TALKING POINT

Cost, quality, and district management

CHARLES D SHAW

The recent emphasis placed by the government on the statutory accountability of district health authorities to regions and to the Department of Health and Social Security has emphasised the cost, distribution, and quantity of services provided. This should not supplant the moral (if not legal) responsibility of health authorities to patients and staff for the quality and effectiveness of those services.

Formal routine review of the Health Service promises to concentrate on resources, workload, and structure rather than on results. This is not only because of political pressure for fiscal control but also because the expectations and achievements of such a "service industry" are difficult to define and measure. Furthermore, it has been traditional in Britain for the quality of health services to be regarded as the responsibility of clinical practitioners rather than of management. Yet health authorities have repeatedly been held responsible for failures in the organisation—if not also the delivery—of medical care.

Questions of quality

The repetition, despite inquiries and their recommendations, of institutional scandals suggests that, at least in long term care, authorities have difficulty in responding to the lessons of others. Pressure to monitor the service and to correct observed deficiencies has also been increased by greater public participation of consumers, through community health councils, pressure groups, and the media.

Recent national reviews of subjects such as electroconvulsive treatment, maternal mortality, and deaths associated with anaesthesia have also provided evidence of failures in clinical services for which health authorities may be held at least partly responsible.

Nevertheless, authorities are now faced with minimal (if any) development funds and are required to achieve a 10% reduction in administrative costs. In the face of retrenchment there is good reason for consumers, staff, and authorities to seek some evidence and reassurance that the quality of health services is, and will remain, adequate.

Approaches to monitoring

Practical experience and thus the terminology of systematic monitoring of the quality of health services has come mostly from North America. Despite the differences in the financing and delivery of care, the principles of monitoring apply equally in Britain.

For these purposes health services are often described in terms of a model borrowed from the motor manufacturing industry: input (men, materials, machines), process (production

system), and output (completed vehicles). These are readily quantified in numbers of units, cash value, and time. In health services the input is equally measurable, but the process and, especially, output are not. Since the latter must ultimately be the criterion for the service considerable efforts have been made to measure it; most have either failed or ended in compromise. It is also particularly relevant to cost containment that resources do not have a constant relation to outcomes; a cheaper service is not necessarily any worse, nor a more expensive one any better. A review of how resources are organised, such as by policies and procedures, may be more rewarding than counting the resources themselves. And a review of cost should not ignore quality and vice versa.

Review (whether of structure, process, or outcome) may be merely descriptive ("quality assessment") or may be part of a cycle intended to correct and improve ("quality assurance"). This cycle means looking at actual practice compared with agreed standards, identifying discrepancies, deciding and implementing solutions, and then looking again for the desired results. It is analogous to budget systems, management by objectives, servomechanisms, and neuromuscular feedback loops. Surveillance—that is, quality assessment—of subjects that a health authority has no intention or ability to influence is of little practical value.

Quality assurance divides theoretically into clinical audit (by clinicians), and monitoring of organisational performance (by management). In practice (and in law) it is difficult to separate these, and the district health authority may be held accountable for both. But how can an essentially lay body fulfil this responsibility for monitoring highly technical and often confidential activities?

Options for quality assurance

It would not be appropriate for the members of the district health authority, as a policy making board, to participate directly in management, but it would be reasonable for them to require the district management team to introduce mechanisms that could contribute to quality assurance on their behalf. Many of these are not usually included in budgetary or planning reviews. But much of the information required is or should be readily available. Some examples are given here.

Routine information

Does management receive an annual analysis of data reflecting the effect of services—for example, on mortality from lung cancer and coronary heart disease, perinatal mortality, childhood accidents, immunisation uptake, long stay psychiatric patients, complaints received, and waiting lists?

Organisation

Is there a staff appraisal programme? How are responsibility and accountability of staff defined—for example, in clinical assistant contracts? Is there an organisational chart available for each department?

Cheltenham and District Health Authority, Burlington House,
Lypiatt Road, Cheltenham GL50 2QN
CHARLES D SHAW, MB, LHA, specialist in community medicine

Policies

Do written policies exist for the organisation and goals of clinical services and, in particular, for management of potential problems, such as sterilisation of equipment, antibiotic prescribing, fire prevention, the extended role of the nurse, and child abuse? Are these policies formally agreed and adopted by the professional groups concerned?

Structure

Is there an effective advisory structure for nursing staff and for paramedical staff? Is there an effective medical advisory structure for all doctors, including a joint forum for general practitioners and consultants?—this could take the form of active specialty divisions or a representative executive committee. Does management regularly consult these groups? Is there a formally constituted ethical committee? Are there active multidisciplinary committees for infection control, pharmacy and therapeutics, research, and maternity service liaison? If not, how are these functions managed?

