Impact of Hospital and Community Provider Based Clinical Audit Programmes: Perceptions of Doctors, Nurses and Other Health Professionals

JOANNE LORD* and PETER LITTLEJOHNS†

*Health Care Evaluation Unit, †Department of Public Health Sciences, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, UK

A postal survey of staff (doctors, nurses, midwives, health visitors, therapy professionals, senior managers and clinical audit staff) was conducted in three English hospital and community healthcare providers. The aim was to assess staff perceptions of the impact of local clinical audit programmes and to investigate differences between staff groups. The questionnaire contained a 24 item opinion scale with a summary total: 371 out of 566 questionnaires were returned completed (66%). The majority of respondents were positive about the impact of clinical audit in their organizations, which is encouraging. However, there was a wide range of responses and significant variations between professional groups. Medical staff were significantly less positive than non-medics (p = 0.0007), and junior staff significantly less positive than seniors (p = 0.0306 for doctors and p = 0.0013 for other health care professions). After over five years experience of clinical audit in UK hospitals and community providers, many local staff remain sceptical about its real value. Copyright © 1996 Elsevier Science Ltd.

INTRODUCTION

Clinical audit was introduced by the UK government and widely welcomed as a professionally controlled system of peer review throughout the National Health Service (NHS) [1]. An extension of existing voluntary projects, it was to be a confidential process through which clinical teams could learn together and improve patient care. At the same time, managerial interests were recognised [2]. Most commentators welcomed the national initiative, but there were warnings and hostile voices. Some questioned the effectiveness and cost-effectiveness of audit as means of changing clinical behaviour [3]. Others were suspicious over the government's motives, fearing that audit would be misused to attack clinical freedom in the interests of cost-containment rather than genuine quality improvement [4].

Since 1989, a lot of time and money has been spent on audit in the NHS [5,6]. The initial concept of "medical" audit has been extended to "clinical" audit, involving the whole range of health professionals, not just doctors. Government funding for clinical audit has been devolved to local Health Authorities, the "purchasers", who have been given responsibility for monitoring audit in their local hospital, community and primary care providers [7,8]. Much effort has gone into evaluating the national clinical audit programme [9–25]. This is an inherently difficult task, because of the diverse nature of the programme, the multitude of confounding factors and the lack of sufficiently broad outcome measures. The quantitative analysis of costs and outcomes that is really needed to assess whether the programme has been an appropriate use of scarce healthcare resources, is still lacking [26,27].

Taking a step back, one evaluative approach
has been to consider the opinions of participating staff. Good attitudes to audit are likely to be a necessary, if not a sufficient, condition for "good" audit. Quantitative surveys of staff attitudes to clinical audit have been conducted in several localities in the UK: they have included primary care practitioners [28-30], hospital and community consultants [31-35], junior doctors [9,35,36], non-clinical managers [31] and audit support staff [9]. However, none have included nurses, midwives, health visitors or therapy professionals—a serious omission given the current emphasis on multi-professional clinical audit. The studies report positive general attitudes to audit and belief in the value of specific local audit programmes, but with certain common reservations and differences between staff groups. Qualitative studies reveal more detail about the nature of staff attitudes and perceptions [37-39].

The above studies were conducted before or shortly after the introduction of local clinical audit programmes except for two recent studies in primary care [29,30]. As part of our monitoring role for the South Thames NHS region, we wanted to assess the views of hospital and community staff on their organizations' audit programmes now, after four or five years experience. Do staff think these programmes have a positive impact? Have the concerns highlighted in earlier studies been allayed? We wanted to include a wide range of staff, from all of the healthcare professions, as well as managers and audit staff, and to investigate differences within and between professional groups.

METHODS

Six provider organizations, NHS "trusts", in the South Thames area were selected to give a geographical spread, and a mix of acute and community units. A letter was sent to the Chief Executives describing the project and asking if they would like to participate. This was followed by a phone call to their audit co-ordinators two weeks later. It was considered important to obtain the agreement of the audit co-ordinators, as we wanted the exercise to be of use to them. Three wanted to participate—two from mixed acute/community trusts and one from a smaller community trust. The level of audit activity in the non-participating trusts was similar to that in the participating trusts (Table 1).

