	35	The Trust location	Level A	33
29	F11	Financial director for Trust	10/08/2017	60	The Trust location	Doctorate in business administration	18
30	C13	operational director for FYPC and also AMH.LD	04/09/2017	35	The Trust location	MSC in leadership	31

Appendix 5

31/10/2017 13:38

Coding Index

Name
Activity data
Benchmarking
Block contract
Budgeting Control System
budgeting system

business thinking
Clinician cost Awareness
Clinicians' power
clinicians involvement
cost driver
Cost improvement programs(CIPs)
Cost improvement schemes
Costing System
Culture issue
direct cost
efficiency thinking
extra problem
Feedback information
Financial and nonfinancial information
Financial accounting information
Financial performance
Financial recovery plan
Financial scrutiny meeting
financial training
Flexibility
funding issues
Hierarchy
incremental budget
Information for contract
Investments
IT
long term planning and strategy
MAs role
Monthly financial report
New thinking or new culture

Non-financial measures
Nurse shortage
operational pressure
organisational performance
other reports
out of control cost
overhead cost
overspending and underspending
PbR
performance analysis
Performance measures
Planning
PLICs System
policy change
Political factor
procedures budget
Qualitative and quantitative information
Quality impact assessment
reference cost
Service Line Report
Short term performance
Short-termism
Solution out of area cost
strategic change
Strategic decisions
Strategic objectives
Strategic tool
Surplus control
sustainability
sustainability meeting

systematic thinking
Technology
The balance between quality and cost
the budget and SLR
The characteristics of the budget
The challenges
The characteristics of MA information
The communication gap
The consistency role of MA
the Demand and the budget
the demand
The dialogue between clinician and finance
The difficulty of achieving the CIPs
the difference between acute hospital and community
the difficulty
The engagement of clinician in the efficiency
the external pressure
The final financial report
The financial position
The Funding
The information technology
The Institutional l pressure
the integrated system
The integration between financial and management accounting
The internal factor
the key financial measure
The lack of accuracy
The lack of financial information
The link between cost and outcome
The link between PLICs and SLR

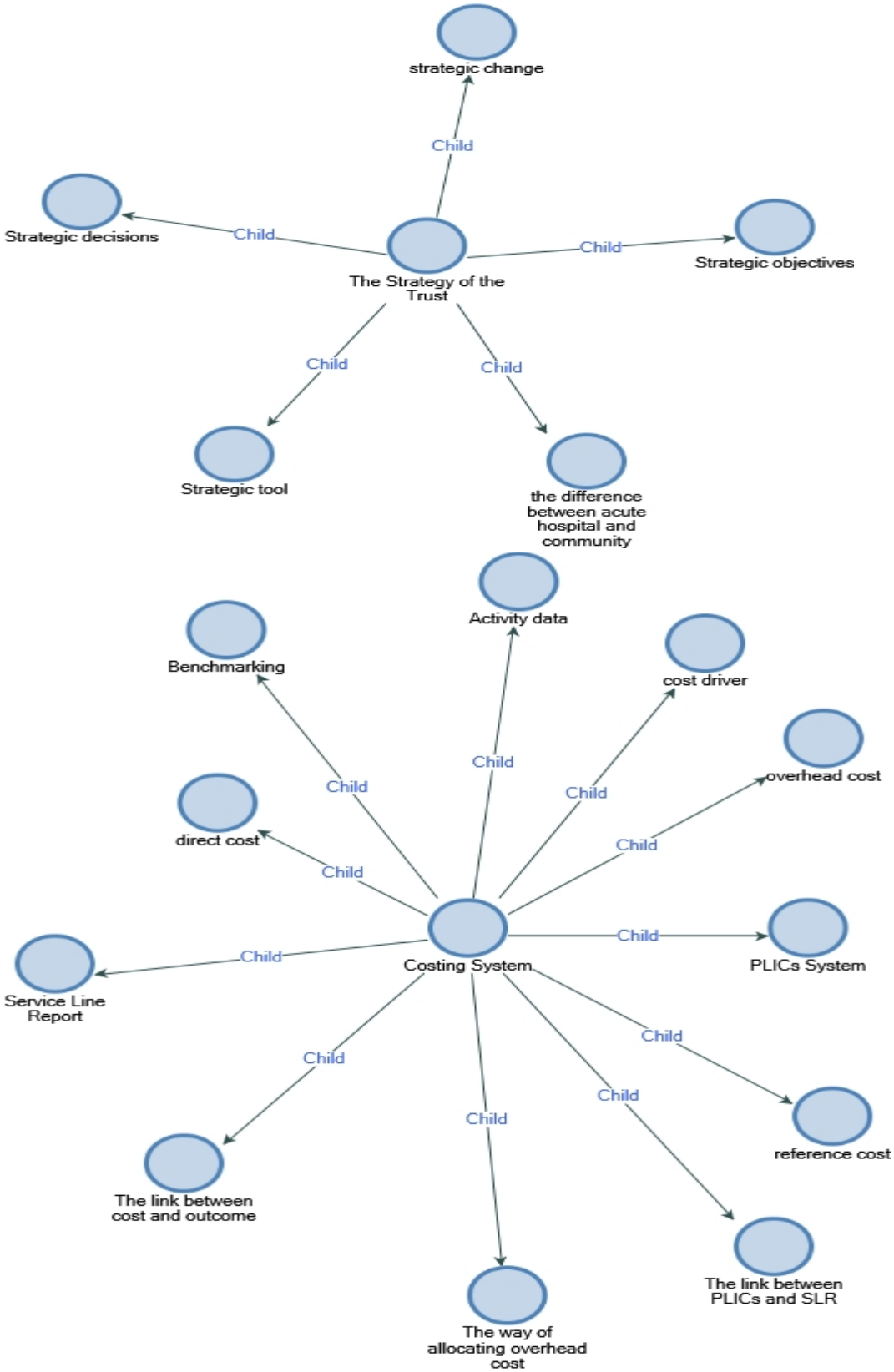
The link between strategy and budget
The main task of MA
The motivation role
the need to change
the operational role of MA
the pressure to change
The relation between budget and cost
The relation between quality and activity
The relation with external bodies
The Role of Management Accountant
The Role of Management Accounting
the scope of financial information
The scope of management accounting information
The shortage of money
The sources of MA information
The strategic role of MA
The Strategy of the Trust
The way of allocating overhead cost
the way of using the budget
Transformational change
Turn around team

