Role of the Audit Commission

Howard Davies

Eighteen months ago the Audit Commission was catapulted into the NHS by the 1990 Act, armed with a duty to promote economy, efficiency, and effectiveness. But the statute was silent, as statutes tend to be, on the way in which these terms should be defined. We have since been engaged in a dialogue, initially with ourselves and now increasingly with others, about what we mean by efficiency and effectiveness in health care. Our conventional definition of effectiveness as "fitness for purpose," which has served us well in other areas, gets us nowhere when the purpose is undefined and the fitness unprovable.

Effectiveness, however, with its utilitarian and cost based echoes, has given way to quality, seen as a more user friendly and open ended term. Some of us regret this linguistic shift. We suspect that the definition of quality put into Donald Trump's mouth in the "Doonesbury" cartoon strip: "Stuff that costs an obscene amount of money" is still shared by some in British public services. But that argument is lost. And, fortunately for those who must also labour in the groves of economy and efficiency, more robust, practical, and less gold plated definitions are now at the centre of the quality debate in the NHS.

Against that background, what contribution can the Audit Commission, a new kid on the block, make to the promotion of good quality care in the NHS? I can at this stage offer only a preliminary answer. But I do see the potential for a significant contribution, based on the commission's ability to spread and promote good practice, in every health authority and hospital in the country. And I think that its contribution can be designed to go with the grain of other developments in the service.

Defining quality

But, firstly, how do we define quality? In the commercial world the notion of good quality has been shifting away from the traditional or technocratic definitions towards a concept based on total quality management (TQM) (fig 1). In both the traditional and technocratic models of quality assurance good quality is regarded as an attainable feature of the product of service. Individual products or transactions are inspected, possibly on a sample basis, to see whether they meet the required standards. If they do not, they are either scrapped or sent back through the production process for a rework. (Though this brutal process does occur in hospitals from time to time, it is not an attractive model for the health care industry!)

The technocratic model acknowledges that good quality resides in *any* well designed and manufactured product that succeeds in doing what it is supposed to do, and not only in the most expensive luxury products, as was assumed under the traditional model. But the fundamental approach to policing quality remains the same.

In TQM theory quality is a continuous striving, in "conversation" with the customer, towards an unattainable goal rather than an attainable product feature. Quality is a journey, not a destination. The goal is to "delight the customer," which means exceeding his or her expectations. And the process is dynamic, as customers' expectations are affected by previous experiences with the product so that it must continue to improve to keep ahead of rising customer expectations. TQM has come to replace the traditional method of maintaining quality by inspection of products with a focus on improving the manufacturing processes themselves. Quality should be designed into the process.

It is now increasingly argued that TQM can be easily adapted to most health care settings, whether primary or secondary.^{2,3} But it is essentially a process and needs a definition of quality on which to bite. Maxwell's commonly quoted definition works along six dimensions⁴:

- Access to services
- Relevance to need (for the whole community)
- Effectiveness (for individual patients)
- Equity (fairness)
- Social acceptability
- Economy and efficiency

These dimensions work well as a checklist but are more difficult to administer as a complete approach to the quality problem. It is not clear whether they are entirely distinct, whether they overlap, or whether they duplicate each other. If, for example, a service is accessible to all, does it follow that it is equitable?

The Audit Commission's working definition of quality is less broad; it is the extent to which the actual care provided as part of an operational service measures up to the best care possible in terms of both efficiency and access to the service. This definition is based on the work of Brook and Lohr⁵; it enables quality to be analysed as a vital aspect of the system but not the overarching aim of the entire service. However, to ensure that other essential attributes of health care services are not omitted from consideration quality needs to be seen as just one of six essential steps for an optimum service (fig 2). These steps are based on, but not identical to, the separate

Howard Davies was controller of the Audit Commission until June 1992, when he became director general of the Confederation of British Industry

**Audit Commission,
London**
Howard Davies,
controller

Correspondence to: Director General, Confederation of British Industry, Centre Point, 103 New Oxford Street, London WC1A 1DU

Source: Audit commission¹

Fig 1 Evolution of quality

Source: Audit commission¹

Fig 2 Six steps to a better NHS

dimensions of Maxwell's global definition. They can be grouped under three essential attributes of a public health service.

