Social Accountability and Audit in UK Hospitals - An Investigation of Stakeholder Perceptions

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Abstract
Hospitals in the UK have undertaken significant changes during the past decade following the National Health Services (NHS) reforms. Under the new NHS, hospitals are obliged to adapt themselves to the new social and budgetary environments. This paper reports the findings of a study into the applicability of social audit as an approach of involving stakeholders in social accountability and decision-making process of UK hospitals. This research, based on 155 useful questionnaires designed to investigate general perceptions of hospital stakeholders on stakeholder involvement in social audit and accountability, has produced several interesting findings. Firstly, the involvement of patients and medical professionals in the process is widely recognised, despite doctors and hospital managers ranking the importance of patient's involvement lower than the average. Secondly, many stakeholders scored the importance of their own involvement in key areas less than the involvement of other stakeholders, indicating that some stakeholders have concerns about their responsibility and feel less certain about the effectiveness of social audit. Thirdly, there is no specific preference of methods of stakeholder involvement in social audit. Fourthly, government league tables and the media were considered less desirable for disclosing social and social accountability information. Incorporating social and social accountability information, however, into hospital annual reports or NHS audit reports was considered a preferred option among the majority of respondents.

Key words: Accountability; Social Audit; Social Performance; Social Reporting; Stakeholders.

I. Introduction

Hospitals in the UK have undertaken significant changes over the past decades following the National Health Service (NHS) reforms. To satisfy government policies and meet increasing public demand regarding the quality of services, the NHS underwent major reforms throughout the 1980s and into the 1990s (although it could be argued that reform or, at least major change, is still on going. Under the new NHS, hospitals are obliged to adapt to new social and budgetary environments.

In the UK, hospitals play a significant role in the NHS. About two-thirds of the NHS £35 billion budget (around 10% of all public spending) goes on hospital and community trusts. For many individuals, hospital is where life begins and sometimes ends. Hospitals, like many similar public-sector organisations, have social, environmental and community based objectives that they are expected to fulfil in addition to providing quality healthcare.

Currently, hospital care is driven by demographic changes and rapid medical and technological advances. Instead of merely improving the quality of care, hospitals are now obliged to play the economic optimisation trade-off between cost and benefit under the new NHS financial system. They have to follow the guidance produced by the National Institute for Health and Clinical Excellence which was created to promote high clinical standards and equitable provision of clinical care in the NHS. Under the new NHS financial system “Payment by Results”, instead of being commissioned through block agreements as previously, hospitals are paid for the activity that they undertake (DoH, 2002a).

Most importantly, hospitals have faced the structural change of care which shifts to patient-focused care. “Patient-focused care is a concept based on the following: care should be organised around the patients' needs; appropriate services should be brought nearer to the patient where possible; and the majority of care should be delivered by a small multidisciplinary care team” (Nicholson 1995, p.23). Patient-focused care needs the direct participation of patients as well as the involvement of other stakeholders in the care process and care decision-making.

Social audit has been proposed as an approach to involve stakeholders in health care (Hill *et al*., 1998 & 2001; Cotton *et al.*, 2000). Social audit can be regarded as a relatively new concept with the phrase "social audit" first used in the 1950s. Much early work took the form of external investigations to assess the impact of large corporations on their workforce, consumers, and the community. In the 1970s and 1980s, the measurement of social performance by accountants was the major focus of social audit practice. In the 1990s, broader developments of social audit have emerged with a view to developing the process of assessing and reporting on social performance of an organisation. Over the last decade, social audit has received some attention in the literature (e.g., Turnbull, 1995; Pearce et al., 1997; Cotton *et al*., 2000; Gao & Zhang, 2001; Hill *et al*., 2001; Zhang et al., 2003; Boele & Kemp, 2005).

Cotton *et al*. (2000) define social audit as "the process which an organisation undertakes when assessing and reporting on its social performance", while Turnbull (1995) defines it as "the process whereby an enterprise measures and reports on its performance in meeting its declared social, community or environmental objectives" (p.10). Vinten (1990) introduces a working definition of social audit as: "A review to ensure that an organisation gives due consideration to its wider and social responsibilities to those both directly and indirectly affected by its decisions, and that a balance is achieved in its corporate planning between these aspects and the more traditional business-related objectives" (p.127).

Overall the social audit concept has developed towards a more systematic assessment of social performance of an organisation, consisting of engaging stakeholders through a dialogue, external verification and disclosure (Cotton *et al.*, 2000; Hill *et al*., 1998 & 2001; Zhang *et al*., 2003). Engaging stakeholders in direct dialogue and listening to their 'voice' are the most salient features of social audit. The purpose of social audit is to make an organisation more transparent and accountable (Zadek & Raynard, 1995). It permits an organisation to monitor and steer its social performance, help the organisation to understand the relationship between social and business objectives, identify the cost and other implications of achieving social, community, cultural and/or environmental impact (Zadek & Raynard, 1995; O'Dwyer, 2003). Moreover, social audit permits the stakeholders in the organisation to affect its behaviour and to influence policies and decisions, provides an opportunity for all stakeholders including the wider community, to judge if the organisation is achieving the social, cultural, community and/or environmental added-value which it set out to achieve the best value (Gray et al., 1997; Cumming, 2001).

Social audit has been seen as a way of managing "competing interests and pressures from stakeholders" (New Economics Foundation, 1996). Hill *et al*. (1998) argue that social audit may bring benefits to a health care setting in three main aspects: Firstly, social audit may improve the transparency of health care decisions particularly in periods of fundamental structure change. Secondly, social audit may provide an extended framework for the accountability of the organisation to its stakeholders. Thirdly, social audit may actualise the ideology of patients becoming co-producers in health. Hill's *et al* (1998) study was predominately based on primary health care. Unfortunately, to the author's knowledge there has been no study undertaking in the hospital setting to assess the involvement of stakeholders and applicability of social audit in improving the transparency and accountability of a hospital.