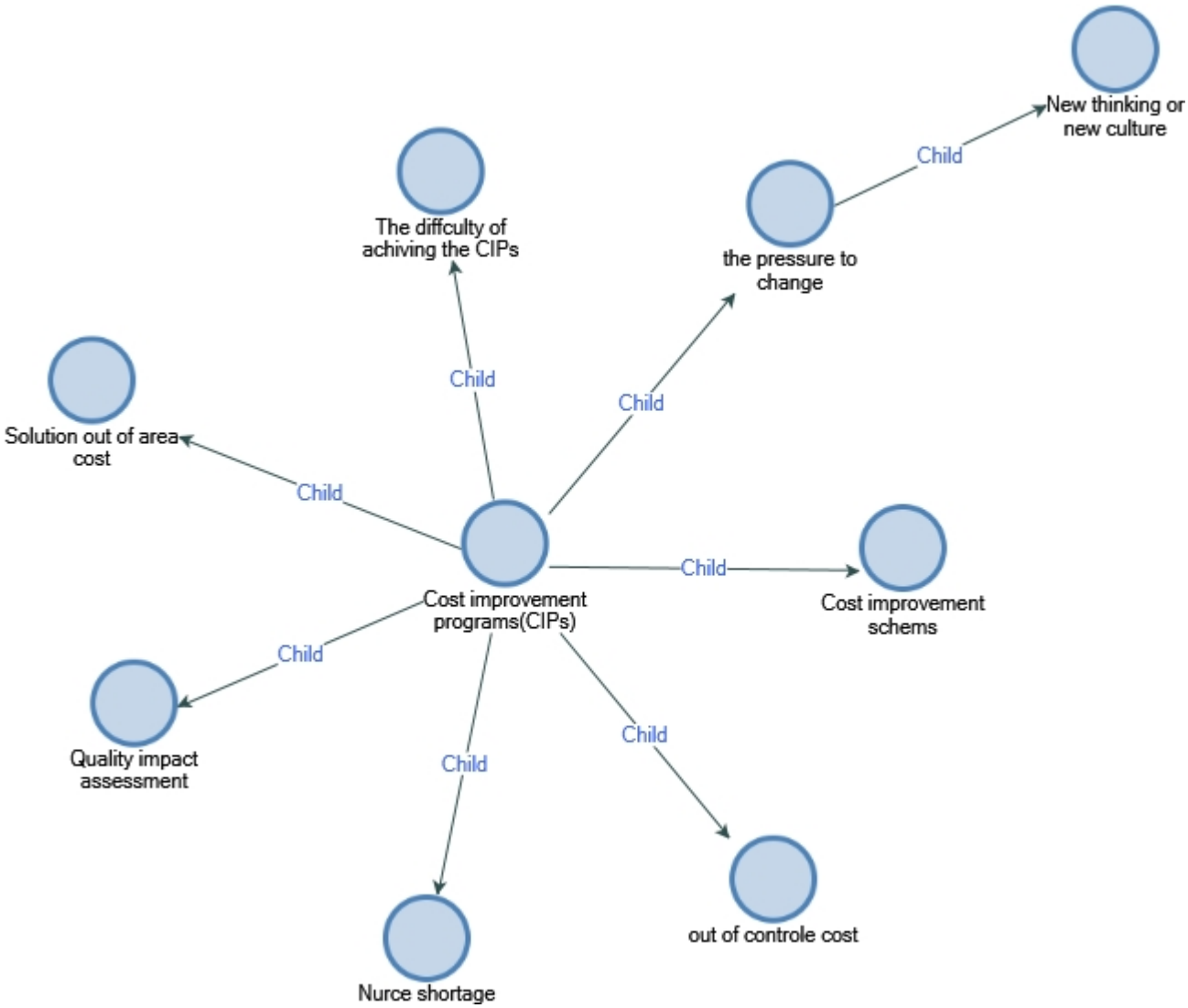
Appendix 6

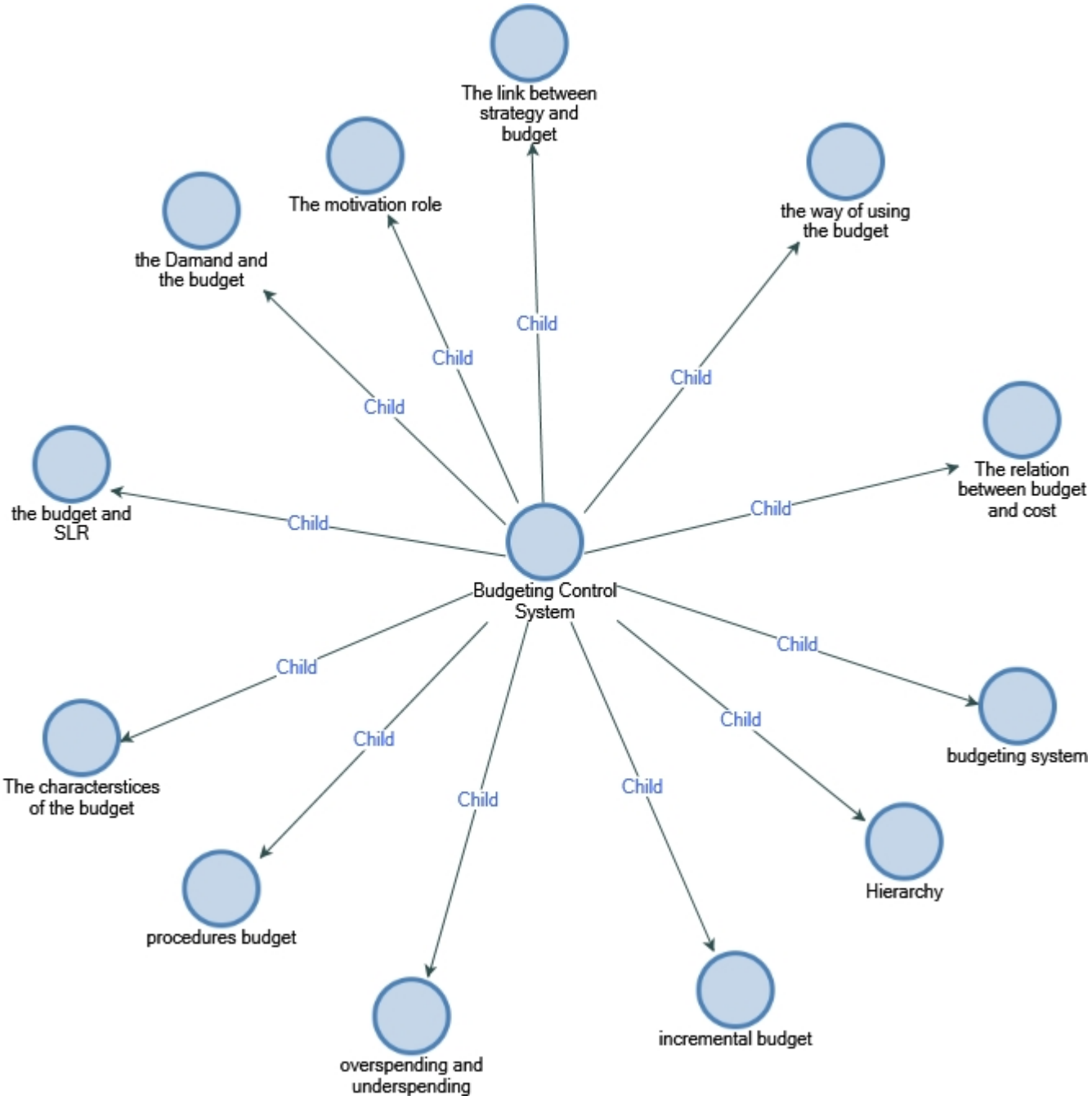
The Overarching Categories and their cods

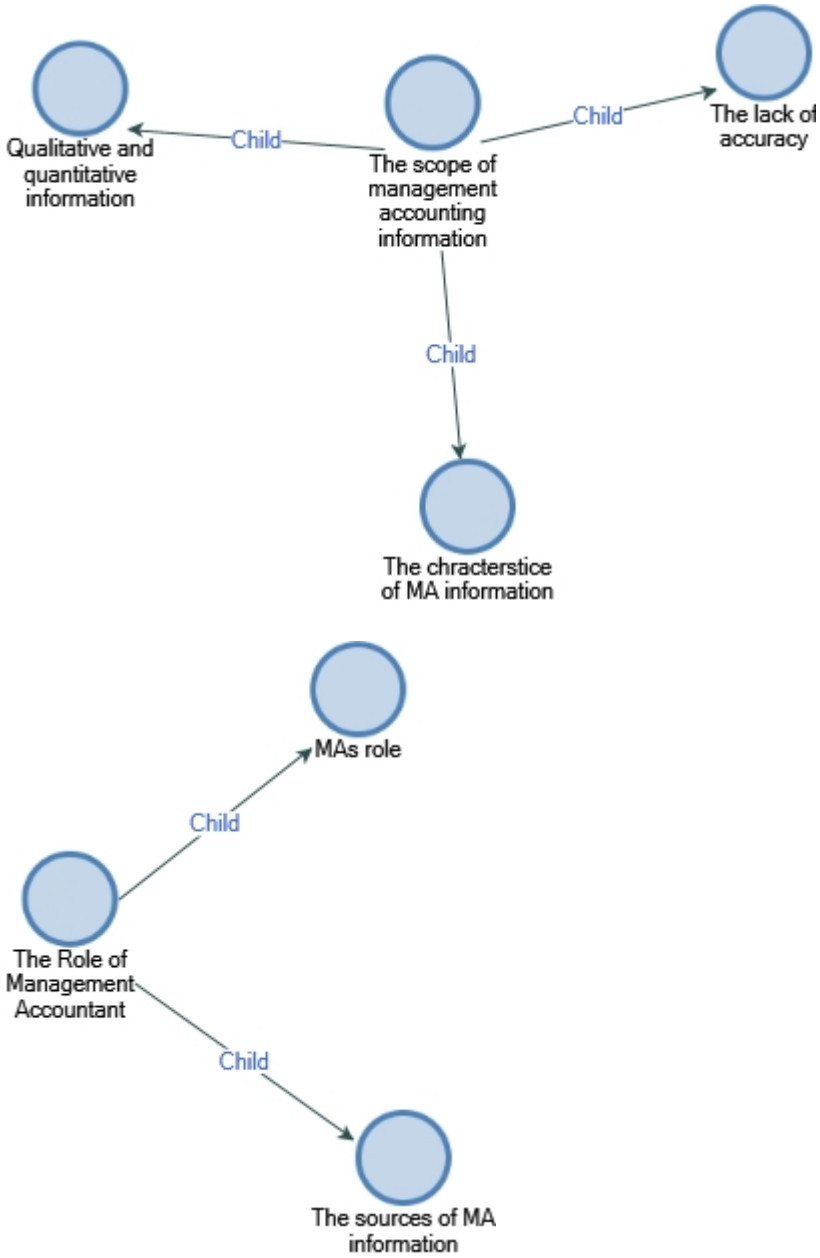
Name	Files	References	Created On	Created By
Budgeting Control System	0	0	25/09/2017 17:16	ALI
The Funding	0	0	25/09/2017 17:18	ALI
Costing System	0	0	25/09/2017 17:19	ALI

