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The Rt. Honourable Mrs. Margaret Thatcher, FRS, PC, MP,
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Dear Prime Minister,

Lord Trafford will submit shortly a Paper which embraces most of my responses to your request for further information from me on medical audit and incentives for change in general practice. I enclose a few other perspectives in the accompanying papers.

Rational debate about the National Health Service seldom occurs in public. The principle reason for this is that those working in the NHS believe that the only way to obtain extra resources is to stimulate public anxiety by highlighting whatever deficiences exist. The Opposition exploit these anxieties and indeed are encouraged to do so by the medical and allied professions. This is not only disruptive to the NHS - and the Government - but also tends to distort the pattern of provision since emotive issues gain maximum publicity and quite often, therefore, more resources (e.g. AIDS).

It would be in the interests of both the National Health Service and the Government to establish an alternative outlet through which those working in the health service could channel their anxieties and thoughts about the level of resources or quality of care provided. In the accompanying papers, I refer to an independent medical audit authority. This may be the appropriate body to which such concerns should be made known.

I shall be happy to discuss these ideas or any other aspects of the NHS review with your office in the future.

Yours sincerely,

Clive Froggatt

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NHS Review : Independent Medical Audit Authority

The absence of clinical and financial audit in the National Health Service lies at the root of the problems confronting the service today. Without financial audit it is impossible to make valid comparisons between two health authorities or reliable judgements on the value for money obtained from certain procedures. Without medical audit the performance of the medical and nursing profession cannot be assessed properly and decisions on clinical priorities have to be taken on less objective grounds (making managers more susceptible to the vagaries of medico-political pressure groups). Demands for additional resources, either in terms of finance or personnel, are more difficult to assess. This makes inappropriate decisions more likely leading to secondary problems for patients, those working in the health service and the Government. Political challenges from the Opposition (or medical profession itself) are clearly more difficult to counter unless precise information on matters of fact is available.

Evaluation of the effectiveness of the health service is highly complex and needs to embrace aspects such as quality of care, the importance of patients perception of good care, clinical freedom and the balance of quality and quantity of life. It is made more complex by the vested interests of Government, DHSS officials, politicians, RHA and DHA managers, consultants, nurses and the patients themselves.

With greater autonomy and more responsibility for service provision being devolved from the centre to the periphery, it

becomes increasingly important for all concerned that an independent body is charged with the responsibility to audit health care services.

Such a body must establish independence both from the Government, Health Authorities and any other vested interests. It must establish a reputation for analysing the problems of health care delivery and it must make a practical impact on the delivery of health care services.

The remit of the body should extend from financial management into area of clinical audit with protocols being established centrally, but implemented locally, by District Clinical Audit Officers working alongside those responsible for financial audit. Together they would work on value for money reviews of the services provided.

Like local authorities, health authorities face many new challenges in the next few years. Demands on health services are changing and the way in which resources are used will come under ever increasing scrutiny.

Over the past five years, the Audit Commission has established itself by demonstrating the strategic importance of audit and value for money (VFM) review of many public and semi-public services delivered locally. Its reputation for independence and penetrating analysis makes it well placed to assume the responsibility for independent medical audit. The organisational structure of the commission lends itself to a fairly simple adaptation enabling it to embrace the proposed responsibility for health care services.

At the outset the Audit Commission was viewed with considerable scepticism and even hostility by local authorities. The health service, particularly the medical profession, are likely to have a

similar attitude. There may be some token resistance from the medical profession particularly on clinical audit, since it favours peer review and self-audit - claiming that this is taking place already to a significant degree. Evidence exists to show that this is not the case. However, local authorities no longer oppose the Commission's existence and engage now in a regular constructive dialogue about its work and future direction.

The Audit Commission has undertaken special studies involving the police, education and social services. Hostility and scepticism were overcome by having seconded to the study group professional and technical experts who enjoyed the confidence of those working in the special fields under audit.

Special studies generate two products. The first is a report which aims to describe best practice and demonstrates the way in which others could move towards a best practice approach. It indicates opportunities for savings and improvements in effectiveness. The second product is a detailed guide for use at local level. It gives comparable statistics, performance indicators and an analytical approach so that key drivers of performance could be identified quickly at a local level. The methodology of such studies already undertaken in local authorities is directly applicable to the health service. Other features of the Commission include a quality control function with close links to the accountancy bodies which would be invaluable to District Financial and Clinical Auditors.

