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 cosy 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 FHSA 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.

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Clinical audit 1993 – collaborating for quality in the management of clinical care. NHS Management Executive clinical audit conference, Nottingham, February 1993

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 and that audit must become part of 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 – that is, half 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 to 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 this 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 specialised audit groups – 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
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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 ten 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