The purpose of this paper is to investigate the perceptions of hospital stakeholders on their involvement in social audit with a view to understanding how social audit could fit into hospital care and, how it could be used to improve the quality of patient-focused care. Specifically, this research attempts to assess how stakeholders view the importance of their involvement in a variety of social activities and performance areas of a hospital (e.g., the involvement in decision-making process on "range of medical services provided", "formulating hospital care policy", "implementing patients' charter", "monitoring patients' waiting time", "evaluating hospital performance" and "consultation on patient treatment". This

research also looks into stakeholders' view on the methods of stakeholder involvement that could be adopted in social audit in NHS hospitals, including a stakeholder representative council, a stakeholder focus group or committee, ombudsman, anonymous interviews and regular questionnaire surveys. In addition, this research investigates the stakeholders' views on the ways of assessing and reporting on social performance.

II. Research Method and Design

It has been suggested that discussions of method (i.e., techniques for gathering evidence/data) and methodology (i.e., a theory and analysis of how research should proceed) should be intertwined with each other and with epistemological issues (i.e., issues about an adequate theory of knowledge or justificatory strategy) (Harding, 1987: 2). Epistemological concerns are about the 'what' and 'how' questions concerning knowledge, including questions about definitions of knowledge and the processes involved in knowledge production. Knowledge is overall grounded in empirical investigation using scientific methods underpinned by inductive and deductive reasoning, and the emphasis is on systematic and rigorous study to produce generalisable explanations that can be verified and tested. Popper (2002) highlights that scientific discovery is almost impossible since any hypothesis is not testable without limitation of time or space. One could conclude that even a given “fact”, such as the existence of a natural force termed gravity, is open to falsification since it has not been tested in every single application. Therefore this study attempts to develop knowledge based on some people's views in a specific environmental setting but does not attempt to claim any objective truth for the findings.

This research adopts the inductive approach with quantitative techniques. Quantitative techniques focus on the measuring of things that can be counted “using predetermined categories that can be treated as internal or ordinal data and subjected to statistical analysis” (Patton, 1997: 273). Such data are typically gathered through surveys and tests. A research design is a “blueprint” of research, dealing with at least four problems: what questions to study, what data are relevant, what data to collect, and how to analyse the results (Philliber *et al.*, 1980), whereas a data collection method is mainly concerned with how to gather data. The choice of research design is a matter of matching the requirements of a study with the characteristics of a particular design. Survey analysis is more appropriate for studies with “who”, “what”, “where”, “how many” and “how much” questions (Yin, 1989). Considering Yin's arguments, with additional consideration of generalisation, the survey (questionnaire) design was chosen for this study as it is suitable for research with questions of “perceptions”, and “how to implement”. This study aims to explore the applicability of social audit in the UK's hospitals by investigating the perceptions of stakeholders involved in social audit. The primary concern is “what” are the views and concerns of different stakeholders and “how” social audit can be operationalised in the context of NHS hospitals. The study requires information on the perceptions of individual stakeholders regarding the applicability of social audit in SHC, the major concerns stakeholders have, and the suggested approach to implement social audit. Since this information is not readily available, archival analysis is ruled out. Given the nature of this study, the use of experimental design is obviously inappropriate as the researcher is unable to control or manipulate stakeholder groups and their perceptions. The case study approach is disqualified as this study intends to examine the perceptions of a wide range of stakeholders across cases (i.e., hospitals). Consequently, survey research (e.g., questionnaire) remains the only viable design and is consistent with prior research in the primary health care setting, such as Hill et al. (1998). A major ingredient of a survey design is a sample, which represents the population under investigation. Findings obtained from the sample can be generalised to the population under statistical inference. This is a major advantage over other types of design since the use of sampling techniques strengthens the external validity of a study (Frankfort-Nachmias and Nachmias, 1992). A further merit is the fact that survey studies are carried our in real life settings which fit well into the nature of this study.

Using a survey design, there are three main methods for gathering data, namely, personal interview, telephone interview and mail questionnaire. The general characteristics of the three methods are well documented in the literature. Each has merits and shortcomings (Frankfort-Nachmias and Nachmias, 1992). With reference to Dillman (1978) and Frankfort-Nachmias and Nachmias (1992), the questionnaire method is selected for gathering stakeholders' perceptions as it is relatively economical and less time-consuming. Also, questionnaires can be made anonymous which can result in more honest responses, especially in more sensitive areas of health care. The questionnaire can cover a wide range of individuals with greater spread than other methods. Unstructured personal or telephone interviews are not suitable for obtaining consistent data. Telephone interviews were excluded, because the researcher is unable to have access to individual (especially, patients' private) phone numbers.

The disadvantages of the questionnaire approach are that there is no personal contact with the respondent which can lead to misinterpretation, no assurance that the questions were understood and whether the respondent was the one who answered or honestly, and poor response rate. Nevertheless, the questionnaire approach is considered the most appropriate method when primary data is being collected, in comparison to observational and extensive interview methods. For this research, it was impossible to obtain the postal addresses of many individuals (in particular patients), thus questionnaires could not be posted. Instead, most of the questionnaires were handed to individuals and some were distributed by a nurse-in-charge of a hospital ward to patients.

The piloting process started with drafting a set of questions to facilitate feedback from social accounting experts and nurse academics. Also, the researcher asked for advice and comments on the drafted questionnaire from fellow academics with experience in questionnaire design in the area of health care. In the formal pilot study, 36 questionnaires were sent out to identified individuals through various sources of contacts; 12 to medical professionals, 12 to academics in the health faculty of a university and 12 to outpatients. Of 27 replies, 9 came from professionals, 9 from academics and 8 from patients with an overall response rate of over 72%. In addition, 6 meetings were organised with these respondents with a view to discussing the questionnaires and particular issues facing them when they were completing the questionnaire. Also, as part of the piloting process the time taken to complete the questionnaire was noted. It took ten to fifteen minutes to complete the questionnaire, which was generally regarded as acceptable. The major issues raised during the pilot study included the classification of stakeholders, the wording of some questions and the format of the questionnaire. Specifically, it was discussed whether each stakeholder group should have different questions and a resultant separate page, and whether the questionnaire should include more stakeholder groups (including, for example, GPs, the local community, and charities).

Following the pilot study, a revised questionnaire was further discussed with four experienced researchers. A revised version including cover briefs and the stakeholder map was then finalised as the questionnaire. The sample size was determined according to some practical advice by Hoinville et al. (1989, p.61): “In practice, the main determinant of sample size is almost always the need to look separately at the results of different subgroups of the total sample (separate age groups, social-economic groups, and so on). The total sample size is usually governed by the sample size required for the subgroup: as a rough guide, the subgroup will need to have between fifty and a hundred members.” 400 questionnaires were distributed.