The Commission has also developed coherent and disciplined mechanisms for bringing the central work into the audit process and vice-versa. These involve:

*The development of unit cost profiles

*The preparation of VFM focussed audit guides

*Tracking systems to monitor efficiency gains achieved

Finally, having recognized that management structures and competence are critical to efficient service provision, the Commission has developed a methodology of analysing central management and administration. The two local auditors, financial and clinical, will combine an understanding of the principles of good management with close knowledge of local circumstances and will be well placed, therefore, to help those authorities which lack now a strong corporate management.

Conclusion

The Audit Commission structure and methodology is readily adaptable to the health service; and, its political independence is acknowledged. It is placed uniquely to audit, advise and stimulate the National Health Service. Its experience shows that it can co-ordinate the skills and procedures required to promote economy, efficiency and effectiveness in the running of the NHS and, at the same time, provide hard data upon which the Government may base its plans for future provision within the health service.

Incentive for change

The single most important incentive is financial. Professional satisfaction is highly valued but not as much as money.

The profession should be approached with a carrot and stick. The carrot will be a modest increase in remuneration and the stick will be contractual changes designed to ensure that greater attention is given to the outcome for patients. The intention will be to reward a better quality of patient care.

Quality

It is difficult to measure quality and impossible to define precisely what makes one doctor better than another. However, by broadening the basis of assessment, using a basket of performance indicators, it would be possible to identify practices which are either better than others, or better than they themselves used to be.

A dynamic shift towards higher standards of care can be taken as a sign of improving practice and should be rewarded appropriately. Once the base-line levels of provision have been established, practices can be given annual targets to achieve.

The parameters of assessment will include: levels of vaccination/ immunization, screening for cervical cancer and other aspects of care which may be covered currently by the "items of service" category. In addition, the assessment of quality will include information on, for example, the percentage of a practice's elderly population that have been screened, the number of patients who attend the practice

based smoking cessation course, and the provision of, and use of, a wider range of services, such as minor operations, hypertension and diabetic clinics etc. Finally, comparative consultation rates, average time taken to obtain an appointment, referral and admission rates, prescribing patterns and practices, and, possibly, the frequency of complaints could all be taken into account.

A district based clinical auditor will be able to assist in the evaluation of the practice profile that will have been built up from the performance indicators mentioned.

The parameters of assessment will be subject to variation from time to time and will be biased towards areas and aspects of health care on which the health service is required to focus.

Most of the information needed on performance indicators can be gathered easily and cheaply directly from practices. Much of the information would be appropriate for inclusion in the practices Annual Report. With the introduction of information technology into surgeries and FPCs, more specific and sensitive information can be gathered.

Other Incentives

Contractual changes should be made which ensure that financial incentives yield identifiable improvements in patient care. GPs need no reminder that their independent contractor status should be valued highly. As such they should demonstrate their entrepreneurial skills by assuming greater responsibility for patients in primary care, remunerated where appropriate by the local DHA. This should be possible once DHAs are autonomous. Diversity of health care provision should be encouraged.

Professional satisfaction is enhanced by the proper, and full, use of anciliary staff - including practice managers. FPCs should ensure that an appropriate balance is achieved in the primary care team.

Finally, continuing medical education (CME) is imperative. Attendance has fallen at postgraduate centres since it ceased to attract any remuneration. Resources need to be made available both to GPs themselves and their clinical tutors. The content of CME should be focussed on those areas which result in higher quality patient care and better value for money for the NHS.

Conclusion

The White Paper contains the framework for negotiations with GPs which are under way now. Its references to contractual changes are implicit and accepted by the profession.

With additional finance on the table, the profession must accept a contract with the NHS which makes specific demands for co-operation on clinical and financial audit. They should be encouraged to be innovative and entrepreneurial. FPCs/DHAs should be encouraged to promote changes in the delivery of care which may involve contractual arrangements with local GPs.

GPs should be committed to CME to raise the standards of patient care and give services which represent better value for money.

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