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Excellent Patient Environments within Acute NHS Trusts: The Leaders Who Enable Them

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A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Business Administration

February 2007

Acknowledgements

I would like to take this opportunity to thank everyone who helped me during the period of the research. While it is not feasible to name everyone I must thank

- FSI who very kindly sponsored my study, without whom this work would not have been possible

- The twenty-two leaders within my Research Group who made me so welcome at their Trusts and put aside their busy lives to spend time with me

- My Supervisors, Professor If Price and Dr Phil Askham, who have given me such invaluable support and guidance during my research studies, far beyond the call of duty

- The Facilities Management Team at the Nottinghamshire Healthcare Trust who allowed me to try out my methodologies and ideas on them and their teams, and gave me full and frank feedback

- My husband, Andy, who has given me so much support and help in my quest for lifelong learning across the years, and in particular with this study

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1.1 The Problem Being Studied

This study examines a professional problem area whereby some NHS Trusts are able to deliver consistently high standards of Patient Environment while others are not. The study focuses on those acute, non-specialist Trusts that have consistently achieved good/excellent scores by Department of Health criteria[1]. Bryman (2001) tells us

> *' ..qualitative research often begins in a relatively open ended way and entails a gradual narrowing down of research questions and problems'*

This is true of this study. In an effort to make clear the emergence of the refocused research question, Figure 1.1 shows how the research idea became more focused as the research unfolded, with a new question being formulated as each previous question was answered.

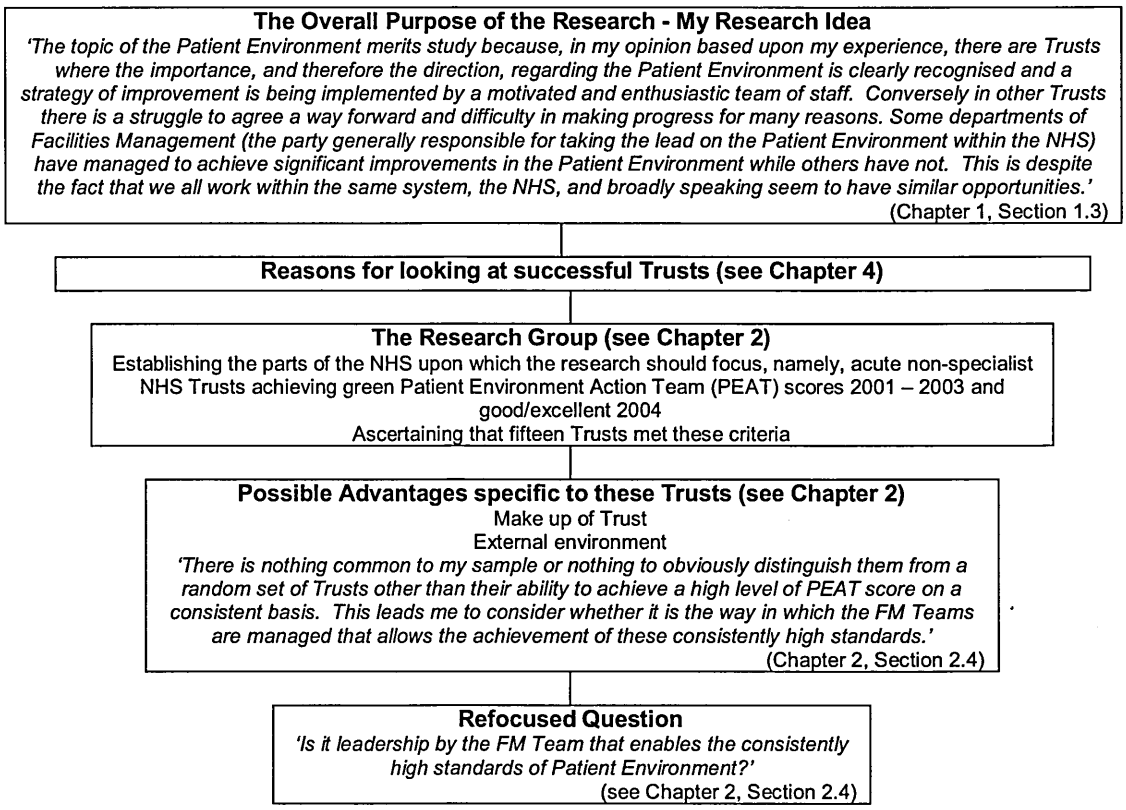


Figure 1.1 Defining the Research Question

[1] See Section 1.5.3 for details of Department of Health Patient Environment Action Team

1.2 Introduction

Alan Milburn (2000), then Secretary of State for Health, called for radical reform of the NHS, saying that:

> *'...the existing NHS belonged to a different era...Too many of its practices are just wrong. The NHS was formed in 1948 when the consultant was king...We live in a different century and it is the consumer who is king.'*

As other service-based industries have been challenged by increasingly informed customers, so these same customers have turned their thoughts to the standards delivered by the NHS. Recognising this, Patricia Hewitt, Secretary for Health (2006) said:

> *'the rise of individualism, consumerism and choice, the collapse of tradition, trust and deference...Today's people expect to have a choice, to have a say, to be offered a range of options – in their lifestyles, their employment and their healthcare.'*

This demand for better standards of NHS services precipitated the launch of the NHS Plan (2000). It set out the political rhetoric as to how reform, linked to increased funding, aimed to: redress geographical inequalities; improve service standards; and, increase patient choice. It heralded the biggest change to healthcare in England since the NHS was formed in 1948.

Based on the findings of the public consultation, the Government included improved standards of cleanliness and food (hereinafter termed the Patient Environment) as a fundamental part of the NHS Plan's commitment to improving patient care. The Department of Health recognised that patients expected a high standard of Patient Environment: tidy wards and corridors; smart main entrances; clean furniture and flooring; good food and, better décor.

In response to this demand for improved Patient Environments the Department of Health launched the 'Hospital Clean Up' and 'Better Hospital Food' initiatives, injecting many millions of pounds into the NHS to assist the increase in standards. At the same

time they initiated the Patient Environment Action Team (PEAT) whose role was to inspect National Health Services Trusts against a set of defined criteria. The results of these PEAT inspections were linked to the Trusts' overall performance ratings.

This link between the performance of the Trust and the delivery of a certain standard of Patient Environment focused attention on the Facilities Management Teams who were seen as responsible for the delivery of the standards[2].