Given the ethical implication of this research, the survey frame was limited to three local hospitals and approval from their ethical committee was obtained. The three hospitals were all comprehensive hospitals with a similar size and organisational structure under one NHS authority in Scotland. The survey was carried out over three weeks. It was the preference of the researcher

to distribute the questionnaires to the nurses, medical staff and patients in person so that the researcher could introduce herself and explain the project for the purpose of improving the response rate. However, due to the policy of hospitals, the questionnaires could only be distributed by the nurse-in-charge of wards to individual patients and medical professionals (mainly nurses, support staff, doctors, Professions Allied to Medicine (PAM) and ward administrators). Finally, 310 questionnaires were distributed by nurses-in-charge to a number of wards in the hospitals, and 90 questionnaires were distributed in person to nursing and PAM academics at a local university. This type of distribution did, however, mean it was impossible to carry out follow-ups in the event of non completion.

In total, 155 completed questionnaires were returned giving an overall response rate of nearly 39 percent. The overall response rate of survey and the number of responses from each stakeholder are given in Table 1.

	Number of questionnaires distributed	**Responses**	**Response rate**
Hospitals	310	124	40%
Academic	90	31	34%
Total	400	155	39%
Stakeholders groups *			**Percentage of total responses**
• Doctors		25	16%
• Nurses		31	20%
• Patients		26	17%
• PAM		21	14%
• Hospital managers		5	3%
• Hospital administrators		5	3%
• Support staff		8	5%
• Pharmacists		3	2%
• Academics in healthcare **		31	20%
Total		155	100%

Note: * Given the nature of this type of research (e.g., anonymity), it is impossible to know how many questionnaires were distributed to a particular stakeholder group in a hospital because 310 questionnaires were handed to people by administrators or nurse-in-charge in a hospital.
** Many of these academics were also practising as nurses or other professionals in hospitals; one-third of responses also gave information as a patient.

Table 1 Questionnaire survey response rates

Table 2 shows the profiles of all 155 respondents to the questionnaires. In terms of age, it is roughly balanced between two main groupings (ages between 19-45, and 46-65) with 86 and 63 respondents respectively. More female respondents than male counterparts reflects the factor that in the environment of the NHS hospital there are generally more female staff members than male

members (in particular nursing and PAM staff) and more female patients than male patients. The majority of the respondents from medical professionals and academics have degrees or professional qualifications.

Age:	No.	%	Gender:	No.	%	Qualifications:	No.	%
Below 18:	1	0.65	Male:	47	30.32	Secondary School:	4	9.03
19-45:	86	55.48	Female:	97	62.58	HNC/HND:	11	7.10
46-65:	63	40.65		144		Degree*:	86	55.48
Over 65	5	3.23	(no indication	11	7.10)	Professional	43	27.74
	155	100		155	100		154	
						(No indication**	1)	0.65
							155	100

Note: * Responses exclude 20 having both degrees and professional qualifications (which are categorised as people with professional qualifications). Overall 106 people have degrees.
** A respondent from the nurse category did not complete the qualification section. It was assumed in the analysis that this person has a professional qualification to be qualified as a nurse and thus accounted as with a qualification.

Table 2 Personal profile of the respondents

For the guidance of the reader the questions are presented in Appendix 1.

III. Questionnaire results

The overall results of the questionnaire survey concerning the importance of stakeholders' involvement are given in Table 3. Generally, differences of responses among various stakeholder groups on the majority of areas listed in the questionnaires are not statistically significant as shown by Kruskal-Wallis Tests in Table 4. On the whole, Kruskal-Wallis Tests of the rankings by different stakeholders indicate that the majority of stakeholders share similar views on many issues in the questionnaire. Nevertheless, stakeholders' views are different in the following questions and the differences are statistically significant:

1. the involvement of patients in 'range of medical services provided' and 'evaluating hospital performance';
2. the involvement of doctors in 'range of medical services provided', 'formulating hospital care policy' and 'monitoring patients' waiting time';
3. the involvement of nurses in 'formulating hospital care policy';
4. the involvement of professions allied to medicine in 'implementing patients' charter'; and
5. the involvement of pharmacists in 'monitoring patients' waiting time'.

	Patients		Doctors		Nurses		Managers		PAM		Pharmacist		Admin	
Stakeholders' involvement in:	N=151	SD	N=155	SD	N=151	SD	N=151	SD	N=152	SD	N=154	SD	N=151	SD
Range of medical services provided	3.96	1.051	4.57	.706	4.20	.803	4.13	1.108	4.11	.776	3.57	1.080	3.20	1.287
Formulating hospital care policy	3.88	.930	4.34	.693	4.34	.731	4.33	1.100	4.03	.697	3.43	.985	3.15	1.254
Implementing Patients' Charter	4.16	.942	4.02	.849	4.27	.778	4.41	.884	3.95	.755	3.40	.989	3.49	1.175
Monitoring patients' waiting time	3.94	.964	3.91	.955	3.86	1.046	4.48	.899	3.65	.990	2.77	1.174	3.79	1.089
Evaluating hospital performance	4.15	.930	4.20	.770	4.14	.825	4.53	.963	3.89	.845	3.45	1.005	3.56	1.268