The two trusts who provide both acute and community services (Trust A and B) have central clinical audit departments, evolved from medical audit departments, and give help and advice to clinicians largely on a project basis. The trust that provides only community services (Trust C) has an audit programme based on a quality improvement philosophy, focusing on the dissemination of quality skills and agreement of outcome targets with clinical teams.

The survey was targeted at all staff who might, or should, have had first hand experience of clinical audit in the trusts. This included: all consultants, senior registrars, registrars and career grades; senior nursing and therapy professionals (Grades G, H and I or equivalent); selected managerial posts; and clinical audit co-ordinators and support staff. Lists of staff were obtained by the trust audit co-ordinators from their personnel departments. Questionnaires were posted between March and June 1995, and a reminder sent to non-responders after a month. The questionnaires were anonymised, but number coded to allow follow-up by us (the trust audit departments did not have access to these codes).

The questionnaire contained 24 statements

<table>
<thead>
<tr>
<th>TABLE 1. The level of hospital and community provider trust audit activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean 1994/95</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Clinical audit revenue (£000s)</td>
</tr>
<tr>
<td>Clinical audit staff (whole time equivalents)</td>
</tr>
<tr>
<td>Number of audit projects</td>
</tr>
<tr>
<td>Number of audit meetings</td>
</tr>
</tbody>
</table>

Source: South Thames Regional Health Authority, Clinical Audit Annual Report, 1994/95.
Impact of audit programs

relating to the perceived effects of clinical audit in the provider organization (see Appendix). These items were derived from a qualitative analysis [40] of policy documents on medical and clinical audit from the Department of Health and other major national organisations [1,5,6,41-46]. Subjects were asked to assess each statement against a standard five-point Likert scale—1 “strongly disagree”, 2 “disagree”, 3 “uncertain”, 4 “agree”, or 5 “strongly agree”. A scale total was calculated by adding up the individual item scores (having reversed the scoring of negatively worded items), and transforming to a scale from 0 to 100. For simplicity each item was given an equal weight. Streiner and Norman argue that more complicated weighting systems make little difference in practice with scales comprising more than about 20 items [47]. Tests of internal consistency were performed, and all items, except two, were found to have a significant positive association with the sum of the other items at the 1% level (Kendalls' τ-b statistic) [48]. The two items that failed this test (C3 and H1) were omitted from the scale total. We took a scale total of 0-50 to represent negative overall feelings about the audit programme, and 50-100 to represent positive overall feelings. Individual items and the scale total were treated as ordinal data and analysed using non-parametric statistics [48].

In addition to the 24 item opinion survey, the questionnaire asked for an overall assessment of the value of the provider audit programme on a seven point scale from 1 for “not at all worthwhile” to 7 for “extremely worthwhile”. There was a fair level of association between this overall assessment and the scale total described above—Kendall's τ-b 0.53. Finally, the questionnaire asked for comments or suggestions on the way in which clinical audit works in their organization. Content analysis [49] was performed on this qualitative data using a classification system developed from that used in an earlier study [36].

RESULTS

Questionnaires were sent to 583 people, 17 of these had retired or left the trust, seven refused to participate, and 371 returned completed questionnaires—an overall response rate of 66%. There were differences in response rate by trust and profession, but these were not significant (Chi-squared tests at 5%). 96 out of 155 staff (62%) responded in Trust A, 206 out of 311 (66%) in Trust B and 69 out of 100 (69%) in Trust C. 229 out of 303 non-medics (76%) responded compared to 141 out of 231 medical staff (61%). There were no significant differences in response rate by grade or department. The results did not differ significantly between early responders (before reminders) and late responders (after reminders), except for one item (D4P) for which late responders were more positive (Mann-Whitney U test, p = 0.0157). There was no significant difference in the frequency with which early and late responders used the five different categories of response (t-tests at 5%).