In a speech to launch the Clean Hospitals Initiative, Health Minister Lord Hunt, said

> *'A good quality environment is essential to give a feeling of well being and confidence in the NHS.'* (Hunt 2000)

The PEAT scores highlight the differences in standards achieved by Trusts when delivering the standards of Patient Environment. I have become interested in the reasons for these differences. My interest is particularly aroused by the small group of Trusts that deliver excellent Patient Environments, at least according to the set of criteria that I will discuss later in the thesis. The thesis, entitled 'Excellent Patient Environments within Acute NHS Trusts: The Leaders Who Enable Them'[3], describes the research programme that I undertook that set out to discover what, if anything, these Trusts had in common.

As the thesis unfolds, the reader will see that I discount possible external influences and Trust characteristics that may have given the Facilities Management Managers in the Research Group an advantage when delivering the Patient Environment at their Trusts. I then turn to thinking about how these managers behave and whether they are displaying attributes and characteristics of leadership. My contribution to knowledge and Facilities Management practice is the evidence that the group of Facilities Management Managers who deliver consistently high standards of Patient Environment manifest leadership language and behaviours as shown in the literature. However, this is more complex than the literature might lead us to believe. The Facilities Management Managers evidence a dual role of manager/leader, using the language and behaviours of leaders to maximise the contribution of their teams. In addition they take up the mantle of strategic broker and use skills in networking and

[2] see Section 1.5 Background to Research for further discussion
[3] See Chapter 2, Section 2.2.3 for a discussion over the Research Group and the use of 'good' and 'excellent'.

boundary management thus integrating the FM agenda with those of the Clinical and Top Team agendas. I also argue that, in the face of little success in delivering a new and different NHS (Kernick 2005), there is evidence of a unique extended leadership role by which the Facilities Management Managers help broker cohesion between the Clinical Teams and the Top Team. I proffer the idea that the organisational context may be key in the success of the leader/manager who can then extend their role to include networker/broker.

This chapter is my introduction to the thesis and I use it to lay out:

- My research idea and how it was defined;
- The content of the thesis and its intentions;
- My positionality;
- Background information regarding the NHS and Facilities Management within the NHS, which will assist the reader to interpret the thesis.

I also identify the research pathway to be used throughout the thesis, see Figure 1.1.

1.3 My Research Idea

The topic of the Patient Environment merits study because, in my opinion based upon my experience, there are Trusts where the importance, and therefore the direction, regarding the Patient Environment is clearly recognised and a strategy of improvement is being implemented by a motivated and enthusiastic team of staff. Conversely in other Trusts there is a struggle to agree a way forward and difficulty in making progress for many reasons. Some departments of Facilities Management (the party generally responsible for taking the lead on the Patient Environment within the NHS) have managed to achieve significant improvements in the Patient Environment while others have not. This is despite the fact that we all work within the same system, the NHS, and broadly speaking seem to have similar opportunities.

My experience seems to be widely shared by others in similar positions as myself and these experiences are talked about within such settings of HEFMA (Health Facilities Management Association), the Facilities Management Health Forum and by the FMGC (Facilities Management Graduate Centre), Sheffield Hallam University.

NHS Facilities Management publications also allude to this difference, occasionally using the Trusts exhibiting high standards to highlight the sorts of environments to which one might want to aspire, for example, best practice guides. However, despite

this level of debate the topic of delivery of high standards of Patient Environment does not appear to have been formally investigated.

1.4 The Content of the Thesis and its Intentions

My thesis will follow the research pathway depicted in Figure 1.1. Hereinafter, at the beginning of each chapter a summary of Figure 1.1 is introduced with the relevant and detailed sections highlighted to signpost the reader through the research pathway.

In seeking to establish why some Trusts are able to deliver consistent high standards of Patient Environment, I needed to be able to identify the Trusts that achieved these standards, and what made this difference possible. In order to do this my research commenced with my forming a position of my own positionality and an understanding of what impact that will have on my research[4].

Section 1.5 Background to Research introduces the environment within which NHS Facilities Management teams found themselves working and the demands this environment placed upon them. I have also briefly researched the relevant history of Facilities Management. Following this I attempted to set out my initial research idea which revolved around the understanding of why some Trusts were consistently delivering high standards of Patient Environment, but at this stage of my research the research question was still woolly and unclear.

In order to bring clarity, I needed to deconstruct some of my language, for example, the use of the word 'Trust' to identify an arena offering a possible sample group. By using the deconstruction of my language, the thesis describes the methodology that I used to identify the criteria for determining high standards and how my Research Group was selected. My reasons for this identification unfold in Chapter 2 Desk Based Study and Section 2.2 Establishing the Research Group.