Table 3 The importance of stakeholders' involvement

	Stakeholders group		Gender		Age	
Questions	**Chi-Square**	**Asymp. Sig.**	**Chi-Square**	**Asymp. Sig.**	**Chi-Square**	**Asymp. Sig.**
Patients' involvement in "range of medical services provided"	10.657	.031*	9.866	.002*	.284	.868
Patients' involvement in "formulating hospital care policy"	8.284	.082	4.707	.030*	3.414	.181
Patients' involvement in "implementing patients' charter"	4.689	.321	3.209	.073	.947	.623
Patients' involvement in "monitoring patients' waiting time"	3.323	.505	.635	.426	1.498	.473
Patients' involvement in"evaluating hospital performance"	13.622	.009*	4.714	.030*	1.213	.545
Doctors' involvement in "range of medical services provided"	10.434	.034*	1.450	.229	.155	.926
Doctors' involvement in "formulating hospital care policy"	11.688	.020*	.386	.534	2.205	.332
Doctors' involvement in "implementing patients' charter"	5.739	.219	3.078	.079	.426	.808
Doctors' involvement in "monitoring patients' waiting time"	12.948	.012*	2.622	.105	.301	.860
Doctors' involvement in "evaluating hospital performance"	3.029	.553	9.293	.002*	.551	.759
Nurses' involvement in "range of medical services provided"	8.827	.066	7.106	.008*	3.052	.217
Nurses' involvement in "formulating hospital care policy"	12.206	.016*	5.179	.023*	1.423	.491
Nurses' involvement in "implementing patients' charter"	9.124	.058	12.340	.000*	.238	.888
Nurses' involvement in "monitoring patients' waiting time"	7.904	.095	8.732	.003*	.127	.939
Nurses' involvement in "evaluating hospital performance"	7.141	.129	9.803	.002*	.910	.634
PAMs' involvement in "range of medical services provided"	6.345	.175	4.449	.035*	3.055	.217
PAMs' involvement in "formulating hospital care policy"	2.820	.588	1.958	.162	1.136	.567
PAMs' involvement in "implementing patients' charter"	13.392	.010*	3.430	.064	1.127	.569
PAMs' involvement in "monitoring patients' waiting time"	7.085	.131	4.355	.037*	3.471	.176
PAMs' involvement in "evaluating hospital performance"	7.272	.122	4.366	.037*	1.226	.542
Pharmacists' involvement in "range of medical services provided"	1.976	.740	1.642	.200	4.585	.101
Pharmacists' involvement in "formulating hospital care policy"	6.491	.165	1.370	.242	2.506	.286
Pharmacists' involvement in "implementing patients' charter"	7.788	.100	4.894	.027*	.295	.863
Pharmacists' involvement in "monitoring patients' waiting time"	12.766	.012*	2.867	.090	.036	.982
Pharmacists' involvement in "evaluating hospital performance"	3.703	.448	3.567	.059	3.481	.175
Managers' involvement in "range of medical services provided"	1.566	.815	1.103	.294	2.580	.275
Managers' involvement in "formulating hospital care policy"	1.138	.888	.041	.839	12.090	.002&
Managers' involvement in "implementing patients' charter"	5.997	.199	.537	.463	9.561	.008*
Managers' involvement in "monitoring patients' waiting time"	.750	.945	.066	.798	8.646	.013*
Managers' involvement in "evaluating hospital performance"	5.404	.248	1.000	.317	16.595	.000*
Administrators' involvement in "range of medical services provided"	5.898	.207	.725	.395	1.726	.422
Administrators' involvement in "formulating hospital care policy"	3.572	.467	1.027	.311	5.479	.065
Administrators' involvement in "implementing patients' charter"	3.303	.508	1.569	.210	7.398	.025*
Administrators' involvement in"monitoring patients' waiting time"	4.853	.303	2.362	.124	7.524	.023*
Administrators' involvement in "evaluating hospital performance"	3.018	.555	2.542	.111	5.498	.064

* significance at 5%.

Table 4 Kruskal-Wallis Tests of the rankings by stakeholder groups, genders and ages [i]

i In this test, five large sample sized stakeholder groups (patients, doctors, nurses, PAMs and health academics) were included. An additional test that includes all stakeholder groups was also carried out, and the difference of results between the two tests is trivial in terms of statistical significance (three questions from the stakeholder groups test; 6 questions from the gender test, and one from the age test).

Interestingly, the rankings by doctors and patients in all questions except the question relating to patients' involvement in “evaluating hospital performance” are not much different in terms of statistical significance. The difference of rankings between doctors and nurses is significant relating to many questions[1]. In the questionnaire, academics and nurses were more or less sharing the same view (except to the questions of doctors' involvement in “range of medical services provided” and “formulating hospital care policy”, and nurses' involvement in “range of medical services provided”). Moreover, there is not much difference between academics and PAM in ranking all the issues except questions of nurses' involvement in “formulating hospital care policy” and managers' involvement in “evaluating hospital performance”. This is not surprising as most academics under this study came from nursing and PAM background. In addition, there were few differences between doctors and managers in ranking all the issues except on patients' involvement in “monitoring patients' waiting time”; however this needs to be treated cautiously because of the small sample size of managers in the survey.

Perceptions are different between the male and female respondents in many issues in the questionnaire. Kruskal-Wallis tests (shown in Table 4) indicate significant differences exist between males and females in a number of areas, in particular concerning the involvement of patients and PAMs in some of the areas and nurses in all the areas. Interestingly, there is no difference of views between male and female on the involvement of both managers and administrators in these five areas. The above result has raised an interesting question for further research that gender could be a factor resulting in the different views on stakeholders involvement in various social issues and policies of a hospital and likely on social audit in general. In addition, the age of respondents has some impact on the results as Kruskal-Wallis tests in Table 4 showing some significant differences existing in the issues on managers' involvement in “formulating hospital care policy”, “implementing patients' charter”, “monitoring patients' waiting time” and “evaluating hospital performance”, and administrators' involvement in “implementing patients' charter” and “monitoring patients' waiting time”. Younger groups of the respondents ranked those issues much higher than older groups. However, the statistical difference of the results disappeared when four aged over 65 were excluded in the test, suggesting that the difference was largely caused by the small sample size of the respondents aged over 65.

This paper mainly focuses on the perceptions of different stakeholder groups. There are differences between a few stakeholders' views concerning the role of particular stakeholder groups in some areas in the questionnaire. For example, differences of views emerge on various issues between patients and the other stakeholders, in particular on the role of medical doctors. Patients view differently from other stakeholders on the involvement of doctors in decision-making of “range of medical services provided” and “formulating hospital care policy”[2]. Patents expect doctors to play more parts in these aspects, as these areas are essential to patients care.

Moreover, patients and other stakeholders perceive differently the involvement of pharmacists in the area of “formulating hospital care policy”. Patients consider pharmacists stakeholder groups to have an important role to play in the formulation of a hospital care policy. Pharmacists are normally excluded from a hospital decision-making on patients care policy. Patients in a hospital require a

1 Questions were ranked differently including: Patients' involvement in “range of medical services provided”; Patients' involvement in “formulating hospital care policy”; Patients' involvement in “evaluating hospital performance”; Doctors' involvement in “monitoring patients' waiting time”; Nurses' involvement in “implementing patients' charter”; Nurses' involvement in “monitoring patients' waiting time”; Nurses' involvement in “evaluating hospital performance”; PAMs' involvement in “implementing patients' charter”; PAMs' involvement in “monitoring patients' waiting time”; PAMs' involvement in “evaluating hospital performance”; Pharmacists' involvement in “monitoring patients' waiting time”; Managers' involvement in “implementing patients' charter”.