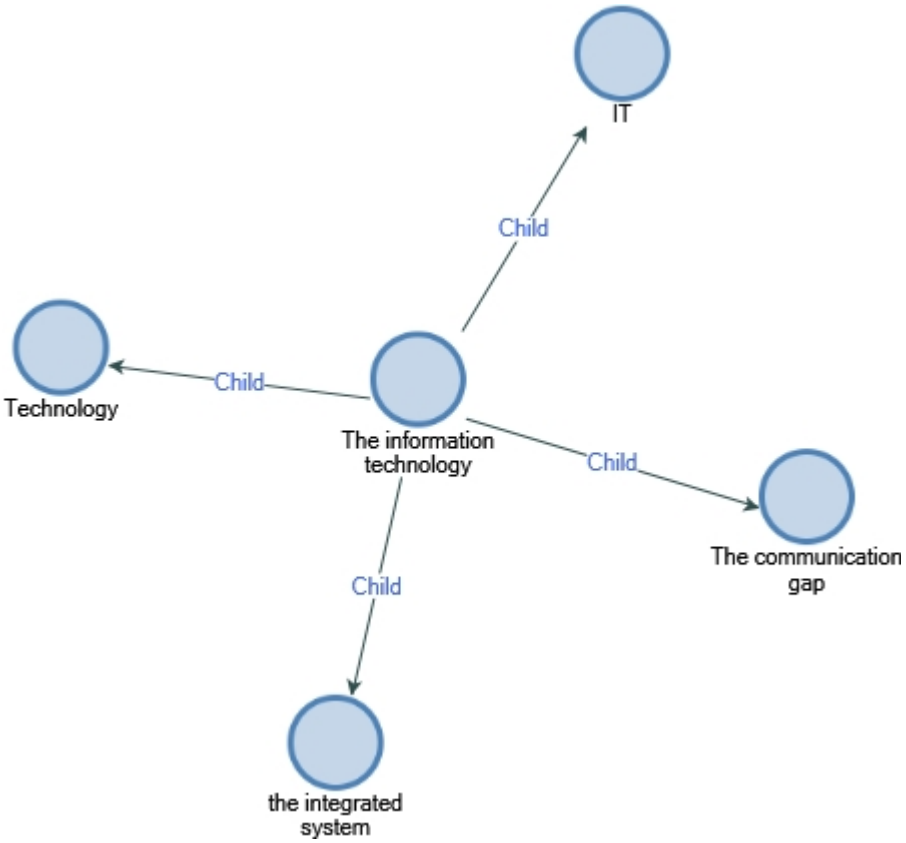
Planning	0	0	25/09/2017 17:21	ALI
Cost improvement programs(CIPs)	0	0	25/09/2017 17:22	ALI
The Institutional l pressure	0	0	25/09/2017 17:23	ALI
The engagement of clinician in the efficicncy	0	0	25/09/2017 17:24	ALI
The Role of Management Accountant	0	0	25/09/2017 17:24	ALI
The scope of management accounting information	1	1	25/09/2017 17:25	ALI
The information technology	0	0	25/09/2017 17:25	ALI
The Role of Management Accounting	0	0	25/09/2017 17:26	ALI
Culture issue	0	0	25/09/2017 19:00	ALI
The Strategy of the Trust	0	0	25/09/2017 19:06	ALI
organisational performance	0	0	25/09/2017 19:09	ALI
The chllenges	0	0	25/09/2017 19:22	ALI
Financial performance	0	0	25/09/2017 19:36	ALI