[4] See Section 1.4 for a discussion on my positionality

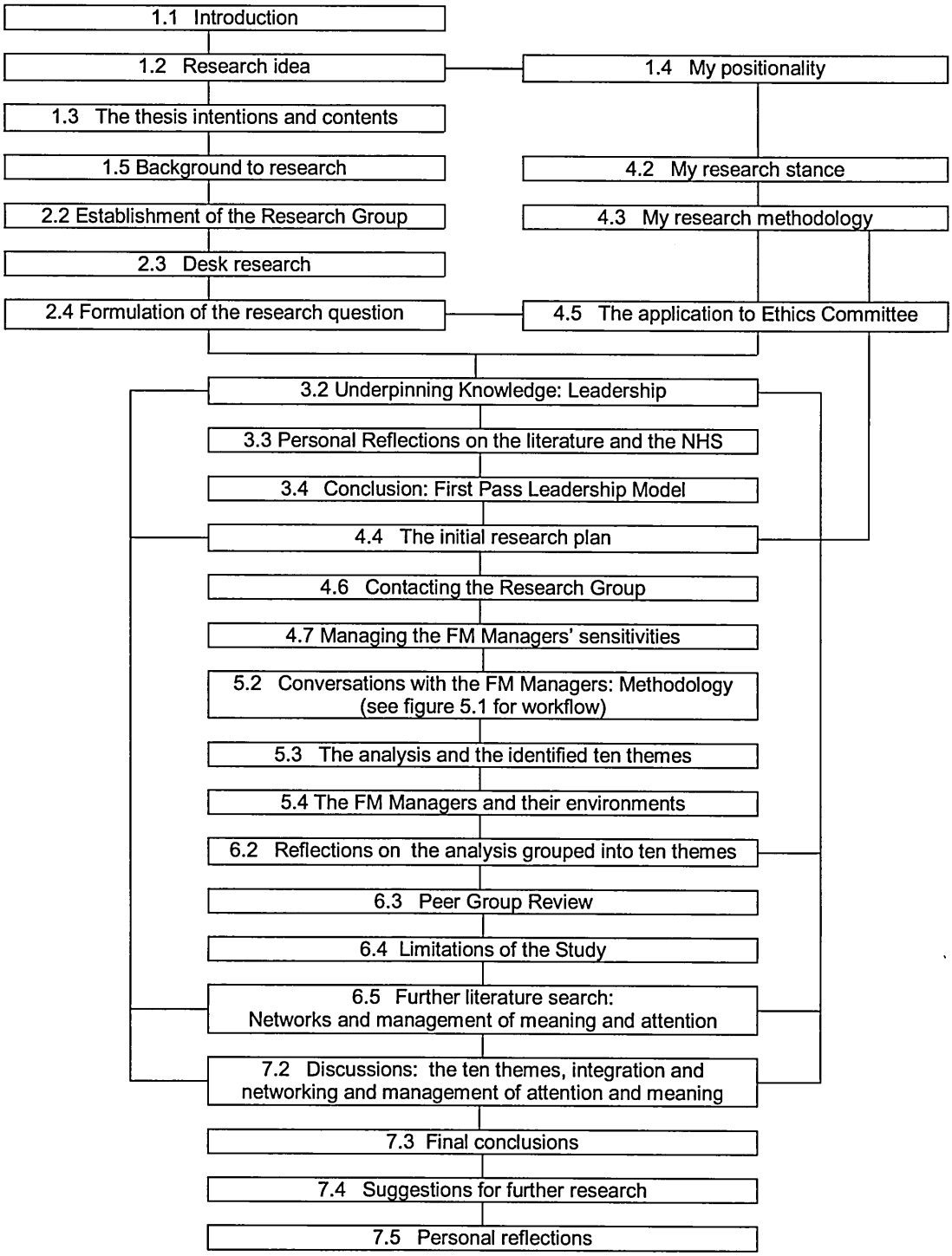


Figure 1.2 The Thesis set out in the Research Pathway

I will not be introducing an original idea of the Patient Environment for the purposes of this research, but will use an existing definition[5]. Therefore it is important to note that when I use terminology such as 'high standards' and/or use judgmental terms such as 'excellent, good, fair, average or poor' when speaking of the Patient Environment I will be using the definition and the judgements made by Patient Environment Action Teams (PEAT) and reflected through PEAT scores formally awarded by the Department of Health to each NHS Trust (see Section 1.5 Background Information). I recognise that using the PEAT scores may have introduced a limitation into the study and I discuss this further in Chapter 6 Reflections, Limitations and Further Literature Search.

Having identified the Research Group using the identification criteria, Chapter 2 Desk Based Study continues by relating the details of the desk research I carried out on each of the identified Trusts. The desk research sought to establish an understanding as to whether there were any shared Trust characteristics that would impact on the Facilities Management Teams delivering the Patient Environment, thus giving them an advantage over other Trusts. I followed this by looking at the population profiles of each of the Trusts in the Research Group in order to ascertain whether any external influences impacted on this group of Facilities Management Teams. Again I was looking to establish whether an advantage existed for the Research Group. As will be seen in Chapter 2 Desk Based Study, Section 2.4 Conclusion, no shared Trust characteristics or external influences could be detected. I reached the conclusion that the difference in the standards of Patient Environment were the result of something that was happening within the Trust and in particular its Facilities Management Teams[6]. At this point I re-formulated my research question and posed it as - is it leadership by the FM Management Team that enables the consistently high standards of Patient Environment to be delivered?

The remainder of my thesis focuses on covering this question. Given this focus, an understanding of leadership was required, and as can be seen from Figure 1.1, I then moved into a literature review that sought to clarify my understanding around leadership. There is a huge proliferation of literature regarding leaders, their followers and leadership itself, consequently to ensure focus I sought to look at the application of leadership within the NHS, or the public sector where possible. This drive for focus

[5] See Section 1.5.3 for a discussion of the Patient Environment Action Team Initiative
[6] See Chapter 6, Section 6.3.1 for a discussion on the limitation around access to the organisational context of the Facilities Management Team

resulted in my using a more deductive approach towards the literature search, as this allowed me to be more structured and build up a model to use for the purpose of my study, thus avoiding a wide ranging literature review that denied me a solid foundation upon which to build my work. My positionality favours an evidence based approach and the literature review provided me with the foundation for my field research with the members of the Research Group, the analysis of which is laid out in Chapter 5 The Conversations with the Facilities Managers.

In parallel to this work, I was working out the best methodology for my study and Chapter 4 Research Methodologies refers to my learning around the methodolgies of research and lays out the methodology I proposed to adopt in order to ensure rigour in my field research and its analysis.

I have taken a traditional approach to the structure of my thesis document in that I lay out: the background to the research topic; address current underpinning knowledge around leadership; move on to an explanation of the research methodology; through the research itself; and, in a section that brings the work to a conclusion, highlight further areas for research and include my personal reflections. However, I have taken a slightly unusual route with my field research analysis presentation, in that I have included a section that brings the conversations with different people at different times together within each of the identified themes and in so doing uses a high level of quotation. I have done this in order to display the various conversations as a cohesive whole to the reader; I attempt to engage the reader in a conversation around each theme, almost as though the contributors are around the table and their discussion is unfolding before us. I have chosen this route because the quotes from the conversations are very powerful in their own right and need to be available to the reader, undistorted by my impact as the Researcher[7]. Furthermore it brings cohesion and a sense of purpose to a number of unstructured dialogues, that I regard to be conversations rather interviews. In this way, I have given each contributor their loudest voice and allowed them to make their own impact on the reader.

My methodology allows for the inclusion on observations on the FM Managers environment, and in moving on to formulate Chapter 6 Reflections, Limitations and Further Research I reflect on the analysis of both the conversations and the reflections

[7] See Chapter 4, Section 4.2 for a discussion on my impact as a Researcher

on the environment alongside the underpinning knowledge laid out in Chapter 3 Underpinning Knowledge. As with any research study there were limitations on my study[8] as no research is carried out in an ideal world. For example, focussing the study within the Facilities Management Teams limited the understanding of the relationship with other managers within each Trust, while time delays and cultural issues provided challenges to the research plan. I also record and discuss some of the challenges which have been thrown down by others, in particular my Peer Review (Chpater 6), during my research.

The final chapter of the thesis, Chapter 7 Conclusions and Suggestions for Further Research concludes with a discussion on the findings, suggestions for further research into to areas of interest that have been raised during my study, and after looking at my personal reflections makes the final conclusions regarding the work.

This thesis seeks to show the reader that my study was a robust and original piece of research in the sense that I could not locate previous research into the impact of the Facilities Manager on the successful Patient Environment. The research allowed me to test existing knowledge around leadership, and look for new knowledge that helps the understanding around how the Facilities Management managers who impact on the Patient Environment do so in a way that delivering consistently high standards of Patient Environment.