2 For these questions, Chi-Squares and p values are 3.952, $p = 0.047$; 4.915, $p = 0.027$ respectively.

wide range of services, not only services from doctors and nurses, but also in many cases from PAM and pharmacists which provide many essential services to the patients and medical doctors. Apparently, there is a need for them to be part of hospital-care policy decision-making process. In a hospital, a prescribed medicine is one of the most frequent clinical services provided for patients. In a typical hospital, 7000 doses are given to patients each day (DoH, 2002b). Indeed, ensuring that medicines are used safely, that patients get the maximum benefit and avoiding the wastage of medicines are very important elements in decision-making in a clinical setting. Pharmacists play a valuable role in meeting the healthcare needs of patients. Delivering a service that offers better access and better choice for patients, pharmacy is an integral part of the NHS family, and stakeholders would like to see pharmacists strengthening their contribution to the provision of high quality, patient centred NHS services in hospitals.

Over the five areas investigated by the questionnaire the importance of the involvement of stakeholders in the various areas was ranked to some extent differently. For example, the involvement of managers in the areas was highly ranked and in three out of five areas, the ranking of managers' involvement were much higher than other stakeholders' involvement and the differences are statistically significant. Moreover, the involvement of patients was considered not much different from the involvement of doctors and nurses in three areas. The details of rankings in these areas are analysed below:

1. For the area of 'range of medical services provided', the involvement of doctors was considered more important than the involvement of any other stakeholder groups. The difference of views on the extent of the importance is statistically significant at 5%. This result indicates that doctors were considered the most important stakeholder group to get involved in decision-making on the medical services provided in a hospital. However, the differences between managers and patients, nursing and PAM in terms of their involvements in this area are not significant statistically at 5%.
2. For the second issue “formulating hospital care policy”, Table 3 shows higher scores were given to doctors, nurses, managers and PAM (over 4) than other stakeholder groups[3]. Patients were not ranked highly in this issue and the difference of scores between patients and doctors, nursing, and hospital managers are statistically significant at 5%. This indicates that stakeholders consider medical professionals (e.g., doctors, nurses) and hospital managers (they are all key stakeholder groups within a hospital) have a more important role to play than patients in formulating hospital care policy. This may reflect the common perception that formulating hospital care policy is an “internal” issue and that external stakeholders are considered less important.
3. Concerning the role of stakeholders in 'implementing patients' charter', managers, nurses, patients and doctors were all ranked above 4 as shown in Table 3. Pharmacists were given a lower score and ranked differently from all other stakeholder groups (except administrators) and the differences are statistically significant at 5%. Similarly, administrators were ranked lower and the scores were different from patients, doctors, nursing, PAM and managers, and differences are statistically significant (at the confidence level of 95%, all p = 0). For this question, managers were ranked highest, and the differences between the managers and patients, doctors, nurse, PAM and pharmacist are statistically significant at 5%. There is no statistically significant difference of rankings concerning the involvement of patients, and doctors and nurses in this area. This indicates that hospital managers have the overall responsibility to implement patients' charters, whereas nurses, doctors and patients equally have an important role to play in implementing patients' charter; but pharmacist and administers have a relatively less important role in this area.

3 However, stakeholders ranked the involvement of doctors and nurses in this area differently and the differences are statistically significant as Chi-Squares and p-values are 10.434, 0.034; 12.206, 0.016 respectively.

4. For the issue of 'monitoring patients' waiting time', managers were ranked the highest, and the differences of rankings given to managers and to other stakeholder groups are all statistically significant. This might suggest that patients' waiting time is a resource-allocation and management issue, and the managers have the key responsibility to manage it effectively and thus monitoring patients' waiting time is an important part of this management process. Interestingly, the score given to patients (score 3.94) is not significantly different from the scores to doctors (3.91), nurses (3.86) and administrators (3.79). This indicates that patients have an equal role to play with doctors, nurses and administrators in getting involved in 'monitoring patients' waiting time'. This is an area from which patients are normally excluded, but indeed an area where patients could get involved, perhaps with a fairly restricted and limited social audit (if they could fully share the information with hospital managers, doctors and nurses). In the context of social audit, however, patients' role in monitoring patients' waiting time should not be limited to their own contribution in the queuing system; it is actually more of a monitoring and decision making contribution.
5. The managers' role in 'evaluating hospital performance' was recognized and was given the highest ranking (score 4.53). The differences of scores between the managers and all other stakeholder groups are statistically significant at 5%. The score given to patients (4.15) is not statistically significantly different from scores for doctors (4.20) and nurses (4.14) for this issue. This indicates that patients were considered to have the same role as key medical professionals in getting involved in 'evaluating hospital performance'. This result suggests another area where patients could get involved in social audit and play a key role in evaluating hospital performance. It must be, however, recognized that such an involvement realistically can only be limited to a non-technical level. Although the White Paper “Our Healthier Nation - Saving Lives” (DoH, 1999) promote the idea of “Expert Patient” and a task force was set up to design an expert patient programme, this term “expert patient” is limited specifically for individuals with chronic illnesses. As Tang & Anderson (1999) argue, an individual (such as one with a chronic illness) cannot be simply recognised as an expert until structural constraints and equal access to resources are addressed. Under the current health care system in the UK with limited patients' access and widespread constraints upon patients, patients could not be accepted as the equal expert as the medical profession (Wilson, 2001). As a result, the inequality between technical/medical and non-technical evaluation would be detrimental to the level of patients' involvement.

The questionnaire sought to gather views on the involvement of stakeholders in consultation on patients' treatment. The survey results by and large reflect the common view that medical staff should have more to say concerning patient treatments. The result is shown in Table 5. The involvement of doctors, PAM, nurses and patients are ranked the most important (scored over 4.5), followed by the involvement of pharmacists, managers, and administrators. The respondents ranked the question differently, however, the difference of rankings for the involvement of the first four stakeholder groups (i.e., doctors, patients, nursing staff and PAM) is quite small (the score difference is merely between 4.4 to 5.0) as shown in Table 5. The differences are not statistically significant.