- (1) Individual effectiveness is produced by efficacy and quality. It is, or rather it should be, the corner stone on which all services rest. There is no justification for health authorities spending money on services that do not result in positive benefit to at least some patients. If efficiency is the ideally attainable, quality is the extent to which it is achieved. Efficiency results from research, quality from everyday practice
- (2) Cost control involves questions of economy and efficiency and reflects the hard reality in the NHS of continuous pressures to conserve resources. In the

cash limited parts of the service in particular, resources saved in one area can be used directly to improve some aspects of effectiveness in another. So cost must form part of the equation.

- (3) Collective effectiveness embraces quantity and equity. These are both of fundamentally important significance in a publicly funded health care system, and, in some respects, cannot be left for market forces to resolve.

A forthcoming consultation paper *Minding the Quality* by the Audit Commission will describe this approach in more detail.¹

But as Berwick *et al* point out: "However hopeful TQM may be as a useful approach for increasing the capability of the NHS, only a fool would claim that its promise is certain!"³ They agree that leadership and commitment are essential and emphasise the need to create an atmosphere of collaboration, in which cross professional and professional-managerial approaches can be fostered. Both of these requirements will be difficult to achieve unless the context is one in which there is an incentive to enhance quality. Is that so in the NHS?

Incentives to improve

Companies in competitive markets need to improve quality in order to stay in business. Improving quality is a kind of "chain reaction" which, according to the quality guru W Edwards Deming, culminates in "jobs and more jobs."⁶ In the NHS, at least before the creation of an internal market, there was no chain reaction. Instead there were disincentives both to improving the service and to

Source: Audit commission¹

Fig 3 Reasons for improving quality: does the NHS have them?

reducing its costs. If providers made visible improvements to service quality, referral rates and therefore waiting lists were likely to increase. Conversely, if a department managed to reduce its costs, it would often find its budget cut the following year (fig 3). Central management initiatives could override these negative factors by dictat, and control systems were put in place which did deliver improvements in productivity and effectiveness. But the system carried within itself no dynamic to improve.

The internal market now offers at least the potential to overcome perverse incentives and set a chain reaction in process. Providers can, in theory, increase revenues if they perform well – and go out of business if they perform badly. But certain preconditions are needed for this chain reaction to work. Firstly, purchasers and providers need to be able to understand and assess the costs and quality of any services provided. Secondly, purchasers need the motivation to do the best job possible in buying health care for populations they represent. And, thirdly, providers must have a real potential to expand if they perform well and be at risk of closure or shrinkage if they perform badly.

So there is a lot to be done if the internal market is to turn into an effective mechanism to promote quality. The NHS needs to establish ways of giving all its customers the information they need. Both purchasers and providers need, in particular, to find out what patients think about the care they receive. But patients' views are most useful if they are

based on realistic expectations and comparative information about other services.

Within the service itself there is also great need to bring together quality systems. At present the gap between professional activity and quality promotion and management remains wide. And managers complain that many theoretical approaches to quality care are downright impossible to turn into practical initiatives at local level.

The Audit Commission's role

Within this framework, then, what role should the Audit Commission have? Can its activities help to bridge the gap between professions and management and between theory and practice?

The commission has some important competitive advantages. It is independent of both political parties and professions, and it has a clear statutory duty. It is a permanent presence (until parliament changes its mind) with a field force located in or near to every health authority and trust. The breadth of its remit, both in definitions and institutional terms, is a further advantage. And the commission is rooted in the financial reality of a cash limited service. It is not prone to making expensive recommendations to which its clients cannot respond.

But there are drawbacks. The commission is not part of the NHS. It has little (though some) clinical expertise. Its staff are, frankly, still learning on the job. With many important professional groups its credibility has still to be established.