1.5 My positionality

Having already drawn the reader's attention to the idea that I will make an impact as a researcher on my study, it is only right to make my positionality clear at the start of the thesis. It is necessary for the reader to understand my positionality and therefore be able to form their opinion around the impact that I will make.

Early in my thinking around my approach to this study, I formed the view that my knowledge and experience of working within the acute sector of the NHS and within Facilities Management (and thus my ontology (Gruber 2006)) could have a positive effect on my efforts to provide the NHS with a study that was of practical use as well as of academic rigour. So, in order to form an opinion on my own epistemology (deRose

[8] See Chapter 6

2006) and ontology, and therefore understand my positionality and the impact on my research, I reviewed my life, starting with childhood where many fundamental values and beliefs are formed.

As a child I was brought up in a Christian household, where the study of books was encouraged in order to further understand, and thus be able to live by, the teachings of the Bible. My parents were both practical people and I soon came to recognise that concepts learnt from books were only valuable when put into practice in everyday life. The belief in our family was that Christian principles were to be understood and then applied on a day-to-day basis. The practical approach adopted by my parents also resulted in my being brought up with a very strong work ethic, where hands-on work was seen as the main purpose in life.

However, I found I did not always enjoy this hands-on life, although my siblings did, and often found myself as the 'odd one out'; the one loving school, the one who would rather read than go out to play, and the one who failed to carry out their chores before enjoying the luxuries in life such as reading stories. I learnt to read very early, finding it to be an escape from everyday work and responsibility. Reading also encouraged my vivid imagination, with books often suggesting creative solutions to everyday life.

My working life started with a career as a chef, but I soon found that I was dissatisfied, as it was insufficiently mentally challenging or creative. Again, books offered me an escape from this hands-on lifestyle, by providing me an entry into management, an area of work that has provided me with a very successful and fulfilling career and has offered me a unique opportunity to progress from the shop floor to the boardroom within service environments. My childhood was a good foundation, as it enabled me to develop my skills of taking theories and turning them into practical applications. I have worked both within the private sector and the NHS in various management positions as I progressed up the management career ladder to director-level, and found my ability to grasp new ideas, think creatively and find practical solutions much in demand over this time. My childhood education has been supplemented all along the way with additional studying, in an effort to understand the theories that could improve my performance and thus my contribution to the organisation and my workforce.

Working in the NHS has been a very interesting experience for me, much of it enjoyable, but some of it very challenging. I have learnt the difference between convincing rhetoric and reality, and the value of being able to differentiate between

these by interpretation of unspoken languages such as symbols. I entered the NHS to work as a senior manager within a Facilities Management team, with the firm belief that the management theory could be applied to the NHS just as well as to the private sector, but would require a different interpretation to allow for the more political and complex agenda. I still hold to this belief although now look through a different lens, working within the NHS whilst not being within their organisational structures. What I have learnt in the intervening 12 years is a little of the motivations that result in the rhetoric remaining as rhetoric and not becoming reality. What I admire is the commitment of the people within the NHS who have made a positive impact on patient services.

The use of theory underpins most of my management work, with facts and concepts being my main tools in decision making. However, the ability to turn theory into practicality in a creative way remains my main skill and drove me to seek employment as a Director of Facilities Management, as part of my constant search for the best vehicle with which to improve patient services, this time through the power of position. Even in this interim period where I am working part time in order to complete my doctoral studies I am working within Primary Care directing a number of change programmes, still searching for the ultimate theory that will provide the ideal patient service[9]. I still believe in the search for excellence, and the ultimate solution that will ensure everyone 'lives happily ever after' that I discovered in those books of my early childhood. As living happily ever after is not a 'real' concept the search can never end and no theory can be seen as the end solution; the perfect solution. My need to find the 'live happily ever after' means that I will constantly seek improvement for others and myself through the development of people and their ideas, and the turning of these ideas into practical solutions.

I would therefore state that my positionality is one of accepting that knowledge exists, but in an imperfect or incomplete way, and only for a period of time; that knowledge will always be superceded by additional theories that become accepted knowledge for that period of time. No solution to a problem is ever perfect, implying that each fact is incomplete, or could be improved with more knowledge, or by an improved description that facilitates a fuller understanding. I see a fact as being of a transient nature, indeed I wonder if there are such things as facts; or whether they are ideas that merely last

[9] See Chapter 7, Section 7.4 for the personal reflections on my change of career

longer than other ideas. I see that humans turn a belief into a fact and see it as absolute, but it will be abandoned for a new fact when the old one is proven 'wrong'. The laws of physics may be seen as irrefutable by some, but scientists develop knowledge by the day and questions raised attack previous beliefs and knowledge and spawn new facts. I believe that knowledge is powerful to the person that believes in that knowledge, but knowledge is more powerful if it is constantly updated, beliefs reviewed and better applications constantly sought.

When I first started to think about my positionality for the purposes of this research, I had not discovered the ironist. I knew that I needed to be able to put some sort of label against my stance, if only to feel that I recognised myself against some of the theory (my quest for theory as above). To my satisfaction, I have now identified a theory that expresses something of my epistemology and fits my interpretative perspective. This topic is covered in more depth throughout the thesis, with Chapter 4 Research Methodology talking a little more about the ironist, while Chapter 7 Conclusions and Further Reflections, Section 7.4 Personal Reflections looks at the personal impact of this discovery.

My positionality pointed me towards a qualitative research methodology, although the final decision had to result in a methodology appropriate for my research question[10]. I hold the opinion that it is inevitable that a researcher will impact on their research, and in qualitative research events such as the study I am undertaking this adds value. Therefore I acknowledge my impact as a qualitative researcher and my skills and experience drawn from my time as a professional Facilities Management Director.

1.6 The Background to my Research

This section sets out some background information on the some of the key concepts alluded to throughout the thesis, thus providing the reader with an interpretation of my language:

- The External Influences on Healthcare;
- Trust Star Ratings;
- The Patient Environment Action Team Initiative; and
- Facilities Management within the NHS.

