Enter the men from the Audit Commission

Richard Smith

The government's white paper on the NHS published in 1989 announced that the Audit Commission, which had been auditing local authorities since 1983, was to take on the external audit of the health service. On 1 October 1990 this responsibility began, and at the end of October the commission published its first report—on day surgery. This report was well received, and the Royal College of Surgeons acquired 12 500 copies to circulate to its members. Early in November Richard Smith went to speak to Howard Davies, controller of the commission, and Ross Tristem, director of health studies.

RS: Tell me about the origins of the Audit Commission.

HD: It was a creation of Michael Heseltine. In the 1970s people argued that audit of local authorities was seriously lacking because it was not independent and was too narrowly financial. Nobody was asking whether local authorities were delivering value for money. Thus Heseltine's legislation took audit of local authorities away from the Department of the Environment and gave it to the Audit Commission, which was made up of representatives from both major parties, businessmen, and accountants. The commission was to promote economy, efficiency, and effectiveness.

From 1983 to 1990 the commission's mission has been to promote value for money in local government. We've looked at issues from the nitty gritty end—like refuse collection—right through to care of people with mental handicap. The two duties of the commission have been knitted together in that at the centre of the commission there's a think tank which produces reports on important issues which then feed through into the local audits carried out by our auditors in the regions.

Howard Davies worked in the Treasury before doing a business degree at Stanford University, California. In 1982 he joined the consultants McKinsey but returned on secondment to the Treasury to advise Nigel Lawson on monetary policy. He joined the commission in 1987

RS: And is the idea now to use this same model for the NHS?

HD: Yes, very much the same model. The government decided that the model would easily apply to the NHS. Indeed, we and others encouraged them to adopt that view. The same problems arose as in local authorities in that the Department of Health was auditing health authorities, and we just don't think that that's a good idea. Independence is essential. And that was a big thing for government to swallow—that its audit should be taken away and given to somebody else.

RS: Because, of course, it's one thing for central government to say that local government should have independent audit but another for it to hand over audit for something for which it's directly responsible.

RT: There's another difference too. In local government if you can improve efficiency then the money saved could go into more services or it could be used to reduce the community charge. In the health service we are required to accept that the overall amount of money voted by parliament is the "right" amount. What we are interested in is helping managers deliver the best service they can for the money they have available. We're not into cost cutting; we're into service enhancement.

What to study

HD: But our methods are the same. With the help of outside experts and people from the health service the central commission will produce reports and set out general principles, and the local auditors will then look at how health authorities are doing by applying those principles.

Ross Tristem has a PhD in business studies and has worked in several government departments, including the Treasury and the Department of Health

RS: But that doesn't mean that they will be looking at only the subject of one report.

HD: No, we will do at least three major projects a year. The number we do is driven by the capacity of our local auditors. We could produce more national reports, but we don't think that is much use if the local auditors can't help get them implemented. There are plenty of bodies that can produce national reports saying how terrible things are. The key thing is to be able to convert a report into local action.

RT: The job of the local auditors is to apply the general principles but take into account the local circumstances.

RS: What's different about your reports is that they provide ways of changing.

HD: We are mainly interested in implementing change, and that's how we measure our own performance. The key objective is to achieve beneficial change at a local level. So we have to produce a manageable programme for our field force, and local health managers can give only a limited number of things top priority at any one time.

One criticism of the government's NHS changes that I give credence to is that local managers are being asked to do too much at once.

RS: How do you decide which issues to study?

HD: We have three criteria. One is materiality—the issue must carry substantial financial costs. It would be rivetting to look at the shape of doorknobs in the NHS—and they are pretty irritating—but it's not a material sum of money. The second criteria is that we've got to be sure that there's an opportunity to achieve improvements. The strength of our method is that it's comparative. We don't think of completely new ways of doing things, but if there are two ways of doing something well and three of not doing it so well then we can make comparisons. We always look at variability of performance. The third criteria for studying an issue is that there must be some likelihood of change. For example, in local government there wouldn't have been much point in us doing a study of whether the community charge was the best way to raise revenue because the government was not about to make a change in that.

The day case study scored highly because it was clearly material—waiting lists are a big thing; the variability is large; and there's a likelihood of change.

