The Proposals

Paragraph 204 of Terms and Conditions of Service

(1) The Secretary of State agreed to the junior doctors' request that paragraph 204 should be removed from the Terms of Service and that thereafter the contents should not apply.

New basis of payment for annual and study leave

(2) It was agreed that a circular would be issued to health authorities authorising the following arrangements for annual and study leave for junior hospital staff for the purposes of drawing up contracts and calculating total earnings:

(a) Where provision is made in the Terms and Conditions of Service or in the Conditions of Service of the General Whitley Council for leave with pay at the full rate for staff in the grades of senior registrar, registrar, senior house officer, and house officer, that pay shall be at the level of earnings for his normal working week and so include provision both for his basic salary and payments for Class A and Class B units of medical time. Other provisions as to rates of pay during such leave shall be construed accordingly.

(b) No assessment should be made of any additional duty which may be incurred as a result of the requirement of paragraph 110(c) that account should as necessary be taken in practitioners' job descriptions of the need for them to provide cover for annual or study leave of colleagues. Remuneration for this cover is taken to be included by the provisions of sub-paragraph (a) above.

(3 Junior hospital staff who are now being paid on the basis claimed by the HJSC (that is, at the level of earnings for the normal working week when they themselves are on annual or study leave, and with an allowance of UMTs in their contracts for covering for the annual and study leave of colleagues) would continue on that basis for the duration of their present contracts. Junior hospital staff who are now being paid on a less favourable basis could choose to continue to be paid on that basis during the currency of their present contracts, or could opt to move on to the basis set out in paragraph (2). That option would need to be exercised within eight weeks of the issue of the circular referred to in that paragraph, after notification in writing by the employing authority to each doctor setting out the options.

(4) All junior hospital staff would move on to the basis set out in paragraph (2) when they moved to new posts with new contracts until new arrangements apply.

(5) The offer which has been made by the Secretary of State of protection of existing levels of remuneration on a personal "mark-time" basis is open to staff affected by the arrangements in paragraphs (2)-(4) above. That offer is to be reconsidered by the HJSC.

(6) The basis of payment for annual and study leave set out in paragraph (2) above would remain in force until Phase 2 of the Government's current incomes policy allows for its replacement by the basis claimed by the HJSC. The Secretary of State has reaffirmed his acceptance of the latter basis in principle and his willingness to implement it as soon as incomes policy makes it possible for him to do so. He has also expressed his willingness to ask the Review Body on Doctors' and Dentists' Remuneration to make implementation of the HJSC claim the first charge on pay increases for which junior hospital staff will be eligible to be considered, under Phase 2 of current incomes policy, in April 1977. In doing so he has recognised, as have the junior doctors, the independence of the Review Body. The Secretary of State has expressed himself satisfied that it would be possible to fund the HJSC claims within the sum which will become available under the incomes policy in April 1977.

(7) The date of implementation of the arrangements accepted in paragraphs (1) and (2) would be the date of issue of the agreed relevant circular to health authorities.

Hours of work of junior staff

(8) It was agreed that the following should form a new Term of Service for junior hospital doctors and dentists: "It is recommended that, in the assessment of contracts, a minimum of 88 hours per week of assured periods of off-duty, including freedom from on-call liability, should be made available to practitioners, always provided that the needs of patients permit."

(9) This new Term of Service would take effect from the date of the circular referred to in paragraphs (2) and (7), of which it would form part.

(10) The Secretary of State made it clear that this recommendation in itself should not be used as a basis for a claim for a new category of payments for work over 80 hours. It does not in any way alter the terms of paragraph 110 of the Terms and Conditions of Service.

Note: An agreement between the Health Departments and the HJSC would be subject to approval by the Staff Side of the JNC as a whole.

COMMENTARY

An alternative approach to audit

RUDOLF KLEIN

Recently there has been increasing discussion about the possibility of introducing some system of medical audit in the National Health Service.[1] The concept of audit is, of course, as old as government itself: stripped of jargon, it simply means that those who use public resources should be accountable to the public for the way in which they dispose of those resources—that they should be answerable for using them effectively, efficiently, and economically.[2] The difficulty arises when this concept is applied to something as complex as medicine and to something as elusive as the quality of health care.[3]

Faced with this problem, the temptation may be to go for an off-the-peg solution: to import a ready-made formula. In particular, the example of the United States would seem to offer a model. Not only has peer review been long practised there, but it has now been institutionalised in the Professional Standards Review Organizations (PSROs). Each local PSRO has the responsibility of developing its own "norms of care, diagnosis, and treatment based upon typical patterns of practice."[4] These in turn will be reviewed by a National Professional Standards Review Council. The United States would thus appear to be on the way to developing national standards by which to assess the performance of individual hospitals and practitioners. This system of audit is essentially one that is based on norms.

Extending the HAS

Before deciding whether or not the NHS should go in the same direction, however, it is worth considering the possibility that Britain—without any conscious intent and without realising it—may, in fact, have developed an institution which in the long term could offer an alternative way of tackling the problem of audit. This is the Health Advisory Service, previously known as the Hospital Advisory Service.

