information services should be included in NHS trust and health authority information management and technology strategies.⁴ However, there are no references to libraries in the white paper, merely the statements that "a quality organisation will ensure that ... evidence based practice is in day to day use with the infrastructure to support it," and "the R&D programme will work to improve access to research findings across the NHS, including development of a new database."

National Institute for Clinical Effectiveness—This new body will coordinate the development and implementation of national evidence based clinical guidelines and audit methods; its links with the York Centre for Reviews and Dissemination are not spelt out. Also, since the most effective guidelines are those that have been locally adapted,⁵ the role of national guidelines needs clarification. Professional societies currently receiving NHS support for guideline development may experience a nasty shock if it is channelled instead to the new institute.

Clinical governance will augment high quality clinical audit data with peer feedback and board level commitment to quality of care. However, some clinicians may fear that governance will lead to occasional mistakes becoming too widely known—especially with the forthcoming Freedom of Information Bill. The professions need to debate urgently what constitutes appropriate publication of clinical performance data, to complement the confidentiality safeguards covering individual patient data.

By March this year there will be three pilots of the NHS Direct help line, by December regional pilots linking general practices with pharmacies, and by the

end of 1999 all computerised surgeries will be receiving some test results over NHSNet. Much of the technical work has already been piloted, but other aspects, such as national production of clinical guidelines, require technical developments to harmonise with professional and organisational change. This can cause conflict and delay, as seen in the stand off between the NHS and professions over confidentiality—which set back clinical use of NHSNet by at least two years.

Finally, the white paper provides further welcome evidence of this government's enthusiasm for piloting and evaluating technical and managerial innovations.⁶ It also sends an important message by defining NHS information technology projects using clinical, not technical, language. Thus the white paper includes proposals to reduce patient waiting time, ensure prompt access to specialist services, and rapidly share reliable information among clinicians; these projects would once have been described as "clinical messaging," "telemedicine," and "electronic patient records." Hopefully, these good omens will be reflected in the revised NHS information strategy due soon and will result in real patient benefits from NHS information systems.

- 1 Audit Commission. *For your information: a study of information management and systems in the acute hospital*. London: HMSO, 1995.
- 2 Smith R. The future of health care systems. *BMJ* 1997;314:1495-6.
- 3 Wyatt JC. Clinical data systems, part III: developing and evaluating clinical data systems. *Lancet* 1994;344:1682-8.
- 4 Fraser V. *NHS Guidelines on library and information services*. Leeds: NHS Executive, 1997.
- 5 Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993;342:1317-22.
- 6 Friedman C, Wyatt J. *Evaluation methods in medical informatics*. New York: Springer, 1997.

Guidelines and quality of clinical services in the new NHS

Jos Kleijnen, Gouke Bonsel

The English white paper emphasises the importance of national leadership by the Department of Health and the NHS Executive (including the regional offices) in supporting local developments. The NHS Executive will be charged with ensuring that quality and responsiveness are instilled at all levels in the NHS. Services and treatments that patients receive should be based on the best available evidence of what does and does not work and what provides the best value for money (clinical and cost effectiveness). Because there are unjustifiable variations in the application of evidence on clinical and cost effectiveness, and patients have not had fair access to the best the NHS has to offer, the government will spread best practice and drive clinical and cost effectiveness in several ways, including the establishment of two new national bodies:

- a National Institute of Clinical Excellence to promote clinical and cost effectiveness by producing clinical guidelines and audits for dissemination throughout the NHS;
- a Commission for Health Improvement to support and oversee the quality of clinical governance and of clinical services.

Several comments can be made. Firstly, experience already exists in Britain and in other countries, such as America and the Netherlands, in quality assurance and the production of guidelines. The National Institute of Clinical Excellence could profit from these experiences, notably about the processes which work or do not work. However, it is the lessons about approaches that are transferable, not necessarily the guidelines themselves.

