failed, but there will be those who dare not jeopardise their own "accountable officer" role by allowing any local leeway and whose assessment of local flexibility may not extend beyond the provision of a few marginal activities. At the heart of the Darwinian, evolutionary rhetoric lies the potential for Stalinist centralisation.

These are the risks of planning based on functional principles rather than structural mechanisms, and we should tolerate them in moving from the latter to the former. However, we need also to consider how to facilitate the change. "Tight-loose" management works only if the balance of tight and loose is right; in the present structure bound NHS "loose" often seems to mean enough rope to create a noose, rather than any true devolution of responsibility. Enormous organisational development is required to change the "blame frame" within the NHS, one which encompasses every level of the service, and which encourages a more mature attitude to staff and organisations in their stewardship of public services.

Permissive accountability encourages organisations to do more and to carry an increasing share of responsibility for their actions; punitive accountability, the form of performance management apparently more prevalent in the current NHS, does exactly the opposite, in that it expects bad behaviour and tries to

prevent it. *The New NHS* depends on all its participants seeking to do more, wanting more responsibility, and expecting to be acknowledged and rewarded for so doing, and it will fail if they do not do so. Much remains to be done in embedding such a culture change, a task which is being recognised within the service, but which will need explicit planning and resourcing if it is ever to become a widespread reality.

Evolution may be preferable to revolution, but selective breeding produces better results more quickly and is more cost effective, even if it is more expensive in the short term. It would be a shame if we lost the war for the want of this one horseshoe nail. Explicit reinforcement of the successful "flowers" would be helpful, perhaps through executive letters or by more direct rewards. Clearly there is a paradox in directing health authorities to be less directive, but it may be an acceptable price for promoting change in the shortest time. Certainly the perverse incentives which encourage negative ways of managing the service must be weeded out, and seen to be so. Once the change is underway we may genuinely see a move away from our traditional punitive, puritanical approach to the use of public money to a more open, encouraging format. It would be a shame if we lost the war of local sensitivity and appropriate devolution for the want of encouragement.

Clinical governance: fine words or action?

Nick Black

The current purchaser efficiency index has resulted in perverse incentives and a distortion of clinical priorities.¹ In the name of increased efficiency, cost saving measures have been rewarded while few attempts have been made to assess the quality of care provided. When attempts have been made, variation has often been shown in the quality of care delivered and the outcomes achieved by different providers.

In a significant and welcome change from the previous administration, the new government recognises these problems and proposes several measures to deal with them—at every level of the NHS. At the centre, a National Institute of Clinical Excellence will promote clinical and cost effective care by producing research based guidelines. National service frameworks will also set out the patterns and levels of service which should be provided for major care areas and disease groups, along the lines of the current reorganisation of cancer services. This fits with recent calls for a national clearing house to support the commissioning of specialist services.² Meanwhile locally the new purchaser organisations, the primary care groups, will be expected to include explicit quality standards in their service agreements with provider trusts.

For the first time in the NHS monitoring and ensuring quality of care will be a statutory responsibility, with trust chief executives personally accountable. This extension of corporate governance from financial to clinical matters is one of the most fundamental and radical of the government's proposals.

To support, and more importantly, oversee the quality of clinical governance and of clinical care, a Commis-

The extension of corporate governance from financial to clinical matters is among the most radical of the white paper's proposals

sion for Health Improvement is proposed. This statutory body, "at arm's length from government," will publish information on the comparative performance of trusts in relation to all three dimensions of quality: effectiveness (health outcomes), equity (access to their services), and humanity (patients' and carers' views). In many ways it can be seen as a natural extension of the current work of the Audit Commission.

While the proposal to improve "clinical governance" in the NHS should be universally welcomed by clinicians, managers, politicians, and the public, the

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mechanisms for monitoring and managing clinical performance will almost certainly prove more controversial. The white paper correctly notes that in the past "performance was driven by what could readily be measured." To avoid this in future the government must recognise the inadequacies of routine administrative data, such as Hospital Episode Statistics, for measuring most aspects of quality. Information which purports to compare the performance of trusts (such as the clinical outcome indicators due to be published for the first time in England later this year) is likely to harm the already damaged reputation of interhospital comparisons.

Instead, there should be much greater reliance on national specialised clinical databases, such as that in intensive care, which can potentially achieve much higher levels of detail, completeness, and accuracy.³ These features are essential if differences between trusts in case mix are to be adequately adjusted for.

If the key role of specialist databases is accepted, then it follows that the Commission for Health Improvement should not involve itself directly in large data gathering exercises but act as an umbrella

organisation, harnessing help and input from the specialist groups. The commission would need to monitor the quality of the databases. This would mean that initially it monitored only some areas of health care, but this is preferable to a potentially misleading comprehensive audit.

Whichever organisational model is adopted, there is no escaping the fact that information of the quality required for clinical governance will prove much more expensive than that required for financial governance. Unless each level of the NHS is prepared to accept that and provide adequate funds for clinical data collection and analysis, the good intentions contained in the white paper will not be realised. Making trust chief executives personally responsible for the clinical performance of their services might prove to be just the incentive needed.

- 1 Ferguson B, Baker M. Shifting finance out of acute hospitals. *J Health Serv Res Policy* 1998;3:3-5.
- 2 Black NA. Commissioning specialist services in the NHS. *BMJ* 1997; 315:1323-4.
- 3 Black NA. Developing high quality clinical databases. *BMJ* 1997; 315:381-2.

Will improved clinical information help realise the new NHS ?

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In 1995 the Audit Commission urged the NHS to revise its information systems, changing their goal from managing financial data to improving clinical information.¹ In his foreword to the white paper Tony Blair promises "a new NHS information superhighway that links GP surgeries to any specialist centre in the country," and we are invited to judge progress towards the new NHS by the efficiency of this highway and the NHS direct information service for the public. Suddenly, improved clinical information is central to modernising the NHS, facilitating integrated care, and ensuring that NHS organisations focus on quality and clinical accountability, or "governance."

The figure shows the new information services and flows underlying the new NHS, the main innovations being the following.

NHS Direct patient information service—This help line should ensure a more informed public—a key feature of 21st century health care²—by providing "immediate, convenient access to advice and information." Free access to the help line is not promised but would be consistent with the government's concern about health inequality. American health maintenance organisations and insurers already offer members such services, but the usage patterns and effects of NHS Direct on service demand are unclear. It is also unclear exactly how the service will work. For example, what information sources will nurse-advisors turn to, will they send a record of patients' symptoms and the advice given to general practitioners, or keep a copy in case the patient phones again or, worse, sues?

Clinical information services—Several new services are promised for general practitioners, including electronic delivery of laboratory results, prescriptions to pharmacies, and hospital appointment booking. While such incentives are necessary to encourage clinicians to use computers,³ computers have already penetrated nearly all British general practices, whereas few hospital doctors use them. Yet the white paper offers no fresh carrots for hospital clinicians. One compelling incentive would be electronic access for all doctors to the knowledge they need to do their work—up to date evidence based textbooks, phone directories, image reference databases, or full text journal articles. Recent NHS guidelines on library and information services concluded that "Access to the health knowledge base is essential to the delivery of high quality health care ... [and] should be free at the point of use" and that

Proposed additional clinical information flows in the new NHS