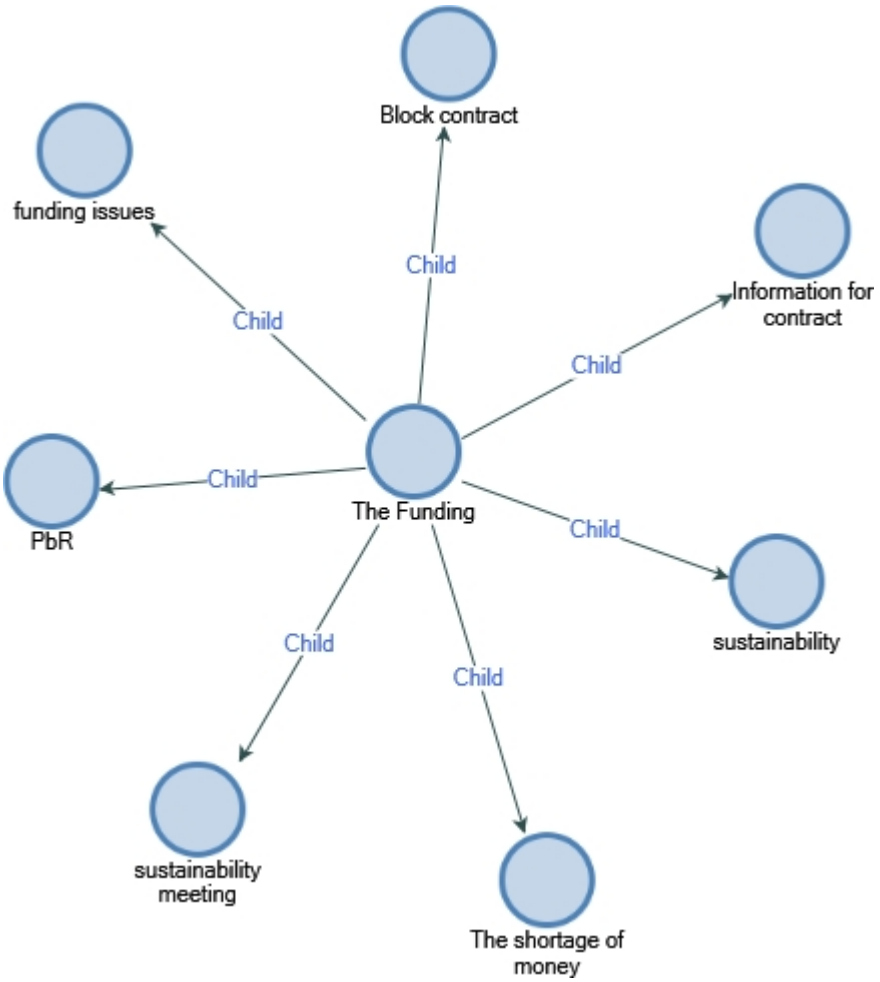

strategic change
Child
Strategic decisions
Child
Child
Strategic objectives
The Strategy of the Trust
Child
Child
Strategic tool
the difference between acute hospital and community
Activity data
Benchmarking
cost driver
Child
Child
Child
overhead cost
direct cost
Child
Child
Child
Child
Service Line Report
Costing System
PLICs System
Child
Child
Child
Child
Child
reference cost
The link between cost and outcome
The link between PLICs and SLR
The way of allocating overhead cost

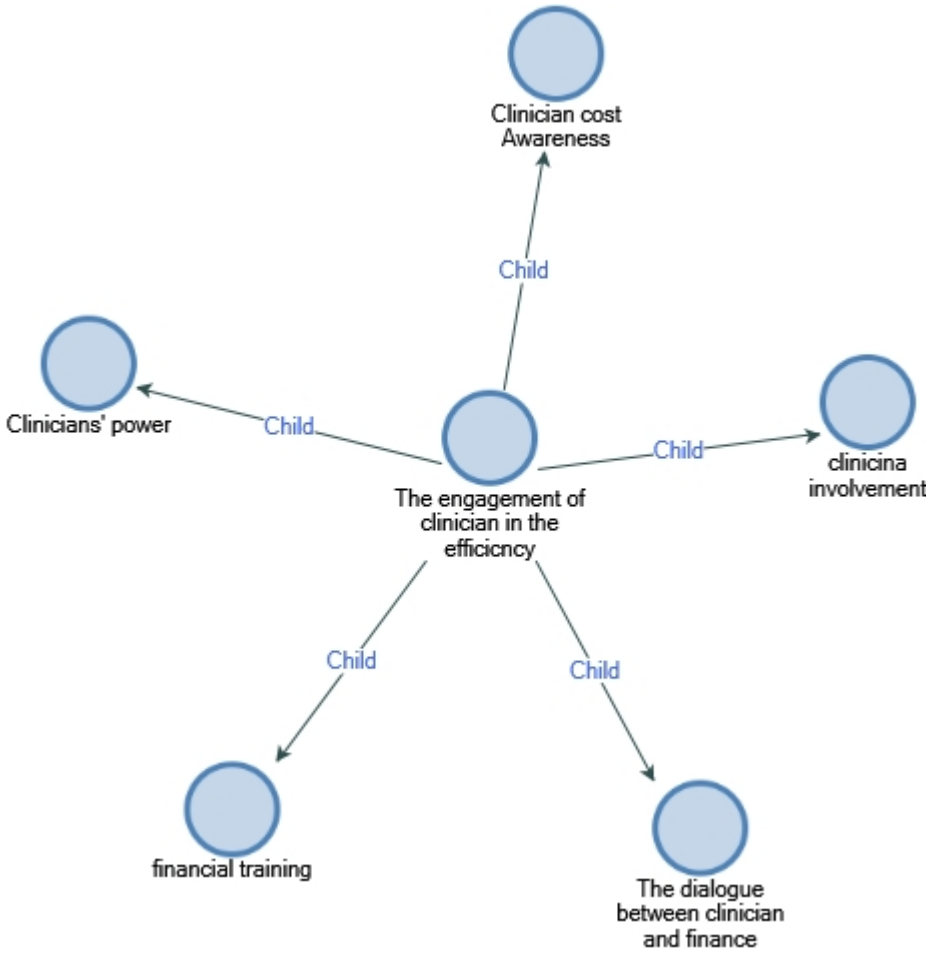

New thinking or new culture
Child
The diffculty of achiving the CIPs
the pressure to change
Child
Child
Solution out of area cost
Child
Cost improvement programs(CIPs)
Child
Cost improvement schems
Child
Quality impact assessment
Child
Child
Nurce shortage
out of controle cost