More respondents were positive than negative about their experience of clinical audit, but there was a wide spread of responses (Fig. 1). The scale total median was 52.3, just on the positive side of neutral, and it ranged from 13.6 to 84.1. For most items the median response was 3, “uncertain”, but for some the median was 4, showing more positive perceptions about:

• the focus of audit on important topics (A2);
• its effectiveness in changing clinical practice and improving patient care (B3 and B1);
• its educational role in improving professional knowledge and helping clinicians to learn together (C1 and C4); and
• equal expectations of involvement from different professional groups (G2).

However, the median response was 2 for the following items, showing that most respondents agreed that:

• professionals found audit threatening (C3);
• there was no real sharing of information about audit between professionals and managers (D3);
• time spent on audit disrupted patient care (E2); and
• that there was unequal access to resources to support audit activity (G1).

Results varied between the trusts (Table 2). The scale total for Trust C, the smaller community trust, was significantly higher than that for the other two trusts (Mann-Whitney U test, p = 0.0014). There was no significant difference between Trust A and B.

There were significant differences by profes-
sional group and grade (Table 2). Medical staff were significantly less positive than other staff (Mann–Whitney U test, \( p = 0.0007 \)). Junior doctors (senior registrars and registrars) were more critical than senior doctors (consultants and career grades) (Mann–Whitney U test, \( p = 0.0306 \)), and junior nursing and therapy staff (Grade G or equivalent) were more critical.

![Figure 1. Frequency distribution for the scale total.](image)

**TABLE 2. Median scale total by provider trust, professional group and directorate**

<table>
<thead>
<tr>
<th>Provider trust</th>
<th>Number of valid responses *</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust A</td>
<td>91</td>
<td>50.0</td>
<td>18.2–79.5</td>
</tr>
<tr>
<td>Trust B</td>
<td>190</td>
<td>51.7</td>
<td>13.6–73.9</td>
</tr>
<tr>
<td>Trust C</td>
<td>63</td>
<td>55.7</td>
<td>25.0–84.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Number of valid responses *</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior (consultants and career grades)</td>
<td>97</td>
<td>51.1</td>
<td>13.6–73.9</td>
</tr>
<tr>
<td>Junior (senior registrars and registrars)</td>
<td>27</td>
<td>40.9</td>
<td>18.2–71.6</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>49.4</td>
<td>13.6–73.9</td>
</tr>
<tr>
<td>Nursing and therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior (Grades H and I)</td>
<td>32</td>
<td>56.8</td>
<td>23.9–72.7</td>
</tr>
<tr>
<td>Junior (Grade G)</td>
<td>96</td>
<td>48.9</td>
<td>25.0–71.6</td>
</tr>
<tr>
<td>Total</td>
<td>205</td>
<td>54.5</td>
<td>23.9–84.1</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>59.7</td>
<td>34.1–75.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical department</th>
<th>Number of valid responses *</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women and child health</td>
<td>57</td>
<td>55.7</td>
<td>29.5–72.7</td>
</tr>
<tr>
<td>Medicine/elderly</td>
<td>39</td>
<td>51.1</td>
<td>13.6–73.9</td>
</tr>
<tr>
<td>Mental health</td>
<td>14</td>
<td>50.6</td>
<td>42.0–69.3</td>
</tr>
<tr>
<td>Surgery</td>
<td>36</td>
<td>45.5</td>
<td>18.2–65.9</td>
</tr>
<tr>
<td>Community</td>
<td>120</td>
<td>53.4</td>
<td>23.9–84.1</td>
</tr>
<tr>
<td>Other</td>
<td>74</td>
<td>54.5</td>
<td>22.7–75.0</td>
</tr>
</tbody>
</table>

* The numbers reported in this table are less than the total number of staff responding in each group, as the scale total can only be calculated where respondents have answered all of the 22 items comprising it.
than their senior colleagues (Grade H and I or equivalent) (Mann–Whitney U test, \( p = 0.0013 \)). Differences were also observed between clinical departments within the hospitals (Table 2). Staff working in women and child health were most positive and surgical staff were most negative. Except in Trust B, community staff were also quite positive. Comments from health visitors, district nurses and community nurses at Trust B pointed to particular problems. They had had little experience of clinical audit other than a single study led by management. This appeared to be a time-and-motion study rather than clinical audit. Staff were highly suspicious of the motivation behind this project, and very critical about its conduct.