[10] See Chapter 4 for my research methodology

1.6.1 The External Influences on Healthcare

Most Western healthcare organisations are in the spotlight as they are required to become more effective and efficient to satisfy the demands for service and the requirements of the financial constraints brought by increasing numbers of people demanding more and improved care. This includes a call for improvements in the English[11] National Health Service (NHS), following growing public concern that standards were unacceptable. To quote Dearden (1991 p40-48)

> *'The NHS is beginning to emerge from the world of imposed formal organisational structures and more or less standard processes. The rolling away of some of our traditional fogs and tensions, the provision of specific high quality information of use to practitioners and managers, and the creation of a competitive environment all lead to a world with far more opportunities (and threats) than we are used to...There will be greater rewards and penalties for relative success and failure.'*

Literature from the United States echoes the events being experienced in healthcare in England when it speaks of changes in demographics increases in users' expectations and competition along with pressure from government that demanded high levels of change. This level of change calls for fundamental change and creation of new value. (Chow, Ganulin et al. 1998)

One of the real catalysts for change came in 2000, when the Government launched the NHS Plan. The Department of Health (2000) heralded the plan as

> *'...the biggest change to healthcare in England since the NHS was formed in 1948. The document sets out how increased funding and reform aim to redress geographical inequalities, improve service standards, and extend patient choice.'*

The pressure of this new and radical Government policy has been huge as the NHS attempts to realign itself to this new world, whilst being challenged by its hierarchical structures, an internally focused culture and traditional ways of working. Jargon employed includes 'Modernisation', 'not more of the same, just more' and 'working

[11] See Chapter 2 for the reasons for confining the study to the English NHS

smarter'. The newly formed Foundation Trusts[12] are seeking to exploit their new freedoms in order to be successful within this new world. There is recognition by some within the NHS that radical business process improvement is needed.

This is not a new conversation for the NHS. Looking back across the literature, I found the same ideas around the times of the reforms following the NHS and Community Care Act 1990; this was the legislation that enabled the establishment of NHS Trusts, some of whom are now moving towards Foundation Trust status. In 1996, Ashburner et al. looked at the effects of government sponsored initiatives to change the way that the NHS was managed. They examined the changes over a three-year period since the reforms and found that the NHS was at the brink of an organisational transformation. Robbins (1996) and Newman (1996) were both interested in the internally focused culture of the NHS, while Pasternack and Viscio (1998) were highlighting the hierarchical structures and Parston (1994) the silo mentality of these structures. The language of re-engineering appeared: the Healthcare Advisory board offered a paper on Re-Engineering with Patient Focused Care in 1994; Greene (1994) delivered a speech on Hospital Process Re-Engineering; while Bolton and Gordon (1994) were aligning the success of re-engineering with strong leadership; and, Carmicheal (1994) was making the case for reform.

The Government believed that performance management was the answer to demonstrating that the NHS had improved its performance, and set up a series of performance measures that the NHS should meet. Mr Blair, Prime Minister told health professionals that he did not believe that the changes to performance in waiting lists and waiting times would have happened without the targets being there (Blair 2007). At the time of the 2005 election there were 206 targets in place across the NHS. The emphasis placed by Trusts on the targets is reputed to demonstrate that patients' needs are being better served. Certainly reductions in waiting times for elective surgery and for treatment in A&E departments have been publicised; with Mr Blair, Prime Minister, recognising that waiting lists, which he called the biggest problem facing the NHS in 1997, had come down (Blair 2007).

[12] Information on Foundation Trusts is available at: www.dh.gov.uk/PolicyAndGuidance/OrganisationalPolicy/SecondaryCare/NHSFoundationTrusts/fs/en

1.6.2 Trust Star Ratings

A star rating scheme was set up to support these Government performance targets. It was led by the Healthcare Commission (2004), and Trusts were scored against a set of performance measures, ranked according to their performance and awarded a number of stars. The performance measures that were used to establish these star ratings are shown in Figure 1.2. Performance against Key Targets was assessed in terms of: achieved; some degree of underachievement; and, significant under-achievement. Trust performance is considered to be of concern if there are: a sizeable number of targets with some degree of underachievement; a smaller number of targets that have been significantly underachieved, or, combination of each

The remainder of the targets made up a 'balanced scorecard' with targets grouped against headings of: Patient focus; Clinical focus; and, Capacity and capability. These additional targets were used to refine the judgement on ratings (see Figure 1.2). Trusts with high performance ratings need to have done well against all the targets. Trusts are then awarded stars, from nought to three, with three being awarded to the high performing trusts.

The performance targets are not restricted to the clinical services, but encompass all activities within the NHS, including Facilities Management. The targets identified for Facilities Management took two forms. The first were the Patient Environment measures known as PEAT[13]. These measures contributed to the star status of the Trust as a whole, by providing outcomes for the Key Performance Indicator for hospital cleanliness, and the Patient Focus Indicator for Better Hospital Food. Over time PEAT has also evolved to include information on the Patient Focus indicator for Privacy and Dignity. Figure 1.2 shows the measures over which Facilities Management Teams have direct influence, or influence that is of more indirect nature. It should be noted that Hospital Cleanliness is one of the key targets for Trusts to achieve.

[13] See Section 1.5.3 for information on the PEAT Initiative

Key Targets	A&E emergency admission waits (12 hours)
	Cancelled operations not admitted within 28
	Financial management
	***Hospital cleanliness** **
	Improving Working Lives
	Number of inpatients waiting longer than the standard
	Number of outpatients waiting longer than the standard
	Total time in A&E
	Two week cancer waits

Capacity and capability	Consultant appraisal
	Data quality
	Fire, Health and Safety*
	Information Governance
	Junior doctors' hours
	*Sickness absence rate^*
	*Staff opinion survey^*
Clinical focus	Clinical Negligence
	Deaths within 30 days of a heart bypass operation
	Deaths within 30 days of selected surgical procedures
	Emergency readmission to hospital following discharge
	Emergency readmission to hospital following discharge for children
	Emergency readmission to hospital following treatment for a fractured hip
	Emergency readmission to hospital following treatment for a stroke
	Infection control procedures
	Methicillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia improvement score
	Thrombolysis treatment time
Patient focus	A&E emergency admission waits (4 hours)
	Better hospital food*
	Breast cancer treatment
	Cancelled operations
	Day case booking
	Delayed transfers of care
	Nine month heart operation waits
	Outpatient A&E survey - access & waiting
	Outpatient A&E survey - better information, more choice
	Outpatient A&E survey - building relationships
	*Outpatient A&E survey – clean comfortable, friendly place to be^*
	Outpatient A&E survey - safe, high quality, co-ordinated care
	Paediatric outpatient did not attend rates
	Patient complaints procedure
	Privacy & dignity
	Six month inpatient waits
	Thirteen week outpatient waits
	Total inpatient waits
	Waiting times for Rapid Access Chest Pain Clinic

Figure 1.3 Performance Indicators for Acute Star Ratings, Department of Health
Denotes areas where the Facilities Management Teams have direct influence
^ Denotes areas where Facilities Management Teams have influence, but this is more indirect

The second set of performance measures for Facilities Management was the Estates Returns Information Collection (ERIC) (Department of Health 2005), which at the time of writing comprise some 2000 individual measures, covering items such as the cleaning costs per square metre and total pay costs for directly employed maintenance

labour. These returns are sent independently by each Trust to the Department of Health. The Department of Health states that ERIC is a useful tool to allow analysis of Facilities Management information across the NHS. However, those within Facilities Management continue to discuss whether the outcome from this measurement tool forms a basis of acceptable knowledge that can be used to access the performance (and therefore the room for improvement) of the business processes within the Facilities Management service.