Despite the role of managers being highly recognised in many areas their involvement in consultation on patient treatments is considered relatively less important (scored only 3.11) than the involvement of medical professions and patients (i.e., doctors scored 4.81, nurses and PAM 4.72, patients 4.54 respectively). However, stakeholders hold different views on the role of managers in consultation on patient treatments, as the Kruskal-Wallis test result (Chi-Square 10,640, p = 0.031) shows the difference is statistically significant at 5%. Interestingly, the

managers ranked their own involvement lower than the average score on this specific issue[4]. This suggests that the managers themselves were not confident in the area of patient treatment and that they had to rely on the medical professions to make a decision (as they gave the doctors top score 5, nurses 4.4 and PAM 4.8). Doctors expressed the similar opinion as they also ranked the involvement of managers (scored 2.826) less than the average score of 3.11.

Surprisingly, the managers ranked the importance of patients in this question (scored 4.4) much higher than the score they gave to themselves (only scored 2.6). In contrast, the patients ranked the importance of managers in this question (only scored 2.588) much lower than the score they gave to themselves (scored 4.4) and the average score of 3.11. This result may suggest there was an existence of distrust between the managers and patients. On the one hand, the hospital managers highly valued the patients' involvement in the consultation process, which signifies a 'trust' towards patients. On the other hand, the patients did not consider the involvement of the hospital managers in consultation on patient treatment important, and there apparently was no confidence about ('distrusted') the managers in this specific area.

	Overall N=155		Ranked by individual stakeholder groups								
Stakeholders	**Avge**	**K-W Test X2**	**Doct N=25**	**Nurs N=31**	**Pati N=26**	**Magr N=5**	**PAM N=21**	**Supp N=8**	**Pham N=3**	**Admi N=5**	**Acad N=31**
Doctors	4.81	1.345	4.750	4.733	4.769	5.000	4.789	4.875	5.000	5.000	4.867
Patients	4.54	5.893	4.480	4.567	4.400	4.400	4.588	4.625	5.000	4.600	4.609
Nursing staff	4.72	5.311	4.565	4.800	4.654	4.400	4.842	4.625	5.000	5.000	4.733
PAM	4.72	1.366	4.680	4.760	4.526	4.800	4.714	4.750	4.667	4.800	4.833
Pharmacists	3.88	5.250	3.870	4.120	3.882	3.400	3.400	3.500	4.000	3.600	3.955
Hospital managers	3.11	10.640*	2.826	3.591	2.588	2.600	2.333	3.667	3.333	3.000	3.455
Administrators	2.63	4.053	2.478	3.045	2.471	1.400	2.000	2.333	2.333	2.750	2.909

* significance at 5%

Table 5 Views on the involvement of stakeholders in consultation on patient treatments

Regarding the methods of stakeholder involvement in social audit, there is no specific preference model as shown in Table 6. On average, the five methods (stakeholder representative council, stakeholder focus group, ombudsman, anonymous interviews, and questionnaire survey) scored between 3.35 and 3.96, and the differences are not statistically significant[5]. This result indicates that the respondents share similar views and do not have a strong preference on a specific model. Indeed all these models have pros and corns in terms of the operation of social audit as discussed in the literature (e.g., Turnbull, 1995; Gray et al., 1997; Cumming, 2001; Hill et al., 2001). However, the main stakeholder groups[6] have different views on “regular questionnaire surveys”, “anonymous interviews” and “ombudsman”, and the differences are statistical significant at 5% as shown by Kruskal-Wallis test (see Table 6). Doctors, managers and administrators gave low scores 2.96, 2.40 and 2.40 to “regular questionnaire survey” respectively, comparing with other stakeholder groups. This can be explained by the fact that the regular questionnaire survey would have an impact on the workload of managers and administrators. For medical doctors, completing regular questionnaire survey would be an additional burden to their busy schedule and could create time pressure on their prioritisation of medical care.

4 Managers also ranked the same mean score as the patients, however due to small number of manager respondents (n=5), statistical test would not be valid; thus no test was conducted.

5 A referee rightly points out a potential bias caused by stakeholders' insufficient understanding of the models to be able to make an informed judgement. In the discussion section, this was noted as a reason for the finding.

6 Main stakeholder groups include academics, doctors, patients, nurses and PAM as their sample size is over 20. The samples of the rest groups are too small to be valid for statistical analysis.

	Overall N=155		Ranked by individual stakeholder groups								
Stakeholders	**Mean**	**K-W Test X2**	**Doct N=25**	**Nurs N=31**	**Pati N=26**	**Magr N=5**	**PAM N=21**	**Supp N=8**	**Pham N=3**	**Admi N=5**	**Acad N=31**
Stakeholder representative council	3.96	8.872	3.545	4.069	3.846	3.200	4.105	4.125	4.000	3.800	4.276
Stakeholder focus group or committee	3.88	7.806	3.435	3.929	4.000	4.000	3.947	4.000	4.000	3.400	4.067
Ombudsman	3.68	11.314*	3.348	3.862	3.520	3.000	3.632	3.286	3.333	3.600	4.172
Anonymous interviews	3.35	14.245*	2.783	3.621	3.154	2.200	3.737	3.571	3.333	3.200	3.600
Regular questionnaire survey	3.40	12.995*	2.958	3.786	3.333	2.400	3.842	3.250	3.000	2.400	3.567

Table 6 The rankings of methods of stakeholders' involvement

The questionnaire also seeks to gather the views on the preferred information channels, asking "How desirable do you consider each of the following to be as ways of providing information to stakeholders on the performance of a hospital". The average scores of rankings by all stakeholders along with different stakeholders' rankings are given in Table 7.

Apart from the media[7], NHS audit report and separate social audit report/statement, there are minor differences of scorings in the ranking of other information channels under the Kruskal-Wallis test, as the scores are between 3.12 and 3.78 with no statistical significance in differences. Both government league table and media were scored lower than 3, indicating that these information channels have less popularity to be used for disclosing information. However, stakeholders have different views on the effectiveness of the media, NHS audit report and separate social audit report/statement, reflected from statistical significance in the Kruskal-Wallis test shown in Table 7. Likewise, separated social audit reports/statements are not considered in terms of score of ranking the most favourable information channels.