**District nurse**

"Lack of communication between management and staff makes audit threatening. As far as staff are aware only money seems important!... results are not fully explained or acted upon in a beneficial way to staff and patients."

Community nursing staff were much less positive in their assessment of audit than other staff in Trust B (scale total median 44.3 compared to 53.4 respectively, \( n = 55 \) and 134, Mann–Whitney U test, \( p = 0.0000 \)).

For one of the trusts in the survey (Trust B) there was information available on the audit experience of staff over the last year: attendance at audit meetings and participation in audit projects. There was a higher level of audit activity amongst doctors than amongst other staff. Only four out of 63 doctors (6.3%) reported that they had not attended an audit meeting or participated in an audit project over the last year, this compared to 66 out of 142 other staff (46.5%) (Chi-squared test, \( p = 0.0000 \)). Staff who reported that they had attended at least one audit meeting or participated in at least one audit project in the last year were significantly more positive about audit than those who had not (median scale total 53.4 compared to 47.7, \( n = 121 \) and 65, Mann–Whitney U test \( p = 0.0017 \)).

A total of 197 out of the 371 respondents (53%) added written comments or suggestions (Table 3). The most common concern was the shortage of clinical time in which to undertake clinical audit.

<table>
<thead>
<tr>
<th>TABLE 3. Classification of written suggestions for improvement</th>
<th>Number of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td></td>
</tr>
<tr>
<td>Resources for audit</td>
<td>39</td>
</tr>
<tr>
<td>Resources to implement change</td>
<td>6</td>
</tr>
<tr>
<td>Audit process</td>
<td></td>
</tr>
<tr>
<td>Organisation, strategy and co-ordination</td>
<td>29</td>
</tr>
<tr>
<td>Selection of topics</td>
<td>4</td>
</tr>
<tr>
<td>Data collection</td>
<td>5</td>
</tr>
<tr>
<td>Methods of audit</td>
<td>4</td>
</tr>
<tr>
<td>Setting of standards/guidelines</td>
<td>3</td>
</tr>
<tr>
<td>Implementation of change</td>
<td>5</td>
</tr>
<tr>
<td>Cooperation</td>
<td></td>
</tr>
<tr>
<td>Between specialities/departments/professions</td>
<td>17</td>
</tr>
<tr>
<td>Between clinicians/managers</td>
<td>1</td>
</tr>
<tr>
<td>Between secondary and primary care</td>
<td>2</td>
</tr>
<tr>
<td>Between providers</td>
<td>3</td>
</tr>
<tr>
<td>Ownership</td>
<td></td>
</tr>
<tr>
<td>Commitment of clinicians</td>
<td>9</td>
</tr>
<tr>
<td>Feedback to clinicians</td>
<td>9</td>
</tr>
<tr>
<td>Encourage clinician involvement</td>
<td>9</td>
</tr>
</tbody>
</table>

**Senior Registrar, psychiatry**

"In practice carrying out audit activity without support staff feels like a burdensome chore—on top of an already overloaded timetable..."

**Senior midwife**

"The reality is that the patient/client needs must be met on a daily basis. Releasing staff for training and/or enabling/facilitating the audit process is extremely difficult even though the commitment is there."

A large number of respondents criticised the organisation of clinical audit in the trusts and argued for better inter-departmental and inter-professional working on audit. Some suggested that there is a problem with clinicians' attitudes to audit. Others suggested that more should be done to encourage clinicians, of all professions and grades, to participate in audit and that more feedback of audit results is needed.

**DISCUSSION**

Staff from only a small number of hospital and community provider trusts were included in this
survey, and it can not be claimed that they are representative nationally. Their decision to participate probably indicates selection bias in favour of audit. The problems discussed below are likely to arise in other provider trusts, possibly to a greater extent. The purpose of the survey was to elicit opinions related to specific experience of clinical audit within the organisations, not general beliefs about whether audit is, or is not, a “good thing”. Of course, the two are not always separable, and some responses clearly reflected general concerns about clinical audit, or wider concerns about developments within the health service.