Review

External review—Have outside bodies—for example Hospital Advisory Service, management advisory service, national development team, royal college assessors, General Nursing Council, community health council, etc—visited recently or provided reports? Who received the reports? What action was taken? Do all laboratory departments participate in an external quality control programme?

Internal review—How do clinicians formally review clinical work? Do they have adequate support—for example, clinical information, financial information, and clerical help? How are long stay institutions monitored? Is there a joint confidential inquiry into perinatal deaths? Has the nursing process been implemented? Is local research encouraged into methods of providing care, and does the district health authority receive the conclusions of such research? Is there a mental handicap register? Is there a child health computer system?

National publications

How does the district consult on and respond to recent reports such as *Maternity Care in Action*, *Deaths Associated with Anaesthesia*,

Electroconvulsive Treatment in Great Britain (1980), and DHSS hazard notices?

Comment and conclusion

Many of these indicators are of process, rather than of outcome, and lie in the no man's land between clinicians and managers where accountability is shared. Jointly agreed policies for the use of resources, in particular, may be able to resolve the apparent dilemma of reconciling demands for economy with insistence on quality.

Only clinicians can ultimately assess clinical care; one role of management is to provide the appropriate environment for them to provide that care. Between these two activities, however, there is the issue of process—that is, how resources should be organised and controlled. Counting the cost of services is tangential to the issue of quality of care, but it is one of the few readily available tools that management can use.

This emphasises management's reliance on clinicians (nurses, doctors, therapists, and others) to analyse their own work. Management cannot do this for them, but can reasonably ask for some evidence that this is being done. The health authority employs a large workforce and must be responsible for its performance. Exactly how far this responsibility can be defined either legally or morally is only beginning to be tested in Britain. There can be no doubt, however, that management is directly responsible for organising non-clinical work that ultimately affects the quality of service.

There are three principal channels by which management may consider the quality of services for which it is responsible—indirectly, through clinicians reviewing their own practice; externally, through the advice of outside agencies; and directly, by management control.

I should like to thank Mr Chris Ham, School for Advanced Urban Studies, Bristol; Mr John Hoare, Wessex Regional Health Authority; Professor Colin Roberts, Welsh National School of Medicine; and Mr Michael Sweeney, Management Advisory Service, Cheltenham, for their helpful comments.

(Accepted 3 May 1983)

From the JCC: Nursing process criticised—continued from page 439

change with these health care professions."

A member of a regional nurse training committee, Dr I R Gray (Royal College of Physicians of London), said that one object of the process was to make the relationship between nurse and patient more personal. He thought that if the jargon was ignored there was much that was valuable for clinical nursing and nurse training. Dr Gray did admit that there were some ill chosen words. *Towards Standards*, for instance, said, "Doctors and nurses must both recognise that their goals for a patient may differ or even conflict." The nurses with whom he had discussed the process had not envisaged any difference in aims.

But Mr Russell Hopkins (CCHMS) was not as sanguine. Many senior nurses thought that the doctor was superfluous in this exercise. He did not think that the process did anything to reverse the shift to nursing management. In *Standards of Nursing Care* it was stated: "It was felt that only professional nurses could set standards and assess and measure the quality of care given." Mr Hopkins believed that many doctors thought that they were being left out

of assessing quality of care; they wanted to be convinced that the new process was benefiting patients.

One of the representatives of the British Dental Association, Mr M S Jones, said that the introduction of the process in his area had led to a row. There had been no consultation and some consultants had walked on to the wards and said that it would not be used for their patients. The battle was continuing about who was in charge of the clinical management of the patient. He criticised the fact that nurses spent hours summarising their notes.

Professor Alwyn Smith, an observer from the Community Medicine Consultative Committee, had a different story. He had nothing but praise for the process, which had been in operation in Manchester since 1970.

In some areas the process had been introduced under duress from the General Nursing Council, which said that without it the hospitals could not be recognised for nurse training, Dr W J Appleyard said. No study had been done to see whether the process had been effective. In his view it created more paper work and less patient care.

No one was against improving patient care, Mr L P Harvey (CCHMS) said, but there was no consistency in application; the nursing process was an attempt by the nurses to create their own empire.

Mr David Bolt reported that he had met representatives from the Royal College of Nursing to discuss the process. The college had always made it clear that it did not want to invade the medical field, but it had refused to produce a simplified explanation of the process.

The committee agreed that the fears that had been expressed would be raised with the chief medical officer and that there should also be an attempt to discuss the subject with the Royal College of Nursing.

References

- 1 Royal College of Nursing of the United Kingdom. *Implementing the nursing process*. London: Royal College of Nursing, 1979.
- 2 Royal College of Nursing of the United Kingdom. *Standards of nursing care*. London: Royal College of Nursing, 1980.
- 3 Royal College of Nursing of the United Kingdom. *Towards standards*. London: Royal College of Nursing, 1981.