RS: So you've got your three criteria. What do you do next? How do you get ideas?

RT: We talk to the people on the ground—the managers, the royal colleges, the Department of Health, the universities, anybody with an interest in the health service. We get a shopping list of possible subjects and then go through them against our three criteria.

HD: We propose to the commission what we should do, and the commission takes an active interest in the programme. We now have some health service people on the commission. I can't remember an occasion in the past on which the commission has turned down a proposal, but it does suggest different priorities.

Coming reports

RS: And how many years in advance do you plan?

HD: It varies, but we like to have two to three years of plans. In 1990-1 we will be doing pathology services and estate management—something that we know a lot about from local government—and in the year after we will look at acute bed management, nursing management, and the integration of community health services. Next year's topics are very big topics: their materiality is huge. And the year after that we will

probably—although it isn't firmed up yet—look at the purchaser role. That's an even bigger issue.

RS: That's one where timing will be important?

HD: Yes. People will have had a year or two's experience by the time we will be looking at the issue. That might be the time when somebody from the outside can best look at a broad range of authorities' operations and see what's working best.

And it's likely that as we go on reports will get spun off from the bigger topics. Thus we still theoretically have the rhythm of three topics a year in local government, but we will be publishing a paper every week between now and Christmas.

The commission's methods

RS: Once you have decided what you are going to do are there set methods for the study?

RT: Normally we produce a specification after talking to experts. Then we build that up into a protocol that we pilot in perhaps two sites. Once we've done those we should have a well developed research methodology—what issues we are addressing and how we are going to collect our data. We then collect data at between 10 and 12 volunteer authorities.

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really have achieved something.*

RS: Volunteer? Doesn't that mean that you miss out on deadbeats who don't want to change?

RT: We get them with the local audits. What we are trying to find are people who are at the leading edge. We need to know what levels of performance we can set, and we need to know what it is that makes the best authorities perform well.

RS: I noticed that you included experts in your day surgery study. How do they fit in?

RT: The research team is set up and at the same time we set up an advisory group that meets perhaps three times a year with the team.

HD: And we have professionals working on the team.

RS: How do you select those people?

HD: Well in the case of day surgery we approached the Royal College of Surgeons and asked for a nominee. We are required by law to consult with the relevant professional bodies, and we think it important to involve those bodies to make change happen.

RT: And after a few months on the team the professionals think with the team.

RS: Rudolf Klein says that you are policemen turned consultants. Is that the case here?

HD: That's a perceptive remark, but we chose to adopt the consultant role. We want to achieve change, and there are various ways that we might try to achieve that end. We might produce a report and call for legislation, but we haven't opted for that model. Our experience tells us that there is huge local variation in local government and the health service because of different management styles, professional practices, and local conditions—and it's extremely difficult to legislate to change that. Nor does threatening people achieve much.

RT: Most people in the health service want to change.

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Structure of the Audit Commission

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Our job is to help them, and we have the advantage of being able to look across authorities.

RS: Both you, Howard, and your predecessor worked for the management consultants McKinsey. Is that influence important?

HD: Our problem solving process does owe something to the McKinsey approach, which in my mind has two central features: firstly, a fierce rooting in the numbers, and, secondly, a broad view of the management and the behavioural factors affecting issues. Thus in the day case surgery report we range from numbers through to behavioural factors.

RS: Is the McKinsey model also important in that you find people in the organisation to work with.

HD: Yes, that drives the process of having clients in the investigating team.

Resources of the commission

RS: Tell me about the resources you have for these studies?

HD: The finances of the condition are driven by local audit fees. We don't get central money. We think it's good for our staff to have a price on their head—£250 a day approximately—and good for local authorities to be paying for what they get. The initial view of the department was that it would rather pay, but we dissuaded it from that. We pay for our reports by top slicing 12% off the local audit fees. Local authorities thus get an audit and three major project reports, which if you work it out are very cheap because they are averaged across the whole service.

RS: What about people?

HD: We have about a thousand staff, but that is misleading because a third of the audits are undertaken by private accounting firms. By policy we operate a mixed economy of our own auditors and auditors from the private firms—it helps us to keep up to date on audit practices and allows us to change auditors from time to time.