Overall the opinions expressed in this survey are similar to those reported in other studies of medical staff (9,28–36). The majority of respondents were positive about their experience of audit, they agreed that it leads to changes in practice and improves patient care. They also felt that it is an educational process. This is encouraging as most people would agree that these are the most important aspects of audit. Indeed many staff in all three trusts made enthusiastic comments about the achievements and the potential of clinical audit.

However, certain concerns highlighted in earlier surveys were seen to persist. Many staff in our survey were worried over the resource requirements of audit, particularly its demand on scarce clinical time. There were calls for greater communication and co-operation between professions and departments over clinical audit. In contrast to earlier studies, however, there appeared to be little concern over confidentiality in audit or its possible impact on clinical freedom. A small minority of staff clearly did not believe in clinical audit, and resented being forced to participate. These “pockets of discontent” must represent a problem for the development of organizational quality strategies.

Considerable differences in opinion within and between staff groups were observed. Medical staff were significantly less positive about their experience of audit than non medical staff. Junior staff (both medical and non-medical) were significantly less positive than their seniors. Staff working in surgical departments were significantly less positive, and those in women’s and child health and community departments significantly more positive than others. Three possible explanations for these differences might be proposed: that they reflect different levels of resources available to support clinical staff in their audit activity; that they reflect different experiences of clinical audit; and/or that they reflect differences in professional culture. There is insufficient evidence to support any one of these theories alone, it appears much more likely that they all make a contribution.

Differential access to audit resources does not appear to be a very satisfactory explanation of the observed differences: doctors were more negative about audit, though they have received the bulk of the national audit funds, roughly ten times the money that the, much larger, nursing and therapy professions have received [5]. As mentioned above, shortage of clinical time to conduct audit is seen as a major problem. It is possible that this is more of a problem for some groups of staff than for others. Junior staff, for example, may well feel more pressured than senior staff, and as they are often responsible for collection and analysis of data, this may be one reason for their more negative views of audit. This is certainly reflected in the qualitative comments in our survey and in the more detailed analysis of Black and Thompson [37].

Differences in the amount and type of audit experience may well have an effect. It has been suggested [32] that the reason for surgeons’ less positive opinions on audit compared to other doctors is their greater experience of audit, that this greater familiarity has bred contempt, demonstrating how time-consuming an activity audit is, and how difficult it is to implement changes and bring about improvements as a result of audit. Surgeons also have more experience of large national comparative audits, by comparison with which local audit might appear trivial and unproductive.

Higher levels of audit activity amongst doctors compared to other professions, might actually be used to explain their greater scepticism about audit. Of course, this theory rests on the assumption that audit activity is greater or more widespread amongst doctors than in the other health care professions, for which there is no hard evidence. Certainly, the medical profession has a long history of clinical audit, but a national survey in 1989 actually found more audit and quality assurance projects in the non-medical health professions [50]. The government, has stated that all doctors should partici-
Impact of audit programs

pate in regular audit, but has not placed a similar
requirement on other healthcare professionals
[1]. This suggests that doctors participating in
audit will be less self-selected than nurses and
other professionals.

The idea of a negative relationship between
audit activity and opinions on the value of audit
was not supported by the evidence from our
survey. For one of the trusts, we had information
on respondents’ level of experience of audit over
the last year. There was evidence that more
doctors had attended audit meetings and parti-
cipated in audit projects over the last year than
nurses and other healthcare professionals. But
respondents with experience of audit over the
last year were actually more positive than others
about the value of audit.

Finally, cultural differences between profes-
sions and clinical departments might be used to
explain their different opinions of audit. For
instance, community based departments might
be more used to multi-professional working and
so more open to clinical audit. Earlier surveys
showed high levels of suspicion amongst doctors
over the government’s motives for introducing
clinical audit [37]. Many feared that it would be
used as a “Trojan horse” to challenge their
traditional clinical freedom. This is less likely to
be a problem amongst the nursing and therapy
professions who have never had the same
autonomy. There was no evidence of such
differences between the professions in the written
comments from our survey. In fact, very few
respondents objected to the basic principle of
increased scrutiny of their work by themselves
and others that audit represents. However, it can
not be ruled out that they might be offering
tactical answers, complaining about the organi-
sation and resourcing of audit, to cover more
fundamental problems related to professional
power, that they find difficult articulate openly,
even in a confidential survey.

