professionals—doctors, nurses, therapists, and managers—who will inherit the NHS when we rest. From the viewpoint of improvement, and in pursuit of the ''STEEEP'' aims, our young professionals are emerging ill prepared to help. The education of health professionals generally lacks focus on the skills in systems thinking, statistical thinking, measurement, cooperation, group process, teamwork, and pragmatic ''real time science,'' to name but a few disciplines that provide the foundation for effective citizenship in improvement. The result of missing this knowledge is a workforce that too often seems resistant to change and that lacks sufficient capacity to change the work it does.

So far, as I see it, the processes of change underway in the NHS lack effective connection to consonant changes in the education of young professionals. The omission is costly now, and will be more costly in the future as the workforce continues to be ill prepared to cope with—let alone to lead—a new, evidence based, reliable, patient centered, efficient, and safe system of care. That can easily change in the UK, but only with a totally new level of communication with and involvement of the agencies and leaders who are stewards of the educational systems—the Royal Colleges and others. Very promising changes are now underway in the relationships between the Royal College of Physicians and the leaders of the NHS, and these bode well for the future.

CONCLUSION

I do predict success for the UK in its efforts to build what can become the best healthcare system in the world—nothing less. The task is well started. These three adjustments—to organize care far better at the community level, to raise the bar on patient centeredness beyond what British patients may at first ask for, and to welcome and embed into the improvement process an agenda for change in the education of young professionals—will not be easy, but they are important enough to tackle hard and soon.

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International guidelines

Challenges for an international guidelines collaboration

R Thomson

The Guidelines International Network is a welcome development for improving the quality of health care, but many challenges lie ahead

The emergence of evidence based guidelines may be one of the great successes of the evidence based medicine movement. We now have a mature process of development using literature review and appraisal, aligning strength of evidence and grading of recommendations. This has become an international movement and this global expansion is reflected in the development of the Guidelines International Network reported in this issue of *QSHC*.[1]

There have, indeed, been considerable successes, perhaps exemplified by the groundbreaking work of the National Institute of Clinical Excellence in the UK, building on earlier crafting of structured evidence based guidelines methods.[2 3] This industry was fashioned on the background of concerns about unexplained variations in practice and on the exponential growth of information with the problem for clinicians of remaining up to date with reading and assimilating the immense literature, let alone being able to appraise or assess it.[4] Studies had shown that guidelines available were often widely variable in their content and in their likely impact upon quality of care if applied in practice.[5 6] Early guidelines development, based primarily on consensus methods, was found to be wanting and unlikely to produce valid guidelines.[7]

A poorly developed guideline could be as risky to the public health as a poorly developed drug, where there are extensive regulatory schemes for drug development and approval worldwide. Structured quality assured guideline development, perhaps led by national agencies, would solve these problems and be a more cost effective and safe way of providing valid guidance. More sophisticated and structured approaches have now taken precedence, although they are costly to undertake. Since its inception, NICE has produced over 40 evidence based guidelines. Other bodies have adopted or adapted this approach, both within and outside the UK. Similarly, there has been international development of an instrument to support guidelines appraisal (the AGREE instrument).[8] On the back of this effective international collaboration has grown the latest development—the Guidelines International Network—with the laudable objective ''to protect the health of the general public by seeking to improve the quality of health care''.[1]

But all is not well with the movement. NICE has received criticism in the UK for its perceived failure to support effective dissemination of its guidance—a little unfair since it was not initially responsible for this.[9] Nonetheless, it is now trying to address this key issue. Furthermore, the dissemination of full guidelines, formally targeted at users, may not be read by the clinicians at whom they are targeted—they may even prefer the patient summary versions. This is hardly surprising given the size of modern guidelines. A recent editorial in the *BMJ* graphs out the growth in size of hypertension guidelines as newer versions have been published in the UK and abroad.[10] The second British Hypertension Society guidelines in 1993 were five pages long; the latest version in 2004 extends to 46 pages. There is therefore a problem for the dissemination and implementation of guidelines even if the development processes have been markedly improved.

Furthermore, evidence for the effectiveness of nationally developed guidelines is as yet incomplete, with some

studies suggesting a significant impact and others suggesting little.[11 12] Evaluation of the impact of guidelines and guidelines programmes will be a significant issue. And, as the technology grows and is exported to more and more countries (including those with less well funded health systems), it is reasonable to ask whether there need be multiple national programmes or, at least, how such programmes might support one another.

The Guidelines International Network seeks to address these issues. The recognised importance of implementation is to be welcomed. The early conference and web developments look like a commendable start to this process. For example, the website contains much valuable material brought together in the same place for the first time and includes some topic areas such as a range of guidelines in a specific area such as asthma or ischaemic heart disease. However, it is unfortunate that the full searchable database of guidelines is available only to fee paying members. There is an undoubted need for a searchable site of quality assured guidelines; keeping that part of the site for members only may undermine the aims of the project. In addition, if the network is to achieve its aims, it will rapidly need to decide how it will assure the quality of the guidelines it decides to incorporate on its website. Those available in the topic based section range from fully developed evidence based guidelines using robust state of the art methods to others that have gone through a far less robust process. This not only leads to differences between the guidelines available on the site for the same clinical areas, but also risks repeating some of the problems that the movement was set up to address.

The widely accepted formal definition of guidelines as crafted by the Institute of Medicine—''*systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances*''[13]—also throws up some challenges. The concentration to date has been on clinicians and, arguably, guidelines are rather paternalistic. This will be challenged by the increasing emphasis on patient choice and engagement in decision making. Indeed, there may be a significant tension between applying guidelines based on effectiveness and the drive to engage patients in shared decision making. How will guidelines work in this context?

When we look back in 50 years at this stage of the guidelines movement, the last decade will be seen as a pivotal point. Much progress has been achieved in stimulating high quality methods of appraisal and development and in finding ways of promoting guidelines in health systems. But many challenges remain. The Guidelines International Network has a big job ahead.

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''Role drift''

''Role drift'' to unlicensed assistants: risks to quality and safety

H P McKenna

Health care assistants are increasingly filling the gaps in patient care

Earlier this week I went to my local health centre for a routine blood test. I noticed that the uniformed woman approaching me with the needle drawn had the words ''Health Care Assistant'' on her badge. This is the first time I have had a sample of blood taken by a person who had no formally recognised training and whose role was unlicensed, unregulated and unsupervised. I proffered my arm—not without a little trepidation. The experience led me to wonder how many other health care assistants were practising in the health service, how many other invasive and non-invasive duties were they routinely undertaking, and how many members of the public were unaware that they were receiving care and treatment from such personnel. The answers to these questions raise further questions concerning quality and safety.

Modern health care is complex and hospitalised patients are often in the acute stage of their illness. Patient throughput has increased and new treatments and technologies have brought with them their own hazards. This is also true within the community where nurses are undertaking home based interventions which were recently only practised in the safety of a hi-tech clinical setting. From various countries there is evidence to indicate that better patient processes and outcomes can be achieved by having a high ratio of registered nurses in the clinical setting.[1 2] More recently there have been reports that patient safety is positively