TALKING POINT

Monitoring and standards in the NHS: (1) Monitoring

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In a traditional management structure the doctor is untidy. Though working in a system that must be directed also at regional and national level, he has considerable independent management control by virtue of his direct responsibility for patients. This is also partly true of other clinical professions, but in the National Health Service it was the doctor who was specifically assured "freedom . . . to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference."¹

Quite apart from the special position of the clinical professions, responsibility for management of the Health Service is divided—in sometimes obscure shares—between the Department of Health and Social Security at the centre and the health authorities at the periphery. Despite the theoretical co-ordination by the DHSS and regions, enthusiastic defence of local autonomy can allow established poor management practices to flourish while proved good ideas may be ignored. The problems of this negotiable power structure are emphasised by increasing demands from consumers and from governments for the Health Service (including the clinical professions) to be accountable for the cost of the provision, if not also for its quality. This accountability implies some systematic review and some norms or standards by which to measure.

Until now "monitoring" of the Health Service has been an ill-defined, largely administrative exercise using numerical norms of input that reflect quantity rather than quality. Whether this will be perpetuated by current political enthusiasm to put meaning into monitoring may depend on whether the professions can submit a realistic alternative that focuses instead on quality and standards. The importance of this option, which is still open, is that the groups that control the system of evaluation will also control the form and direction of the service.² This and a subsequent article look at current standards and methods of monitoring in the NHS and suggest the need for a joint initiative from the clinical professions.

Current mechanisms

Some of the technical and professional mechanisms used at present for reviewing various aspects of the Health Service are outlined in the table. Though far from universal, clinical audit is included as an example of loosely structured internal review and to emphasise that it is merely a distant cousin of monitoring. Discussion of the one issue has only limited relevance to the other. More formal mechanisms such as accreditation of training necessitate regular assessment by external visitors, who, using broad published criteria, make essentially subjective judgments.

At the opposite extreme from clinical self-scrutiny are various inspectorates of safety and physical environment. These imply external examinations, some according to explicit published guidelines (based either on statutory regulation or on a national code of conduct) and others according to local practice. Health establishments are therefore liable to separate inspections

Two years ago Dr Charles D Shaw wrote five articles on aspects of medical audit (24 May 1980, p 1256; 31 May 1980, p 1314; 7 June 1980, p 1361; 14 June 1980, p 1443; and 21 June 1980, p 1509). In this, the first of two articles, Dr Shaw discusses monitoring in the NHS. His second article will be on standards.

concerning health and safety (of staff rather than patients), nuclear installations, food and drugs, fire safety, insurance, pharmaceutical manufacturing, and public health. Ironically, the NHS is technically exempt from much of the relevant legislation since, having Crown status, it cannot be prosecuted for failure to comply.³

These mechanisms are of limited value in assessing overall effectiveness since, being designed for different purposes, they have differing approaches to standards and they focus on limited aspects of the overall service. In practice, major problems of organisation occur not within these defined areas but between them.

Overall view

One holistic approach to monitoring is that of the multi-disciplinary development team for the mentally handicapped, whose consultation and advice are backed up by explicit

Looking at health services

What	How	By whom
Local clinical practice	Clinical audit	Local clinicians (doctors, nurses, therapists, etc)
Diagnostic and therapeutic regimens	Evaluation (clinical trials, cost-benefit studies, etc)	Researchers, economists
Training programmes	Accreditation	Professional organisations (GMC, GNC, royal colleges, etc)
Physical environment	Inspectorate	Statutory officers (fire, radiation, safety, hygiene, etc)
Accounting	Financial audit	Internal and DHSS auditors
Administration	?	?

statements of good practice that are available to all those working in the field. A separate but important function of the team is to advise the Secretary of State on the current state of services, as does the Health Advisory Service (HAS)—originally the Hospital Advisory Service—in relation to mental illness and geriatric services.

