The publishers could have been kinder to a European audience. The text would have benefited from shortening, and much of the data in the appendices could have been eliminated. A 100 page softback handbook would be just as helpful and cheaper.

One final observation. The title, *Curing Health Care*—an odd concept as doctors seldom cure anything and quality is about improvement, not answers—and the medical jargon in several chapter headings—for example, “symptoms,” “diagnostic journey,” and “remedies”—are presumably intended to target doctors by making them feel at ease, which is fine, if rather stilted. However, the authors then extend this thinking by arguing that the principles underpinning the project are based on “the scientific method.” This seems to imply two things: that doctors’ practice is really embedded in scientific method (not my experience) and that to change clinical practice the scientific hypothesis has to be shown to have been proved correct. My experience suggests that doctors are not such rational human beings! For example, despite Donabedian’s masterful work in the ’70s and Maxwell’s seminal papers in the ’80s the ability of the medical profession to ignore and avoid addressing quality is striking.

But I am carping. The book is very readable; full of energy and excitement; and, if used astutely, could ferment much needed change in our hospital services.

JOHN MITCHELL  
Fellow, Kings Fund College


MEETINGS REPORTS

Quality management and clinical audit. Study visit to the Netherlands, June – July 1992

Twenty delegates with clinical management backgrounds from across the United Kingdom participated in a three day visit to the Netherlands to study quality management and clinical audit processes. In particular, health care professionals in Britain need to be more aware of the developments in health in other countries, leading to the potential cross-fertilisation of ideas.

A national initiative led by Angela Schofield from the health services management unit at Manchester University, Charles Shaw from the clinical audit unit of Bristol University, and Michael Deighan from Management Development Group of the National Health Service in Scotland, the visit was arranged and coordinated by Drs Paul Touw and Nic Klazinga of CBO (the national organisation for quality assurance in the Netherlands and collaborating centre for the World Health Organisation in quality assurance), widely regarded as an international leader in quality assurance.

The experience of CBO in quality stems from 1976 and continues to expand through a “consultancy” approach to clinical audit facilitated by doctors and other clinicians. CBO has also spearheaded international developments in consensus conferencing whereby national guidelines on a specific topic are developed by (medical) professional bodies and then transferred to local hospitals as a principal topic for developing local standards and care planning.

The programme included visits to centres of excellence in quality assurance and clinical audit implementation with presentations by CBO and workshops at the Academic Medical Centre, Amsterdam, and Stichting Deventer Ziekenhuizen, Deventer; presentations by CBO teams; opportunities to continue to debate specific topics in small workshops with experts; and time to examine and debate topics of common interest with experts.

Statistics and background theory presented on the first day allowed the delegates to widen their agendas and expectations for the subsequent visits to the hospitals. Both institutions dedicated an entire day with several senior clinicians and managers ensuring that delegates were entirely satisfied and fully informed.

During the visits, the delegates examined management and medical structures; current operational and long term strategies; areas of concern where development was required; and, of course, whether all areas of the hospitals were meeting patients’ expectations. It is pertinent that the chief executives of both hospitals had previously been practising physicians, an obviously different situation in the United Kingdom.

Subsequently, listening to presentations by the teams at CBO, the delegates had little doubt that what exists in the Netherlands is a centre of excellence which has been empowered to promote quality assurance across institutionally isolated services, support local implementation plans; the organisation has specific professional development programmes which attract key doctors and health care professionals from all over the country.