1.6.3 The Patient Environment Action Team Initiative

The national consultation over the NHS Plan highlighted the importance placed by the public on the hospital environment and its cleanliness. Following this the Health Minister launched the 'Hospital Clean-Up' initiative that aimed to improve hospital cleanliness and therefore the patients' experiences of their local hospital environment. He said that

> *'Patients expect tidy wards and corridors, smart main entrances, clean furniture and flooring, and better decor. We are committed to improving patients' experiences of the NHS by focusing on their comfort, convenience and dignity...Each trust will now draw up action plans to set work priorities and by the autumn all trusts will have been inspected by Patient Environment Action Teams. These teams, which will include representatives of the Patient's Association and NHS professionals such as infection control nurses, will help make sure that action plans are implemented so that patients start to see positive changes.'*

In 2000 every NHS Trust was required to prepare detailed action plans to improve their patient environment, focusing on nineteen separate elements that were set by NHS Estates (an agency of the Department of Health) in consultation with NHS Trusts. These nineteen elements comprised the Patient Environment and included areas such as car parking, entrances and reception areas, visitors' and ward toilets, cleanliness, the condition and cleanliness of linen, decoration and maintenance standards and the quality of patient food. Within each Trust, an individual Trust Board member was required to be nominated to take responsibility for the patient environment and for the implementation of these action plans. To this day, each Trust Board continues to receive regular reports on Patient Environment issues.

In order to ensure that progress was made by each Trust, Patient Environment Action Teams (NHS Estates 2004) were established to assess hospitals. Inspection Teams usually consisted of nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates directors. They also include patients, patient representatives and members of the public.

Under the programme, every inpatient healthcare facility in England with ten beds or more was assessed annually for standards of cleanliness and food. Prior to 2004 each hospital inspected was awarded a colour to denote a Good (Green), Acceptable (Amber) or Poor (Red) performance. This approach was changed in 2004, with hospitals being rated as Excellent, Good, Acceptable, Poor or Unacceptable from that date.

In 2004 extra elements of assessment were introduced with teams being asked to look at; how well the environment supported privacy and dignity; segregation of men and women in sleeping areas and toilets/bathrooms; and, more detailed arrangements for privacy in mental health units. In addition, a self assessment programme was introduced[14], with all hospitals that achieved a score of 'Good' in 2003 undertaking a self-assessment. The Patients Association and other external validators were involved in undertaking a programme of random visits to those hospitals which self-assessed. This sought to verify that self-assessments were appropriately conducted and scores were being awarded consistently.

The importance of the patient environment has continued to be underlined by the Department of Health (2006) who tell us that

> *'Good healthcare environments are key drivers of patient experience. Good environments matter to patients, their visitors and carers and to staff...Areas covered include clean hospitals, hospital food, basic care services, privacy and dignity, ward housekeeping and the healing environment'* and *'Good environments have a powerful effect on patients and staff. They can enhance clinical outcomes and patient recovery and improve staff working lives. Careful use of colour, light, texture and sound combine to create a healing environment.'*

[14] It could be argued that this self-assessment programme may have allowed for less objectivity in the process. However, the scores achieved by the Trusts in the Research Group remain consistent.

They go on to lay our their view of the healing environment

> *'A healing environment is one which makes us feel better, and feeling better is the key to getting better. Studies clearly show that environmental factors such as lighting, colour, aroma, views, art, sound, texture and materials can have a powerful healing and therapeutic effect on patients. Staff also benefit from a healing environment. Healing environments may lead to:*
>
> - *faster patient recoveries*
> - *reduced pain or less reliance on powerful analgesics*
> - *greater patient satisfaction*
> - *reduced stress levels among staff*
> - *improved staff recruitment and retention.'*

This continued focus on the PEAT initiative resulted in Facilities Management being acknowledged as part of patient care with responsibility for the day-to-day management of the PEAT programme being transferred to the National Patient Safety Agency (NPSA), following the abolition of the NHS Estates. However, the Directorate of Estates within the Department of Health continues to work in partnership with NPSA on the delivery of the PEAT process. Since this move, and in line with the approach taken by the Healthcare Commission, PEAT has become an entirely self-assessed system, although a number of sites still receive an independent validation visit by external inspectors.

1.6.4 Facilities Management within the NHS

Property, as a component of an organisation's facilities, is regarded as an asset that, when properly managed, can add strategic value to an organisation. Added to this is the increase in competitiveness that is putting pressure on companies to reduce expenditure on 'non-core' activities. The increasing requirements for the economic operation of facilities have led to the development of the discipline of facilities management (Shohet and Lavy 2004).

The term 'facility management' was introduced in North America during the late 1970's to describe a developing field of study into design and management of workplaces and their impact on the business of the organisations that occupied them. The same body

of knowledge became known in the U.K. as Facilities Management and workplace design became interwoven with the conversations around the provision of building support services (Haynes and Price 2004).

The British Institute of Facilities Management (BIFM) tells us that Facilities Management is one of the fastest growing professions in the UK. On its website it defines Facilities Management as

> *'the integration of processes within an organisation to maintain and develop the agreed services which support and improve the effectiveness of its primary activities. [It] encompasses multi-disciplinary activities within the built environment and the management of their impact upon people and the workplace.'*

BIFM argue that effective Facilities Management, which they define as combining resources and activities, is vital to the success of any organisation. They state that Facilities Management contributes to the delivery of strategic and operational objectives, and on a day-to-day level provides a safe and efficient working environment, that is essential to the performance of any business, whatever its size and scope. They go on to define the responsibilities of the Facilities Manager as

> *'providing, maintaining and developing myriad services. These range from property strategy, space management and communications infrastructure to building maintenance, administration and contract management.'*

In 1994 Ageros et al. argued that Facilities Management had become recognised as the buzz concept in the support services industry and was steadily gaining recognition as a profession by both the customer and the provider. They said that the performance and success of the core business was directly related to how well the non-core services provided effective support to that core operation. Therefore the appointment of a good facilities manager was crucial for support services to contribute to profitability. A continuing professional approach was being called for in order to ensure that Facilities Management stayed ahead of the game and remained flexible to meet the increasing demands on its efficiency from the Board. In 2000, Green and Price observed that Facilities Management was variously seen as a fad, a new area of business and a new discipline. They argue that Facilities Management had seen an explosive but poorly quantified growth.