We therefore believe that the commission's most appropriate strategy is to act as a "fast follower." It is not a primary research organisation but can act as a "research wholesaler." Where it can score most highly is in spreading good practice to authorities that are average or weak, rather than in making the best even better.

Specifically, in quality promotion the commission aims through its studies at adopting an explicit customer/patient perspective. It is often argued, most significantly by the NHS ombudsman, that "a better understanding of patients' worries must be learned by NHS staff." Other audit and quality initiatives often adopt an "inside out" perspective, focusing on professional activities, with the impact on patients as the final outcome. The commission will explicitly try to adopt an "outside in" perspective, focusing on the needs of particular user groups and how effectively they are met. So all of the commission's study groups will include patient representatives and some of the work will use customer segmentation as the definitional basis. The study of the care of sick children in hospital, which will report later this year, is an example of that approach.

Adopting a customer/user led approach is not easy, since of course professionals tell us, sometimes rightly, that the customer's definition of quality isn't everything in health care. If you ask a physician what constitutes good quality care for a diabetic person, he or she would be likely to talk about keeping blood sugar concentrations within narrow bands or preventing complications such as diabetic retinopathy. A patient, on the other hand, would probably talk of the advantages of seeing the same doctor every time he or she went to the clinic, being treated from general practitioner's surgery, perhaps by a consultant doing outreach clinics. Both perspectives are valid and should, in a non-cash limited world, be consistent and achievable, though when resources are constrained they may conflict. It seems to the commission to be no bad thing, however, to begin at the patient end from time to time.

Particular priority will be given to "cross boundary" issues. The commission is unusual in that its remit crosses institutional boundaries, which is of particular significance in community care. So a heavy focus of its effort will be on the quality of relationships and planning at the interface between health and social services authorities. Many problems arise at that interface, which professionals in the different authorities find exceedingly hard to address.

In some cases this means audits negotiated with more than one authority. For example, the commission is now in the process of auditing arrangements being made by both NHS and local authority social services departments to put new community care plans in place. And it is focusing particular detailed effort on discharge procedures, which it believes to be a barometer of success or failure in collaboration.

Beyond this there are several other ways in which the commission is thinking of developing its role. The first is developing quality assessment tools which can be used by NHS practitioners to monitor changes in delivered quality. An example is the questionnaire on patients' perceptions of day surgery which the commission developed as part of a national study of the incidence of day case surgery across England and Wales.⁷ It was thought vital, if the commission was to recommend increasing day surgery, to provide hospitals with a tool to monitor complications after discharge and patient satisfaction. So a validated questionnaire was commissioned from the London School of Hygiene and Tropical Medicine, which over 50 hospitals have already adopted for local use. The commission is backing it up with central data collection so that participating hospitals can receive an assessment of how their service quality compares with that of the others. I see scope for further developments of this kind if this first initiative is successful. A further possibility which might follow would be for the commission to extend its quality exchange service, now operating in local government, to health authorities and hospitals. The exchange is voluntary. Authorities feed in data on service quality and receive reports on national profiles and how their service quality compares with others. It also provides them with access to a good practice network. The commission is interested to see whether there is a similar market in the NHS.

Working together

There are already rumblings of discontent from clinicians and hospital managers about the range of bodies involved in auditing, monitoring, inspecting, controlling, and accrediting them. Those rumblings will grow in volume unless all those in the quality industry can show that they are adding value to those who are directly delivering services in the front line. This means avoiding duplication of effort. It means providing user friendly information and tools. It means, also, ensuring that recommendations for change are realistic and achievable within the resources available. I believe that the Audit Commission scores quite highly on the last two criteria. But there is a lot to do before we can be satisfied that its efforts are properly coordinated with those of others. This conference and the new journal should both provide forums in which needed collaboration can be developed.

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- 7 Audit Commission. *A short cut to better services: day surgery in England and Wales*. London: HMSO, 1990.