the audience, and the discussion that followed made me feel confident about the future of audit. There seemed to be a 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.

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 unipropfessional 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 audits. He contrasted this experience 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 and 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 a 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 specialist 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
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 paper pages 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
It considers should be adopted in the primary care of the 10 million people with arthritis in the United Kingdom. It has done so along the lines of primary health care charter recommended by the government and it lists twelve services that should be provided. Many of these have been adopted from the charter but, although many are undoubtedly and indisputably the required minimum standards, this document, like the charter, suffers from an air of unrealism because of the extra funding which will be required to introduce the recommendations. At present there is little sign of support for such provision in a primary care setting. For example, direct access to occupational therapy is not generally available and would be unworkable without a large investment in this profession. Prescription of medication is a feature of three of the services and is clearly an area for improvement, although it should be remembered that repeat prescription is one method for patient review. Also recommended is the provision of an up to date list of support and self help groups — this is easy, cheap, and of very valuable service which should be mandatory and well displayed in every surgery.

ADAM YOUNG
Consultant Rheumatologist

29 June—2 July

30 June
Regent’s College, London: Organising for success — a framework for quality in primary health care. A conference examining organisational audit in general practices and health centres within the wider context of quality in primary health care. It will draw on the experience of the pilot sites which have participated in the King’s Fund Organisational Audit Programme, as well as that of respected national figures. (For members of primary healthcare teams, managers of community healthcare services, commissioners, family health services authorities, and community health councils.) (£75) Contact Jane Moulder, King’s Fund Organisational Audit, 14 Palace Court, London W2 4HT (tel 071 221 7141; fax 071 221 1266).

25–30 July
Manchester: Institute of Services Management. 1993 Quality master class. A six day programme, for health service professionals responsible for improving quality and customer service. (£150), including accommodation and all meals.) Further details from Tony Mosely, Institute of Services Management, Manchester Business School, Booth Street West, Manchester M15 6PB (tel 061 275 6333).

2 September
Newcastle upon Tyne: Newcastle Quality Centre, University of Newcastle. Special health services day — Quality and its Applications in Health Care, keynote speaker Professor Richard Grol; part of First Newcastle International Conference on Quality and its Applications (1–3 September). (£150 (£125 before 1 August), including coffee, lunch, and photocopy of health service papers.) Further information from Mrs Val Adams, Newcastle Quality Centre, Centre for Continuing Education, The University of Newcastle upon Tyne, Newcastle upon Tyne NE1 7RU, United Kingdom (tel 044 91 226546; fax 044 91 2227090).

5–7 October
Leeds: Nuffield Institute for Health Services Studies. Coming to grips with quality assurance. A workshop for those with professional and managerial responsibility for, or interest in, quality assurance, whether as purchasers or providers. (£440, excluding accommodation.) Further details from Sally Sandon, Nuffield Institute for Health Services Studies, 71–75 Clarendon Road, Leeds LS2 9PL (tel 0532 459034; fax 0532 460899).

14 October
Birmingham: International Convention Centre. National MAAG delegate day. A national meeting looking at the future of audit in primary care. Topics include clinical audit, MAAG-management relationships, the purchaser-provider role, audit in fundholding, and staff development. (Nominal registration fee.) Further details and programme from Birmingham MAAG, Department of General Practice, University of Birmingham, Edgbaston, Birmingham B15 2TT (tel/fax 021 446 4368).

11 November
London: King’s Fund Centre, British Medical Association, College of Health, BMJ, Quality in Health Care joint conference. Quality 93, a sequel to raising quality in the NHS. (£95 including refreshments and lunch.) Further information from Prue Walters, Conference Unit, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP (tel 071 383 6037; fax 071 383 6400).

QUALITY QUOTES

It is the quality of our work which will please God and not the quantity — MAHATMA GANDHI

Consider the postage stamp: its usefulness consists in the ability to stick to one thing till it gets there — JOSH BILLINGS

I was to learn later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation — PETRONIUS ARBITER

It’s not what you pay a man, but what he costs you that counts — WILLY ROGERS

THE HISTORY OF MEDICAL AUDIT

IN THE EARLY DAYS THERE WAS SOME DIFFICULTY WITH THE CONCEPT OF THE AUDIT CYCLE

"THE MORTALITY RATE SEEMS MUCH HIGHER ROUND HERE THAN THE NATIONAL AVERAGE..."

THE CHARTER OF THE ROYAL COLLEGE OF PHYSICIANS OF 1618 STATED THAT IT SHOULD "UPHOLD STANDARDS OF MEDICINE, BOTH FOR THEIR OWN HONOUR AND PUBLIC BENEFIT."

AND WHY DON’T I NEED A COMPUTER TO DO THIS IT?

"OUTCOMES" — WELL LAST WEEK I HAD ONE WHO ACTUALLY SURVIVED THE OPERATION.

Amusing or erudite items relating to quality — including examples of "qualityspeak", cartoons, etc — are welcomed for publication and should be addressed to the editor.