Extensive literature surrounds Facilities Management but to avoid detracting from the main theme of the thesis I have not entered this debate, other than to look at the changes that have impacted on the role of the NHS Facilities Management manager. To offer a common language for this particular study I use the definition of Facilities Management within the NHS given by the Department of Health (2006)

> *'Strategic development of a flexible and responsive environment for health and social care, delivering improved health outcomes through innovative estates and facilities solutions which enable high quality, safe patient care.'*

Hereinafter to allow simplicity of presentation, Facilities Management is abbreviated to FM.

Within the NHS, FM has been formed by the coming together of the estates and hotel services departments, although there are some Trusts where the FM portfolio does not include estates services, or the department is called Estates and Facilities. Other Trusts choose to place additional services into the FM portfolio. Although there are many variants to be found, the core NHS FM portfolio is shown at Figure 2.3.

Estates	**Hotel Services**
Capital schemes	Cleaning
Estates planning & estates strategy	Housekeeping
Maintenance	Portering
Grounds and gardens	Catering
Telecommunications	Waste disposal
Security	Window cleaning

Figure 1.4 The Core Facilities Management Portfolio after Lyall (1994)

The need for an integrated FM service that can deliver the changes required by the NHS Plan (2000) across the whole portfolio of FM services is indicated in Section A1.7

> *'People want to see the basics put right. Half of people think the condition of hospital buildings needs to be improved. Few people are complimentary about hospital food. One survey found almost a third of patients needed help eating meals but did not always get it. Dirty hopsitals are a big concern. Patients are concerned at mixed sex wards.'*

The management structure overseeing this integrated portfolio of FM services typically includes a Director of FM or Head of Department, senior managers for groups of

services (for example, estates or hotel services) and operational managers responsible for one or more services (for example, maintenance, catering and/or cleaning and housekeeping). I have chosen within this study to generically term all members of the FM management team 'FM managers'. This term does not differentiate by seniority or reporting line, but does reflect the contribution of the FM management team.

Despite this integrated management structure, service integration between estates and hotel services has proved to be difficult, with the emphasis still being placed on the creation of the built environment rather than the facilitation of the best possible patient experience (identified for the purposes of this study as the Patient Environment defined by PEAT, see Section 1.5.3).

Within the NHS, FM services were traditionally headed by managers whose role was that of an estate manager. Their role was primarily concerned with the process of controlling and planning the property assets in a strategic sense rather than that of the facilities manager who is concerned with the servicing and maintenance of occupied buildings and the control of costs associated with that (Balch 1994). However, time has seen the agenda change for the FM manager with the impact of the changes within the NHS, growth of consumerism, and the need for better financial controls and people management. This has resulted in differing ways of managing FM being introduced into the NHS, and the FM managers of today needing different skills to those of their predecessors.

The difference required of the role of the FM manager was reflected by NHS Estates (1996), who set out the three principle aspects of FM as:

- a supporting management function to the core business of an organization;
- it focuses on the interface between the physical workplace and people;
- requiring a multi-skilled approach.

NHS Estates went on to say that FM was a human resource issue, not only concerned with forming excellent built environments, but developing cultures through effective FM teams. They called for a move away from the concept of the FM manager as part of the team who manage the site, towards a role in which the FM leader works with his/her team to create the environment in which other teams work. It is interesting to note that at that time NHS Estates were not recognising the impact of FM on patient services. That was to come later, and from other influences, as the FM service started to mature.

Research supports the idea that the FM manager's role has changed from one of technical management to general management, thus becoming more strategic. Studies have been undertaken that show the seniority of the person leading the FM team has increased over time. In 1994/5 the Centre for FM at Strathclyde Business Centre carried out a study that looked at the FM practice in the NHS (Houston and McFadzean 1995). They looked across the FM organisation, tools, resources, and training and education. Identifying the reporting structure as part of the FM organisation, they found that FM had direct access to the board, with 58% of respondents saying that the FM lead reported to the chief executive, and a further 23% saying that the FM lead reported to a director. This seniority of the management team within the NHS also fell under scrutiny when Rees, Akhlaghi and Smith (1997) identified four types of Senior Manager that existed in 1995. These were:

- a Board Member;
- a Member of the Trust Management Team;
- reporting to a Board Member;
- reporting to a member of Trust Management Team.

Acute Trusts were more likely to have the FM manager as a member of the Trust Board. The research team then built on the findings from 1995 by carrying out a comparison with information in 1997 (Rees, et al 1997). The following was found:

- NHS Trusts had increased in size, largely due to merger;
- There had been an increase in the number of FM departments within Trusts (from 74% to 82%);
- There was an increase in the number of FM Directors on the Board (from 9% to 20%);
- The number of FM managers who sat on the Trust Management Group had fallen (from 87% to 80%) - the researchers felt that this had a negative impact for the FM manager in terms of involvement and decision making;
- Acute Trusts not only had the highest percentage of FM departments, they also had the highest number of FM Directors who were Board members.

Further emphasis has been put upon the modernisation of structures, working methods and capabilities of managers in all areas of the NHS following the launch of the NHS Plan (2000) and its requirement to deliver fundamental change. It is now recognised that good healthcare environments have a powerful effect on patients and staff. They can enhance clinical outcomes and patient recovery and improve staff working lives.

FM managers have not escaped the call for change contained within the NHS Plan; indeed the NHS Plan provided a rebirth of the FM agenda and thus an opportunity to bring it forward onto the Corporate Agenda as business critical, rather than a low risk support service (Price 2004).

Estates and hotel services are beginning to be known as 'hard' and 'soft' FM respectively by those wishing to do away with old boundaries and encourage integration. However, this terminology continues to recognise the traditional differences in the services provided across the portfolio and difficulties continue in integrating the estates and hotel services. For example, in 2000 the King's Fund, supported by the Department of Health, launched a programme known as the Enhancing the Healing Environment Programme. Its overall aim was to encourage and enable nurse-led teams, working in partnership with colleagues and service users, to make practical improvements in the environment in which they delivered care. The programme has won accolades for changes made to the built environment of hospitals, for example corridors, gardens and artwork in waiting and clinical spaces (Hoban 2004). Talking of this programme Palmer (2004) talks of drab, depressing and dirty areas being turned into colourful, cheerful and clean spaces that can do wonders for patients and staff. But nowhere in the rhetoric do we hear the conversation around how those spaces will be maintained and serviced at the standards required by PEAT once they have been created, thus preventing them from becoming the drab and dirty spaces of the future.