During the debates on the final day the delegates explored particularly the issues in promoting and developing quality management and quality assurance for the law makers (government, management executives, regional purchasers and fundholding general practitioners, district medical units and trusts, professional bodies, academic institutions, and consumers). Two major statements emerged: quality management and the move to clinical audit requires a strategic approach supported by the key stakeholders, as has been clearly demonstrated by the approach adopted in the Netherlands, and quality improvement is the responsibility of all health care professionals and requires continuous attention; continuous quality improvement needs to be emphasised, but quality should not become the preserve of one professional group. Managers in the Netherlands have a greater desire (and receive more encouragement) to join professional societies and thus to influence and share in decision making. The Dutch experts emphasised the need for rapid development of clinical audit and quality initiatives as multidisciplinary (agency) functions. One way to achieve this is by introducing a national body for quality assurance in health care to work with legislators and carers alike, whose focus is wider than that of practising professionals and can influence undergraduate and postgraduate thinking—a body operating as a think-tank, with the appropriate time, skills, and funding to amalgamate strategic managerial quality and clinical quality strategies. Such an organisation would need to guard against developing an elitist attitude as it became stronger.

The general consensus was that the visit had been invaluable; the delegates intended to continue to review their thinking regularly by forming learning networks. Nevertheless, modifying health care in Britain on the Dutch model may be difficult to achieve and require much wider explanation of the Dutch approach to be implemented successfully.

MICHAEL DEIGHAN  
Fellow, World Health Organisation, and Project Management Consultants, The NHS in Scotland  
SHIRLEY WATT  
Management Development Adviser, The NHS in Scotland

Welsh Advisory Group on Nursing and Midwifery Audit (WAGNA) conference, Llandrindod Wells, October 1992

Two hundred delegates from Wales attended the first conference of WAGNA to launch the nursing and midwifery audit strategy and to announce the funding of audit development sites in Wales. In launching the strategy, Miss Marian Bannock, the chief nurse for Wales, gave it unequivocal support. Based on the view that education for audit and ownership of the audit process by nurses at clinical level are fundamental for audit to achieve improvement in clinical practice patients’ experience, the strategy aims at encouraging freedom of approach by clinical nurses within a coordinated and supportive framework. The nursing and midwifery audit adviser and coordinator for Wales explained the strategy’s aim of involvement of practitioners and their ownership of the process—supporting local initiatives within a shared vision rather than imposing a central model.
the audience, and the discussion that followed made me feel confident about the future of audit. There seemed to be general agreement that audit at the practice level is an essential component of day to day management and not simply a superficial educational exercise controlled by the profession. But there is more than that. There was also agreement that at a higher level there was a need to broaden audit through cooperation between MAAG and FHAs so that a similar relationship to that within the practice could develop. The proposal for the future expansion of MAAGS into clinical audit advisory groups appeared to go largely unchallenged, the central role of audit in the improvement of quality was accepted, and there was some confidence that audit would justify financial investment. I left with a sense of optimism. Audit is in the process of developing into a broad system to ensure quality. Perhaps we are finally on the threshold of the quality revolution.

RICHARD BAKER
Director, Eli Lilly National Medical Audit Centre


All the healthcare professions were well represented among the 400 delegates at this one day conference, whose theme was how to progress from a uniprofessional to a multiprofessional approach to audit. The chief medical officer, Dr K Calman, chaired the morning plenary session and the chief nursing officer, Mrs Y Moores, chaired the afternoon plenary session, demonstrating the commitment by the Department of Health to clinical audit.

Dr Calman placed importance on clinical audit being professionally led and on effective communication of results. But it must be patient focused and linked with management. Mrs Moores emphasised the need for integration across the boundaries of primary care through to tertiary care and that audit should be an integral part of clinical activity. This would not be fully achieved until audit becomes part of the educational curriculum, and the question of whether this can match the pace of change was raised. Echoing Dr Calman’s statement of the need for information sharing at national level, she stated that subscribing to a philosophy of a quality health care service can only promote this issue.

Brian Edwards, general manager of Trent region, spoke of audit as a sign of maturity in an organisation and emphasised the role of management in helping to process issues arising from audit. Audit must become part of the core funded services. Practical steps in clinical audit, presented by Charles Shaw, raised a series of questions. Recognising that guidelines for medical audit have been poor, we must learn to implement clinical audit in a robust, quantified manner. He advocated keeping topics for audit simple and relevant and tackling issues that could be reviewed in a short time to measure change. He also discussed the issue of time for audit; most people allocate 5% of their working time for audit and of a day per month – and this must be agreed with provider and purchaser managers.