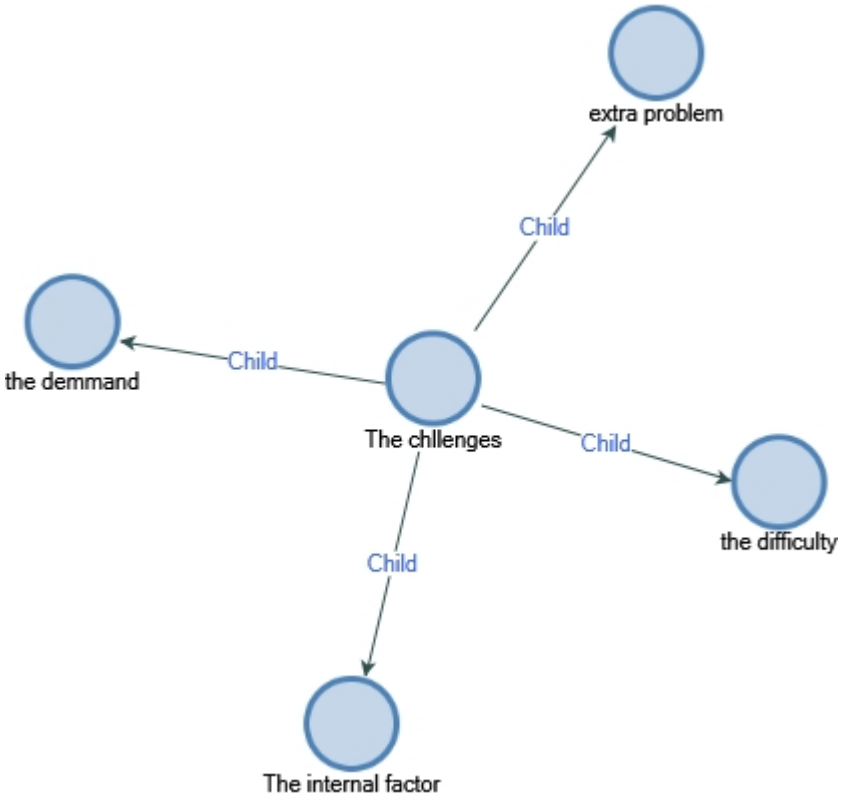

The link between strategy and budget
The motivation role
the way of using the budget
the Damand and the budget
Child
Child
Child
Child
Child
the budget and SLR
The relation between budget and cost
Budgeting Control System
Child
Child
Child
Child
Child
Child
Child
The characterstices of the budget
budgeting system
Hierarchy
procedures budget
overspending and underspending
incremental budget

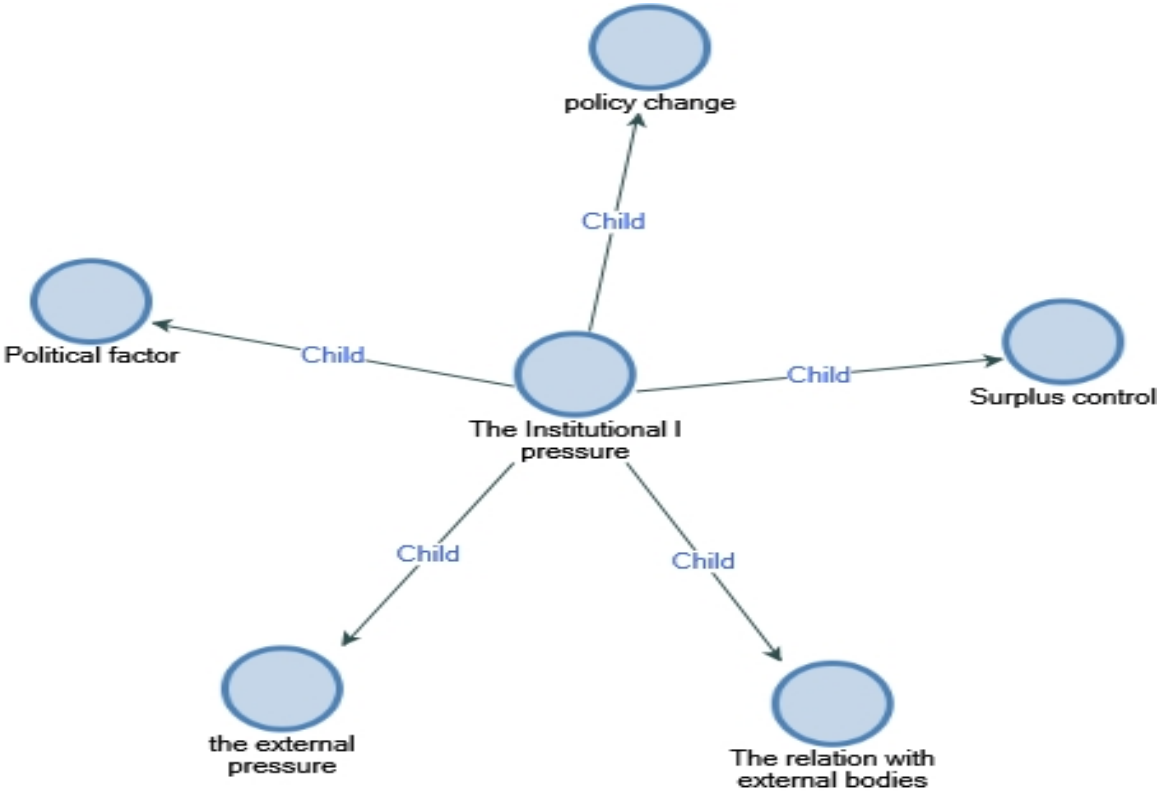

Qualitative and quantitative information
Child
The scope of management accounting information
Child
The lack of accuracy
Child
The chracterstice of MA information
MAs role
Child
The Role of Management Accountant
Child
The sources of MA information