	Overall N=155		Ranked by individual stakeholder groups								
Stakeholders	**Mean**	**K-W Test X2**	**Doct N=25**	**Nurs N=31**	**Pati N=26**	**Magr N=5**	**PAM N=21**	**Supp N=8**	**Pham N=3**	**Admi N=5**	**Acad N=31**
Hospital annual report	3.75	3.434	3.478	3.633	3.720	4.000	3.850	4.000	4.000	4.000	3.867
More frequently hospital report	3.12	11.683	2.652	3.379	3.167	2.400	3.211	3.714	3.667	3.200	3.034
Government league table	2.57	12.525	1.957	2.690	2.654	2.400	2.450	3.500	3.000	2.400	2.700
NHS audit report	3.78	17.371*	3.261	3.897	3.840	3.000	3.900	4.000	3.333	3.200	4.133
Media (e.g., newspaper).	2.59	18.330*	1.958	2.933	2.680	1.800	2.500	3.375	2.000	2.200	2.800
Separated social audit report/ statement	3.37	16.652*	3.136	3.393	3.720	2.000	3.632	3.714	3.667	2.600	3.276
Internet (e.g., website)	3.57	4.396	3.261	3.567	3.615	3.400	3.789	3.429	3.333	3.400	3.767

* significance at 5%

Table 7 The information channels

7 It is noted that main stakeholder groups have different views on the role of "media as a way of providing information to stakeholders on the performance of a hospital", and the differences are statistical significant at 5% as Chi-Square = 35.516 and p = 0.003. Doctors and managers gave low scores 1.958 and 1.800 respectively to the media.

Considering different stakeholders' views on the information channels, the managers gave the lowest score to the media. This is probably because the media has misled the public in many cases on the NHS management (Learmonth, 1997). Doctors also expressed similar views; they gave media and government league table low scores (less than 2). All the respondents gave a relatively higher score (over 3) to the Internet, indicating it has the potential to be the primary information channel. Overall the questionnaire results indicate that hospital annual reports are the most favourable information channel for social information by the doctors, managers, support staff (the same score for NHS audit report) and administrators, while the nurses, patients, PAM and academics prefer NHS audit reports than other channels.

IV. Discussion and Limitations

It should be recognised that the above research findings must be interpreted cautiously given the limitation of the research design and questionnaire method. Nevertheless, the research shows that the involvement of patients and medical professionals in the process is widely recognised. The results indicate that patients would have the same role as key medical professionals in getting involved in 'evaluating hospital performance'. This suggests a particular area where patients can get involved in social audit. However, the doctors ranked the importance of patient's involvement in all these five areas lower than the average. This perhaps suggests that doctors are not interested in patient involvement and empowerment in the areas dominated traditionally by doctors themselves. It appears that the call for changes in medical practice towards more “softer” care recommended by the General Medical Council in the UK and in medical education has had little impact on the attitudes of doctors.

Also, the role of management in the whole process and their involvement in the most key areas (except on patient treatments) are widely perceived as desirable. This implies that the role of hospital management in the development of social audit cannot be overlooked. On the one hand, this is because managers and professionals are often “more educated, have more access to sources of information, and a different language to discuss health issues than either the individuals or the communities for whom or for which they work” (Robertson & Minkler, 1994, p.301). Managers are given the responsibility of running a hospital, thus they are directly accountable for the overall performance of the hospital. However, the above result might contain the potential of the danger of likely managerial “capture” in conceptualising and processing social accountability and audit aspects (Owen et al, 2000; O'Dwyer, 2003). Such capture can result in a myopic and limited number of stakeholders being included. The survey result may to a less context confirm the fear raised by O'Dwyer (2003) of 'manageable' and “downplayed” of any tensions between organisation and social audit goals.

Moreover, many stakeholders scored the importance of their involvement in some areas less than other stakeholders, indicating that some stakeholders have concerns about their responsibility and have less confidence than other stakeholders. For example, the managers ranked their own involvement much lower than the average score on the question relating to “consultation on patients' treatment”, suggesting that managers themselves were not confident in the area of patient treatment and they had to rely on the medical professions (in particular doctors) to make a decision, evidenced by giving top score to the doctors.

In addition, the survey result suggests some “distrust” between stakeholders, especially between the managers and patients, and between doctors and nurses. For example, the hospital managers highly valued the patients' involvement in the consultation process, whereas the patients did not consider the involvement of the hospital managers in consultation on patient treatment important, suggesting patients have no confidence upon ('distrusted') the managers. Nurses hold strong views

that they should be involved as a key player in these key areas, in line with the role of the doctors, which may be due to the extended role of the nurses and the strengthening of their professional status and qualification.

Finally, the questionnaire result shows that there is no specific preference model regarding the methods of stakeholder involvement in social audit. This result might also indicate that as a new area, people have limited knowledge and understanding on social audit and they have the difficulty to select a specific method. In terms of the channels of reporting on social performance, government league-table and media, along with separated social audit reports/statements were not considered desirable channels for disclosing information. Integrating the social audit information into hospital annual reports or NHS audit reports was considered a relatively preferred option.

Every research design has its strengths and weakness. No study can be claimed to be universally accepted as representing a complete and accurate status quo. Although certain limitations were self-imposed due to financial and time constraints, there are certain inherent limitations in a work such as this. It is important to recognise two major limitations of this study. Firstly, the low response rate of the postal questionnaires was predictable. The small sample size conducted in three hospitals located in one area does present a limitation to quantitative work, but in one of a qualitative nature, the sample has proved adequate in highlighting the 'perceptions' of stakeholders on various issues relating to social accountability, social audit and social reporting channels. The small sample size obviously has impacts on statistical testing with a possibility of bias in some findings. Second, the stakeholder base under this study is limited to a few primary stakeholders and as a result the study does not reveal the perceptions of other stakeholders (e.g., local communities, GPs, social workers, etc.). It is also important for the views of those individuals who are neither patients nor medical professions to be considered. A hospital has wide impacts on the society as well as on even those people who rarely use the service (if ever). Given the constraint of time and resource, this study like many other projects had to focus on main stakeholder groups in the survey. In general, hospitals are such highly differentiated places that making comparisons between them is impossible (Llewellyn and Northcott, 2005). In consequence the findings of this study might be difficult to generalise.