The subject of who drives audit in a clinical setting was not discussed at length. Audit committees in hospitals are tackling this issue and in a discussion with hospital and general practitioners, it was obvious there was a difference between these groups. It would be interesting, for example, to know how many medical audit advisory groups have clinical rather than purely medical representation – even their name is outdated.

Offering audit “packages” was a project from Tamar (Working Well in Tamar), illustrating one of the approaches of the Royal College of General Practitioners to audit – that of utilising an audit agency, which seems to be successful, although no follow up data on review of any package were presented.

Talks on clinical audit in hospital focused on collaboration between different professional staff, with the patient as the focus. Perhaps next year presentations will include patient-organised audit of patients’ views on hospital care. The Clinical Outcomes Group is considering patients’ views and that end has taken on two lay members. The message from Dr Calman and Mrs Moores was that they saw clinical audit as having a significant contribution to make to the group.

It was clear from the conference that, although many groups are doing audit, the dissemination of results and coordination of tasks is rather fragmented. The poster session was divided into regions and specialisation and, for example, the King’s Fund and National Nursing and Therapy Audit network – and a phenomenal variety of audits was presented. Some posters showed a lack of hard data, trends to improvement being reported rather than statistical results, and an emphasis on quality measures rather than review. Audit is difficult to measure accurately, but some figures would have been of more value for comparing between groups.

Clinical audit is high on the agenda in the NHS as a measure to improve the quality of care. It must be patient focused and multiprofessional in approach, with sharing of methods and results between the multifarious groups engaged in clinical audit. However, this laudable aim is not easy to reach, for although many people want clinical audit to thrive, the irony is that if teamwork was total, clinical audit as an approach to quality improvement would be the norm. The need to drive clinical audit from the centre highlights the prevailing fragmented approach to patient care. Hopefully, clinical audit can act as the thread to hold together the fabric of a truly integrated, patient centred approach to health care.

MARJORIE WALKER
Clinical Audit Lead

Correction
An author’s error occurred in the report of the Welsh Advisory Group on Nursing and Midwifery Audit conference (Quality in Health Care 1992;1:273). The fifth audit development site in Wales – East Dyfed Mental Health Services, developing an audit based on therapeutic interventions – was omitted.

COMMENT

Microbiology: Accreditation and Quality Assessment Schemes in the UK: Measuring up to Standards. Roberts C, Kelsey MC, eds (pp 32; £3.50). Association of Medical Microbiologists

As the editors state in their introduction to this booklet, this is a guide to the various schemes available and not a critical analysis of their strengths and weaknesses. All of the authors are involved in the schemes which they describe. Four accreditation schemes are covered, together with three principal quality assessment schemes. One of these, the UK National External Quality Assessment Scheme, has several subschemes, three of which are included.

Medical and environmental microbiology has become a high profile activity in the past decade. Microbiologists need an introductory guide such as this to help them to determine which schemes are most appropriate. Membership of appropriate schemes will become essential. The introduction helps by clearly differentiating between quality assurance, quality control, and quality assessment and by listing several key issues that need to be considered.

The book papers are concise and well written. Where relevant they describe how the schemes have evolved, and they strike a balance between too much and too little detail; most provide a few key references. The booklet will be of value to medical and environmental microbiologists because it gathers together useful information from disparate sources. It is also a good starting point for anyone who wishes to look at these schemes in greater depth.

CHARLES EASMON
Professor of Microbiology

Arthritis Care Quality Guidelines No 1. Primary Health Care for People with Arthritis. London: Arthritis Care, 1992

Arthritis Care is a national charity which supports arthritis sufferers in the community as well as raising funds for local and national projects designed to help patients with arthritis. Representing the lay voice on many clinical and scientific bodies involved in rheumatism and arthritis, this organisation is well placed to develop quality guidelines which