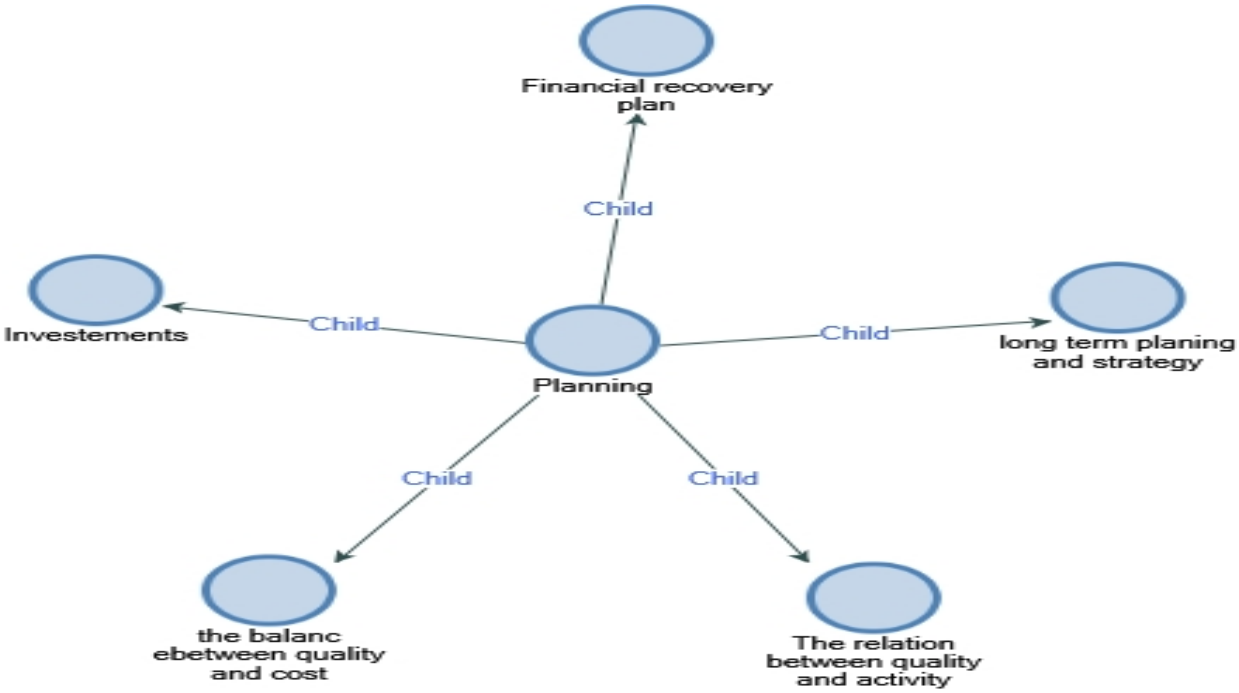

IT
Child
Technology
Child
The information technology
Child
The communication gap
Child
the integrated system


Block contract
funding issues
Child
Child
Information for contract
Child
Child
PbR
The Funding
Child
sustainability
Child
Child
sustainability meeting
The shortage of money

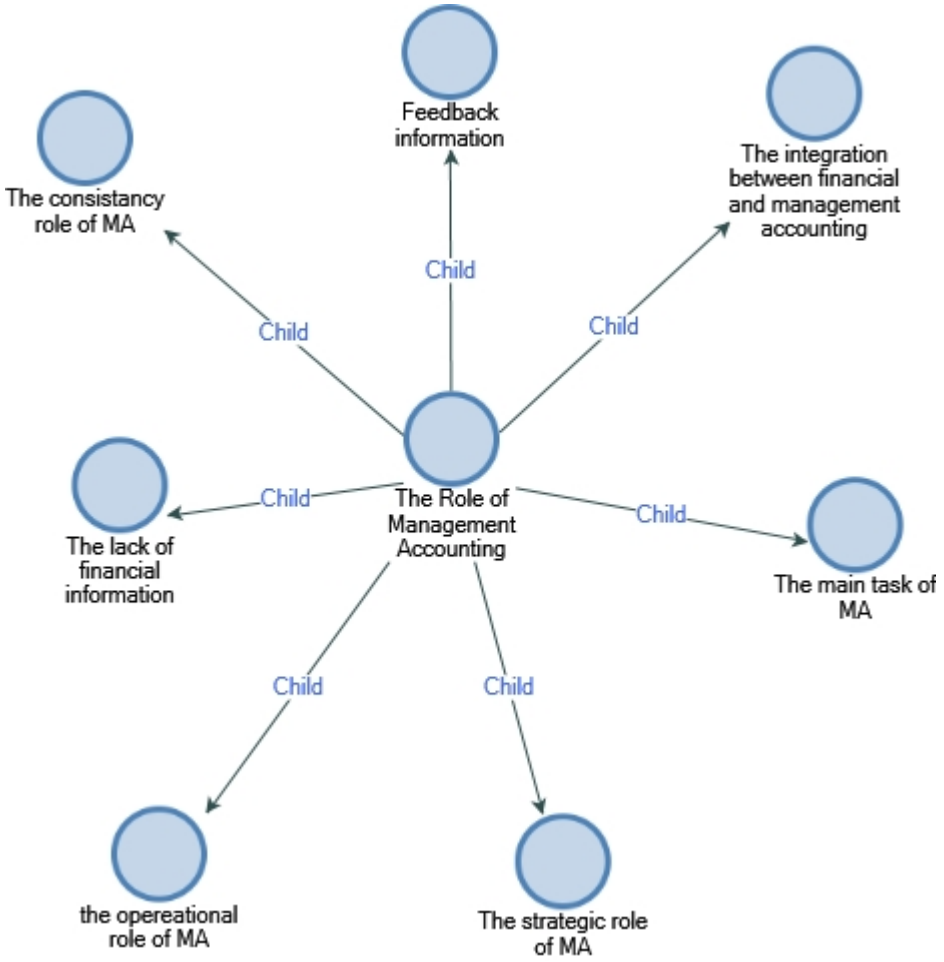

Clinician cost Awareness
Child
Clinicians' power
Child
The engagement of clinician in the efficicncy
Child
clinicina involvement
Child
Child
financial training
The dialogue between clinician and finance


extra problem
Child
the demmand
Child
The chllenges
Child
the difficulty
Child
The internal factor


policy change
Child
Political factor
Child
Child
Surplus control
The Institutional I
pressure
Child
Child
the external
pressure
The relation with
external bodies


Financial recovery
plan
Child
Investements
Child
Child
long term planing
and strategy
Planning
Child
Child
the balanc
ebetween quality
and cost
The relation
between quality
and activity


Finacial and nonfinancial information
Financial scrutiny meeting
Flexibility
opereational pressure
organisational performance
Non-financial measures
other reports
Performance measures
performance analysis
Turn around team
Short term performance
Child