The HAS was set up by Richard Crossman in 1969 in the wake of a series of scandals at Ely and other hospitals for the mentally ill and subnormal.[5] It was partly conceived as a fire-fighting force, designed to alert the Secretary of State about potential trouble and to keep him informed about the most neglected parts of the NHS. But equally, and increasingly, the HAS's task was seen as helping to improve the management of patient care in long-stay hospitals "by constructive criticism and by propagating good practices and new ideas."[6] Additionally, the remit of the HAS was extended earlier this year, when its title was also changed: it is now charged with reviewing all services for the mentally ill and the elderly, whether provided in hospitals or in the community, by the NHS, or by the social services departments of local authorities.[7]

The HAS sets about its work by sending out teams of five or six professionals—doctors, nurses, and others—to visit local services. The team then discusses problems and standards with the staff concerned. The work of the health care professionals is thus reviewed by their own fellow professionals. Most of the team members are active practitioners, seconded to the HAS for a short spell of duty; there is therefore no danger of them becoming professional bureaucrats, cut off from their colleagues.

The HAS does not question clinical judgment, but it does review medical management. For example, in the 1974 annual report,[8] Dr E Woodford-Williams—who succeeded Dr A A Baker as the HAS's director—discusses standards in geriatric services in terms both of resources (staffing levels, equipment, etc) and of methods (diagnostic profiles, clinical case conferences, etc). There is a deliberate emphasis on examining both those standards which can be statistically expressed and those where the measuring rod is professional judgment about quality. Similarly, the HAS not only reviews the care provided to patients but also raises questions about the accessibility and adequacy of services in the light of local conditions.

The HAS approach is thus not vulnerable to some of the criticisms made of the PSRO system and other methods of audit which depend exclusively on statistical analysis and the setting of norms: that these are primarily designed to control costs rather than to improve quality; that they emphasise process at the expense of outcome; that they ignore the medical needs which are not being met; and that they encourage the medical profession to set the norms—for example, of bed stay—as high as possible. The HAS may well start by examining statistics, but it interprets them in the light of discussion and inquiry into the specific local circumstances.

Pros and cons

This would seem to be an attractive model. But there are several problems about using it as the basis of a more complex and comprehensive audit system. Firstly, are the methods evolved in the mental illness and geriatric sectors transferable to the acute services? Clearly, only the professionals concerned can answer that question definitively: however, the example of the Confidential Inquiry into Maternal Deaths would suggest that the quality of care provided can be assessed in the acute sector. Furthermore, although doctors were intensely suspicious of the HAS when it was first set up, experience suggests that it would actually be in the self interest of those working in the acute sector to encourage the extension of its remit. It may be no accident that it is the services covered by the HAS which head the list of the Government's spending priorities,[9] since its activities tend to highlight deficiencies and to draw them to the attention of the Secretary of State.

The second problem stems from the nature of the HAS. In effect, it has two somewhat different functions: a therapeutic role and an inspectorial one. On the one hand, its intervention is aimed to help the professionals concerned to sort out their own problems: to provide, in effect, organisational group therapy. On the other hand, its reports are designed to alert the health authorities to what is going wrong and where standards are inadequate—either because resources are insufficient or because they are being poorly used.

In the long run, it may be desirable to separate these two functions. Many regional health authorities have set up their own advisory teams. These could well carry out the therapeutic role: sorting out problems, as well as diffusing knowledge about good practices. This would allow the HAS to concentrate on developing its inspectorial role—in effect, carrying out an audit into local standards of health care provision. Moreover, freed from the need to keep its reports confidential because they refer to problems involving specific people or clashes of personalities, it could publish its findings: an essential feature of any system of accountability.

Audit bureau

No doubt there are other difficulties as well. Would it be possible to give the HAS a national remit, covering all NHS services, while maintaining its essentially professional, non-bureaucratic character? Would an enlarged HAS be able to maintain its independence of the DHSS, applying exclusively professional criteria? Would its activities be resented and opposed, once it was perceived as an inspectorate instead of, as now, being seen as a helpful ally by most health care providers? The answers to these questions are not self-evident. But, even so, there would seem to be a good case for investigating the possibility of building on the success of the HAS to create a NHS Audit Bureau:[10] an independent agency which would provide a regular review of standards and the quality of care in the NHS, district by district or area by area—and which might make at least some of the many tiers of authorities now charged with "monitoring" redundant. Such a bureau would be a specifically British solution, building on past experience, to the international problem of how to devise an effective system of accountability in health care. It would be a way of informing the analysis of data with the knowledge which can only be obtained by contact with practitioners. And—who knows?—instead of importing a system of medical audit from abroad, the NHS might even become an exporter of ideas.

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Centre for Studies in Social Policy, London WC1N 2LS
RUDOLF KLEIN, MA, senior fellow