Secondly, the prospective users of the guidelines should be involved in preparing them (using an explicit and systematic approach) and potential barriers for implementation should be identified. Last October, the second international conference on the scientific basis of health services in Amsterdam clearly showed that leading clinicians and scientists support guideline development, although it is not easy to make guidelines that will actually be used in practice. The best basis for guidelines is systematic reviews of primary research, as prepared by the Cochrane Collaboration, the NHS Centre for Reviews and Dissemination, and others. Commissioning of systematic reviews should be carefully coordinated, and such reviews should ideally deal with cross cultural differences and cost effectiveness. Good coordination is needed between the many

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groups engaged in doing the reviews and overseeing their implementation, to prevent duplication of effort and waste of money—not an easy task. Recently, programmes in the Netherlands and Denmark have been started in which the different parties engaged in preparing reviews, developing guidelines, analysing cost effectiveness, and performing dissemination and implementation research work together.

Thirdly, explicit attention should be paid to the values and judgments underlying specific guidelines. These values reflect the value structure of the teams developing the guidelines but may be different across countries. Differences in practitioners' barriers, patients' barriers, and cost barriers may also restrict generalisability, especially when it comes to implementation. Guidelines developed in different countries on the same topic are often different and may not always be interchangeable.

Finally, the NHS needs coherent strategy for disseminating and implementing guidelines. Huge gaps exist in our knowledge about what comprises

efficient dissemination and implementation, so research into these should be stimulated as well. Co-operation with centres for evidence based medicine and health care groups within the Cochrane Collaboration, such as the effective professional practice review group and the review group on consumers and communication, will certainly be fruitful. The Commission for Health Improvement will be in a position to evaluate what actually happens in daily practice and provide important data and feedback about research based health care.

Guideline development, dissemination, and implementation can thus be improved. However, it may be a challenge for the Commission for Health Improvement, as top down organisation, to assess and really influence daily practice in the NHS: improvements can only really be made by those engaged in providing the services. The bottom up nature of disseminating guidelines of the National Institute of Clinical Excellence may make its task somewhat easier.

From health care to health

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Health is not merely the absence of disease; nor is the role of the NHS only within health care. This message is made very clearly on the first page of the white paper, with the vision of "an NHS that does not just treat people when they are ill but works with others to improve health and reduce health inequalities." To achieve this vision, we are told, means changing our approach to tackling disease and inequality—with the government ensuring that locally the NHS works with those who provide social care, housing, education, and employment.

The emphasis on the wider health agenda places the white paper among other recent government initiatives—for example, Welfare to Work for young people, the Crime and Disorder Bill, the national child care strategy, and the education white papers—which all highlight the impact of social inequalities and the need to address the problems of the socially excluded. The lead for addressing the health impact of inequalities is firmly placed with health authorities, who will be responsible for coordinating health improvement programmes for their districts across health service organisations and other agencies (see figure).

This responsibility signals a changing role for health authorities and a step forward on the pathway from health care to health. In future, health authorities will provide strategic leadership, freed from unnecessary administration. In partnership with others, health authorities will create a framework for health based on an analysis of health needs and monitored by indicators of quality health care and population based outcomes. These will be jointly agreed, published, and open to public scrutiny. Performance will, in future, be measured not on the discredited efficiency index, which rewarded admission to hospital and throughput, but on indicators which include health improvement and the health outcome of NHS care. The timescale for plans will be a

three year rolling programme—which recognises the long term nature of such an approach so often ignored in the annual contracting cycle. Health action zones, which are to come into being in April,¹ will blaze the trail to developing health improvement programmes. Their accent will be on partnership and innovation, finding new ways to tackle health problems and reshaping local services. In addition the emphasis on clinical effectiveness, quality of care, patients' views, and the public's perspective highlights the contribution to health made by effective and responsive health services.

So far so good—but how this will work in practice is uncertain. As yet we have only some of the pieces of the health policy jigsaw on the table. Developing the health agenda will be a key theme of the green paper *Our Healthier Nation*, expected soon. Without this and the results of other initiatives, such as the chief medical