Feedback information
The integration between financial and management accounting
The consistancy role of MA
Child
Child
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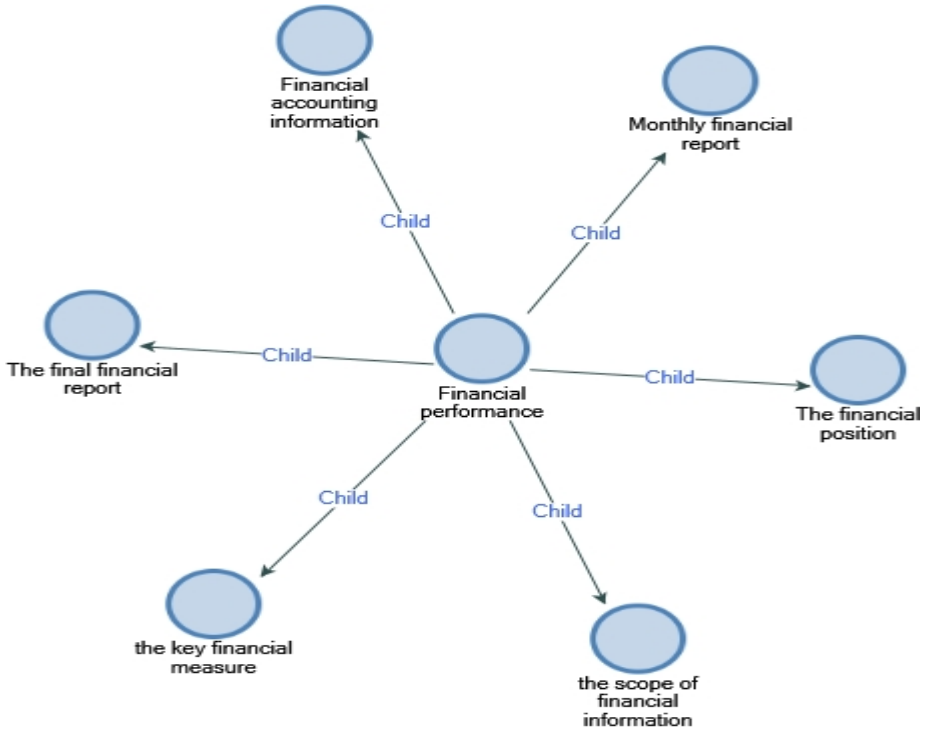
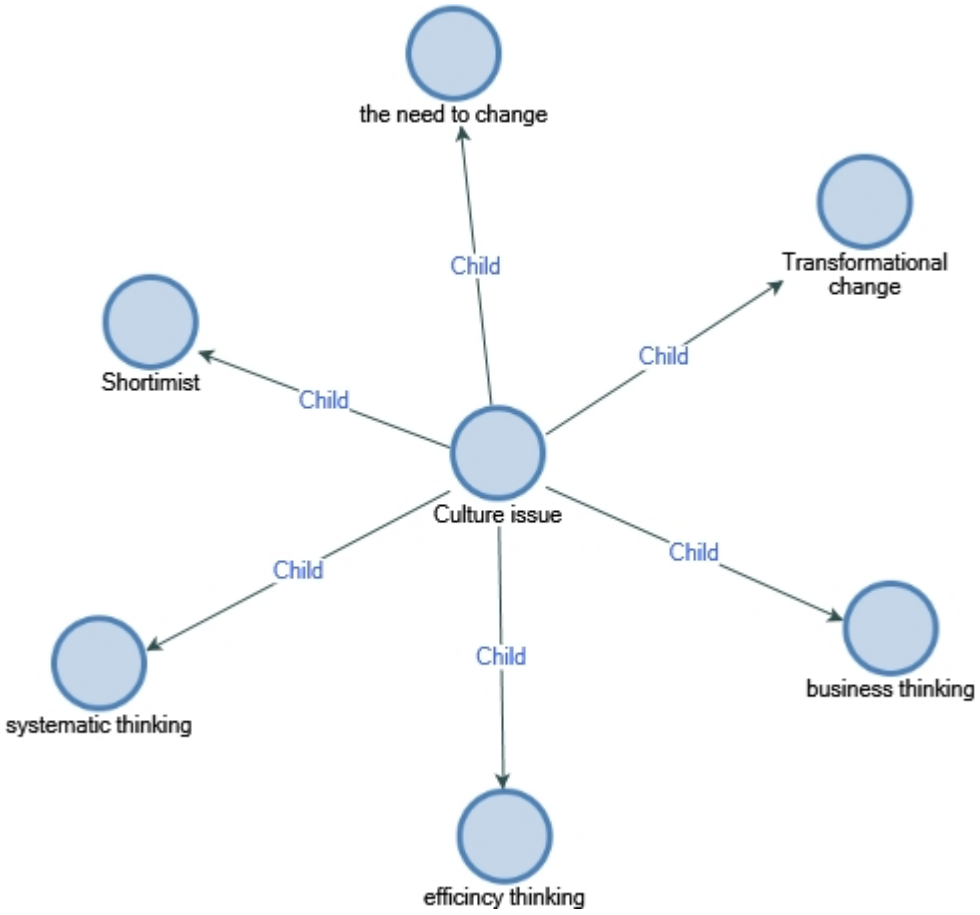
The Role of Management Accounting
Child
Child
The lack of financial information
The main task of MA
Child
Child
the opereational role of MA
The strategic role of MA


Financial accounting information
Monthly financial report
Child
Child
The final financial report
Child
Financial performance
Child
The financial position
Child
Child
the key financial measure
the scope of financial information


the need to change
Child
Transformational change
Child
Shortimist
Child
Culture issue
Child
Child
Child
systematic thinking
Child
business thinking
efficincy thinking