V. Conclusion

This research, based on 155 useful questionnaires designed to investigate the general perceptions of hospitals' stakeholders on stakeholder involvement in social audit and accountability has produced several interesting findings. Firstly, the involvement of patients and medical professionals in the process is widely recognised. However, both doctors and hospital managers ranked the importance of patient's involvement lower than the average. Secondly, many stakeholders scored the importance of their own involvement in key areas less than the involvement of other stakeholders, indicating that some stakeholders have concerns about their responsibility and feel less certain about the effectiveness of social audit. Thirdly, no specific preference has been found of models regarding the methods of stakeholder involvement in social audit. Fourthly, government league table and media were considered less desirable for disclosing social and social accountability information, but incorporating social and social accountability information into hospital annual reports or NHS audit reports was considered a preferred option among the majority of respondents.

Social audit is a new phenomenon in health care, and apparently many issues remain unsolved. There is a huge scope for further research. For example, the small sample of this study can be expended by looking at more broad wide range of stakeholders from wide geographical regions. Given the complexity of stakeholders and their interests in a hospital, a single approach of engaging

stakeholders is inappropriate, therefore there is a need to investigate different ways and their effectiveness of engaging stakeholders at different levels of policy development, decision making and performance evaluation. Research is required to provide guidance and framework so that stakeholders involved in social audit, at whatever level, can be confident that they are following general principles and framework. There is an increasing need to identify possible problem areas and for the production of a framework and guidance for those embarking upon audit, to ensure consistency in approach. Case studies are required to monitor what hospitals are doing in terms of stakeholder engagement and dialogue, and social accountabilities in order to understand the dimensions of partnership/trust and how stakeholder involvement through dialogue can mitigate power asymmetries in hospitals/stakeholders and professions/patients relationships.

Appendix 1. Questionnaire - Social Audit in Hospital Care
Research Title: Social Audit in Hospital Care

Section A - Personal Profile

1. Which of the following best describes you (please indicate with X)

Patients ☐
Hospital managers ☐
Doctors ☐
Administrators ☐
Nursing staff ☐
Support staff ☐
Pharmacists ☐
Academics in health care ☐
Professions Allied to Medicine ☐
(e.g. Radiographer, Physiotherapist or Podiatrist)
Others, please specify ____

2. Please indicate which age group you are in and your gender
Age: below 18 ☐ 19 - 45 ☐ 46 - 65 ☐ over 65 ☐
Gender: male ☐ female ☐

3. Please indicate the level of your highest education level
Secondary school level ☐ HNC/HND ☐
Degree (e.g., BA/BSc, MSc, PhD) ☐ Professional qualification ☐

Section B - Stakeholder Involvement

4. Please indicate how important you consider the involvement of patients to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

5. Please indicate how important you consider the involvement of doctors to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

6. Please indicate how important you consider the involvement of nursing staff to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

7. Please indicate how important you consider the involvement of professions allied to medicine (e.g. radiologist, physiotherapist and podiatrist) to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

8. Please indicate how important you consider the involvement of pharmacists to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

9. Please indicate how important you consider the involvement of hospital managers to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

10. Please indicate how important you consider the involvement of administrator to be in each of the following areas

	not at all important	not very important	neutral	important	very important
a. Range of medical services provided	☐	☐	☐	☐	☐
b. Formulating hospital care policy	☐	☐	☐	☐	☐
c. Implementing patients' charter	☐	☐	☐	☐	☐
d. Monitoring patients' waiting time	☐	☐	☐	☐	☐
e. Evaluating hospital performance	☐	☐	☐	☐	☐

11. Please indicate how important you consider the following stakeholders to be involved in consultation on patient treatment

	not at all important	not very important	neutral	important	very important
a. Doctors	☐	☐	☐	☐	☐
b. Professions allied to medicine	☐	☐	☐	☐	☐
c. Nursing staff	☐	☐	☐	☐	☐
d. Patients	☐	☐	☐	☐	☐
e. Pharmacists	☐	☐	☐	☐	☐
f. Hospital managers	☐	☐	☐	☐	☐
g. Administrators	☐	☐	☐	☐	☐

12. How desirable do you consider each of the following methods of stakeholder involvement to be?

	not at all desirable	not very desirable	neutral	desirable	very desirable
Stakeholder representative council	☐	☐	☐	☐	☐
Stakeholder focus group or committee	☐	☐	☐	☐	☐
Ombudsman	☐	☐	☐	☐	☐
Anonymous interviews	☐	☐	☐	☐	☐
Regular questionnaire survey	☐	☐	☐	☐	☐

Other (please specify) ____

13. How desirable do you consider each of the following to be as ways of providing information to stakeholders on the performance of a hospital?

	not at all desirable	not very desirable	neutral	desirable	very desirable
Hospital annual report	☐	☐	☐	☐	☐
More frequently hospital report	☐	☐	☐	☐	☐
Government league table	☐	☐	☐	☐	☐
NHS audit report	☐	☐	☐	☐	☐
Media (e.g., newspaper)	☐	☐	☐	☐	☐
Separated social audit report/statement	☐	☐	☐	☐	☐
Internet (e.g., webpage)	☐	☐	☐	☐	☐

14. *For patients,* please answer the following questions (14a and 14b)

14a.How many times you were in hospital as a patient in the last year (please indicate with 3).

less than 2 ☐ 2 to 5 ☐ 6 - 9 ☐ 10 or more ☐

14b. What is your occupation? (Please indicate with 3)

Manual ☐ Clerical ☐ Professional ☐ Unemployed ☐

15. *For hospital staff,* please answer the follow questions (15a and 15b)

15a. How long have you worked in this hospital Years______

15b. How long have you worked in the NHS (including the current hospital) Years______

Section C - Other Comments and Suggestions

Please add any other comments and suggestions relevant to this research:

____

____

____

If you would be willing to be interviewed to discuss these issues further, please give your name, phone number or e-mail address

____

____

If you wish to receive a summary of the survey results, please give your name and postal address:

____

____Postcode___________________

Please return the questionnaire in the reply paid envelope provided to Jane Zhang, Division of Accounting and Finance, Caledonian Business School, Glasgow Caledonian University, Cowcaddens Road, Glasgow G4 0BA.

Thank you very much for your help

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