RS: The other two thirds are done by your employees?

RT: Yes, but just as we are independent of the government so the local auditors have some independence from us. We can't tell them what to write in their report, although we can require them to audit particular features of the service.

HD: And local managers can ask the auditors to look at particular bits of their services that worry them.

RS: Tell me about the people you have here at the centre.

RT: We don't employ many people, but we do have three associate directors in health studies—one of whom is a doctor. Others in the section have worked in the Department of Health, and others have skills like knowledge of economics.

HD: More and more as time goes on we will employ people from the health service rather than from the Department of Health.

RS: And do you have equal resources for health and local government?

HD: Almost exactly. [The structure of the commission is shown in the figure.] The health and local govern-

Managers in the health service

RS: What is your impression of the quality of management within the health service?

RT: My first impression is that there is not much middle management.

HD: Local government is strong in accounting and legal services, which gives it a robustness to cope with change. Health authorities lack that robustness, and information is sparse. Another strange thing about health authorities is that in management you have some extremely clever total amateurs—that is, doctors. They are extremely advanced in many matters but effectively have only O levels in management.

RS: Should something be done about that?

HD: I'm unhappy about the notion that it's a good idea to have lots of doctors with MBAs. I'm influenced by Stanford, where hospital managements have sent many doctors to do MBAs and yet say that they have made no difference to the hospital.

RT: Another factor is that being a doctor doesn't give you any more leverage over another doctor's practice than if you're not a doctor.

RS: Do you think it's a waste of time doctors being involved in management?

HD: No, but the most important thing is that doctors should have the information to know what it means to commit resources to one thing rather than another. If that's management then I'm in favour of doctors managing. Doctors need information, but I think that's different from saying that all the general managers need to be doctors.

RS: I think more in terms of the broad management tasks of district health authorities working out what they want to do, where they want to go, and how they are going to get everybody on board? Shouldn't doctors be involved in those tasks?

HD: Absolutely. It's obvious that hospitals and districts are going to need more active management. There will be more explicit choices to make. And once you have that active management then you must involve doctors. Present management is more like safety net or default management: the hospital rubs along until it stops.

ment sections are divided at the centre, but the local auditors audit both local authorities and health authorities. We chose to do it that way because we believe there is more communalism to doing value for money work than there is difference between local government and health authorities.

Extending the commission's work, and its independence

RS: Do you imagine that you might extend to other areas like medical education or medical research?

HD: We think that our method works well with local public services where there are different bodies delivering the same kind of thing at arm's length from the government.

RS: Universities, for example?

HD: Yes, universities might be reasonable bodies for us to audit.

RS: Something you haven't mentioned at all is general practitioners. Do you have any role with them?

HD: Yes. One project we will look at in the next couple of years will be the role of Family Health Services Authorities (FHSAs) in promoting good practice in primary care.

RS: So it's at that kind of level rather than in individual practices. Because when you talk about variability it

makes me think that general practice is famous for its variability.

HD: What we can't do is to look at, say, the chairs in general practice waiting rooms—because general practitioners are independent contractors. But fund holders will be audited by us. We can, however, look at prescribing and referral patterns because of the general practitioner's impact on the rest of the health service.

RT: We can certainly look at anything that the Family Health Services Authorities can look at because we can look at it through the authority.

HD: We must do something with Family Health Services Authorities. We must find people who can manage things better consistently. So we could look at the authority and ask, "What should they be doing to monitor the quality of care in general practice?" We could find an effective role for them, and then we would really have achieved something.

RS: One last question. Independence is clearly important to you. Why then did you publish your report on day surgery on the same day that the Department of Health published the latest waiting list figures. It looked as if you'd provided an excuse.

HD: The question should be why did the Department of Health publish its figures on the same day as our report. Our publication date had been set for weeks. I have to say that I think it was unfortunate that the department did that and I have told them so.

Correction

Guidelines for management of asthma in adults: II—acute severe asthma

A printer's error occurred in the flow diagram of this statement by the British Thoracic Society (6 October, p 799). Two arrows were omitted, and the corrected version is given here. In addition the box should have appeared towards the end of the section on management of patients presenting to an accident and emergency department, after the reference to the box.

Management of patients with asthma presenting to accident and emergency department