The original aims of the HAS, set up in 1969, were to promote good practices in long-term hospitals and to keep the Secretary of State informed.⁴ Unlike the development team, the HAS declined to provide a set of standards applicable to all hospitals,⁵ but it does draw attention in annual reports to general administrative problems, many of which are common to other services

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beyond its jurisdiction. Whether universal standards can be locally appropriate depends on whether they refer to what should be achieved rather than how it should be achieved.

With the exception of the development team and HAS in relation to long-term care there is no comprehensive mechanism for regular review of the NHS. Instead, various groups monitor different aspects, for different reasons, using different yardsticks—and with minimal effect on the coherent functioning of the Service. Ideally a balanced review would be inherent in the process of management; but planning and evaluation have become preoccupied with resources and quantity rather than outputs and quality. This emphasis can be changed only with the active help of the clinical professions in providing more appropriate criteria.

The Royal Commission on the National Health Service suggested that if methods in the existing structure failed to assure an acceptable standard of services an independent special monitoring health authority might be set up.⁶ Perhaps sooner than envisaged the subsequent DHSS document, *Patients First*, reflected this in suggesting that, on a pilot basis in selected regions, groups independent of the health authorities might monitor the "quality and efficiency of the ways in which health services are managed."⁷ This twinkle in the eye of the DHSS soon developed into the idea of a "management advisory service" to monitor quality and efficiency of services and to propagate examples of good practice.⁸

Some schemes for implementing this idea have been put forward by regional health authorities and groups outside the service, but professional groups such as the Royal College of Nursing and the British Medical Association view with suspicion any form of inspectorate.^{9,10} This particular antipathy is shared, among others, by the Royal Commission on the NHS,⁶ but the professions have not put forward any alternative proposals. Whether an inspectorate would be acceptable depends on what or who is being inspected. Many, including the Secretary of State,¹¹ acknowledge that we should monitor what people do rather than the buildings and resources they use,^{2,4,12} but that requires a broader professional input than is offered at present.

Specific proposals

Various proposals have been offered to implement the concept of a monitoring agency.¹³⁻¹⁵ Most of these centre on small independent groups of prestigious professionals who could visit selected services on an advisory basis. In order to emphasise development rather than policing of existing policies the proposal from the Royal Institute of Public Administration favours the term development agency rather than management advisory service and concentrates on providing support to those who wish to innovate and resolve rather than identify problems.¹⁶ Pilot schemes, funded by the DHSS, are planned to start in 1982 in the North-western, Wessex, and, jointly, Oxford and South-western Regions.⁸ The North-western proposal, similar to that of Pethybridge,^{15,17} envisages a cadre of senior officers who would review the organisation and operation of services in each area. Initially, criteria would be existing normative guidelines, but subsequently these would be replaced by empirical standards based on observation. The Oxford/South-western proposal replaces a formal inspectorate with an independent joint team examining selected operational services in the light of systematically collected information. The Wessex scheme of performance review emphasises results rather than observations and would build on previous experience of developing explicit standards for selected tasks and encourage authorities to participate and respond voluntarily.

Having invested heavily in these projects, the DHSS will no doubt look forward to implementing some such system on a national basis within the next five years. It is not yet clear how far clinicians will, in practice, be concerned either in monitoring or in being monitored, but it is clear that so far the initiative

BMA President 1982-3

HRH The Prince of Wales, KG, KT, GCB, will be installed as President of the British Medical Association at the Adjourned Annual General Meeting to be held at the Royal Festival Hall on the evening of Wednesday, 7 July.

has been political and administrative. Though monitoring excludes clinical practice, there remains a substantial area of management and clinical organisation best monitored by the professions themselves—on criteria of quality rather than quantity.

In presenting proposals for the National Health Service in 1944, the Minister of Health outlined plans for a hospital inspectorate, "the foundation [of which] must clearly be a team of highly qualified medical men. In addition to doctors . . . hospital administrators, nurses, catering experts and others should find a place."¹ If doctors and other professionals are to make monitoring more sensitive to clinical reality they must be prepared to formulate standards for clinical organisation as a basis for that monitoring.

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(Accepted 14 December 1981)