Acknowledgements: We thank the staff of the partici-
pating trusts, particularly the audit co-ordinators who
helped in the conduct of the survey. Source of funding:
South Thames Regional Health Authority. Conflict of
interest: none.

REFERENCES

1. Department of Health. Medical audit. NHS
2. Lord J and Littlejohns P, Links between clinical
audit and contracting systems. International
Journal of Health Care Quality Assurance 1995;
8: 15-24.
3. Maynard A, Case for Auditing Audit. Health
4. Jessop J, Audit: all talk and no action? Health
5. Department of Health. Clinical audit: meeting
audit, 1994.
and beyond, 1994
8. Department of Health. The new health authori-
ties and the clinical audit initiative: outline of
planned monitoring arrangements, 1995.
9. Kerrison S, Packwood T and Buxton M J,
Medical audit: taking stock. King’s Fund Centre,
10. Kerrison S, Packwood T and Buxton M J,
Monitoring medical audit. In Robinson R and
Le Grand J. (eds). Evaluating the NHS reforms.
King’s Fund Institute, London, pp. 155-77,
1993.
11. Harman D and Martin G, Medical audit and the
manager: a discussion document. Health Services
Journal of Epidemiology & Community Health
lessons, future directions. The Royal Society of
14. Walthe K and Coles J, Evaluating audit: a
review of initiatives. CASPE Research, London,
1993.
medical audit: the development of audit. Find-
ings of a national survey of healthcare provider
units in England. CASPE Research, London,
1994.
16. Rumsey M, Walshke K, Bennett J, et al.,
Evaluating medical audit: the role of the
commissioner in audit. Findings of a national
survey of commissioning authorities in England.
17. Walshke K, Bennett J, Buttery Y, et al., Evaluat-
ing audit: effective audit? Results of a detailed
review of healthcare providers’ audit pro-
18. Willmott M, Foster J, Walshke K, et al., Evaluat-
ing audit. A review of audit activity in the
nursing and therapy professions: findings of a
national survey. CASPE Research, London,
1995.
19. Foster J, Willmott M, Walshke K, et al., Evaluat-
ing audit. Nursing and therapy audit: a review of
the regions’ role. CASPE Research, London,
1995.
20. Department of Health. Medical audit in the
hospital and community health service, 1994.

APPENDIX

Items for the subjective appraisal of local clinical audit programme

Relevance
A1 The clinical audit programme covers the totality of health care from prevention to treatment, care and rehabilitation.
A2 Clinical audit does not really focus on the important topics *

Effectiveness
B1 Clinical audit improves patient care.
B2 Audit increases the sensitivity of provider staff to the needs and wishes of users.
B3 Audit rarely leads to changes in clinical practice. *
B4 When appropriate, management act on recommendations from clinical audit.

Development
C1 Audit helps clinicians to enhance their professional knowledge.
C2 Health care professionals have confidence in audit as an educational process.
C3 Clinicians often feel very threatened by audit.*
C4 Audit helps clinical teams to learn together.

Collaboration
D1 Audit brings together health care staff from different professions.
D2 There is little co-operation across departmental boundaries over audit.*
D3 There is no real sharing of information about audit between health care professionals and managers.*
D4 Many clinicians take part in collaborative audits with colleagues from other acute or community trusts.
D5 Purchasers make a positive contribution to the audit programme.
D6 Audit helps to improve links with general practice.

Efficiency
E1 The amount of time and money spent on audit in this trust is about right.
E2 Time spent on clinical audit does disrupt patient care.*

Inclusiveness
F1 Patients have the opportunity to make a meaningful contribution to the audit programme.
F2 Patient participation in audit is not really encouraged.*

Fairness
G1 Some groups of staff have less access to audit training, funding and support than others.*
G2 Equal involvement in audit is expected from different professional groups.

Stability
H1 Clinical audit support staff need more job security to be able to work effectively.*
H2 There is a clear strategy for the long term development of clinical audit in this trust.

*Negatively phrased items for which the scoring was reversed.