As discussed in Section 1.5.3 The Patient Environment Action Team Initiative, to deliver a high standard of Patient Environment, FM management teams need to adopt an integrated approach across the FM service portfolio to meet the standards required. With the discussions above in mind, this thesis seeks to understand how some Trusts have consistently delivered high standards across a time period from 2000 to 2004.

1.7 Conclusion

By discussing the content of the thesis, setting out my positionality and the background within which NHS FM managers are working, I have used this initial chapter to set the stage upon which the remainder of the thesis can be played out.

At a time of great change within the NHS with the renewed emphasis on patient choice and the patient as the consumer/customer we see FM being offered a part in the

strategic rhetoric, with star rating including the achievement against PEAT scores[15]. The FM manager has become more senior and in many cases part of the Top Team, transiting from technical expertise to general management. To perform in this new world the FM manager must refocus from the fragmented introversion of technical proficiency to the integrated extroversion of the patient experience.

I use the next chapter as the scene in which the methodology, and the reasons, used to establish the Research Group are discussed and to consider the steps taken to identify the Trusts within this Group. I also discuss the naming of the Research Group, and move on to lay out the desk research that I carried out to ascertain whether there were external influences or Trust characteristics that were shared between the Trusts in the Research Group and could have impacted on the FM Managers when delivering the Patient Environment.

[15] See Section 1.5.2 regarding FM and the Trust performance measures

Chapter 2 Desk Based Study

2.1 Introduction

Figure 1.1 signposts the reader to the position that Chapter 2 Desk Based Study takes in the research route.

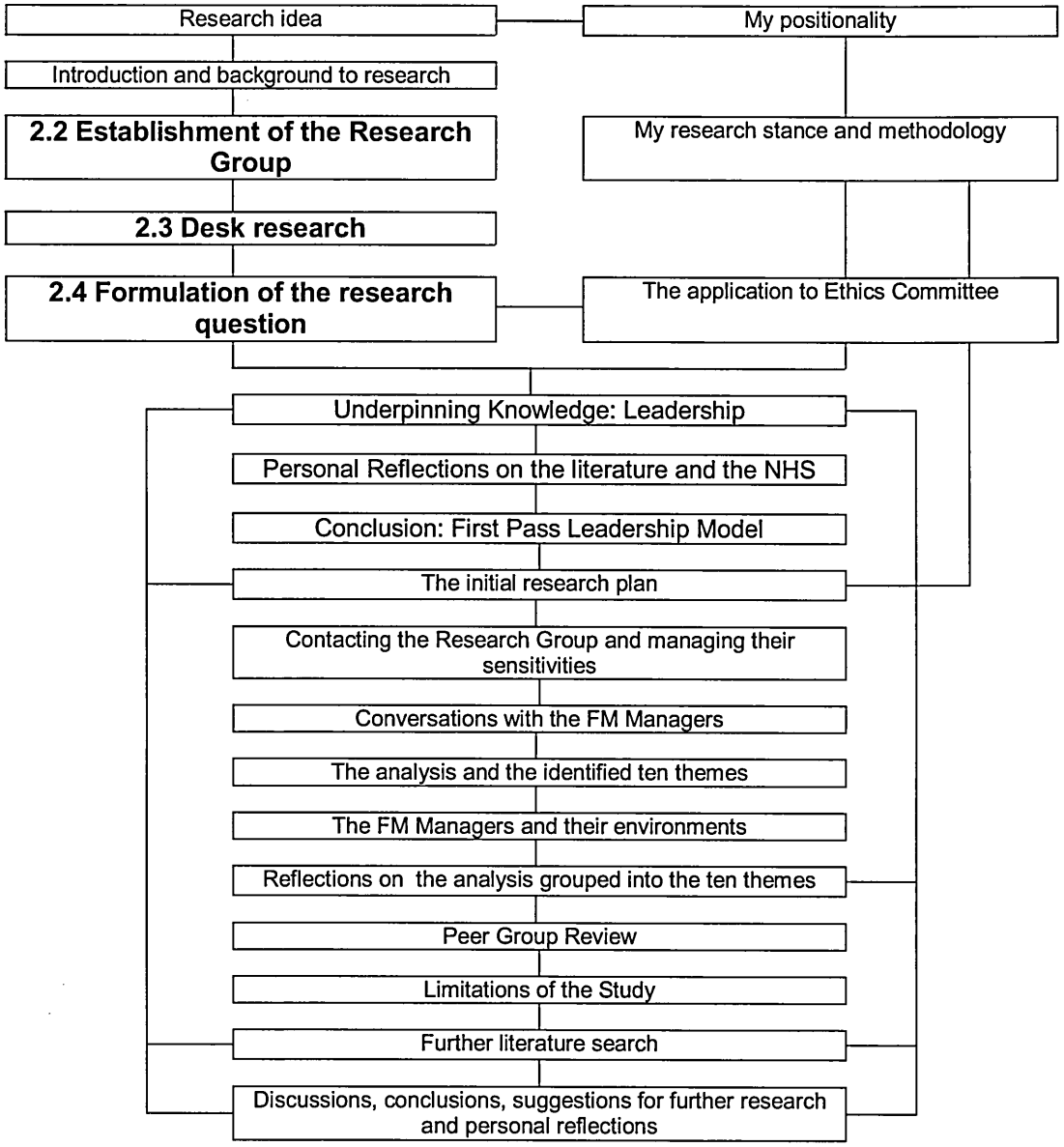


Figure 2 The Thesis set out in the Research Pathway

In Chapter 1 Introduction and Background, I laid out my Research Idea that asked why some departments of Facilities Management have managed to achieve significant

improvements in the Patient Environment and others have not. I laid out the research pathway that I would use to study this phenomenon and talked of the intentions of the thesis. I stated that I, as the researcher, would make an impact on the study and laid out my positionality by depicting my epistomology and ontology.

I brought Chapter 1 to an end by looking at the background information relevant to my study, the main thrusts of which were: the reform which the Government sought through implementation of the NHS Plan (2000); the targets that have been set to evidence this change; the changing role of the manager who works within Facilites Management; and, the impact of the NHS Plan (2000) on the Facilities Management work arena.

This chapter looks at the establishment of the Research Group and the criteria used to do that. It also lays out the desk based research that took place in an effort to ascertain whether the environment in which the FM Managers in the Research Group worked could offer advantages in their challenge to deliver consistently high standards of Patient Environment. Following the conclusions of the desk research I finalise the research question which underpins the remainder of the study.

2.2 Establishing the Research Group

2.2.1 The Criteria Used

The criteria used to establish the research group were:

- An acute Trust in England offering non specialist services;
- The achievement of green Patient Environment Action Team (PEAT) scores from 2001 to 2003;
- The achievement of good or excellent PEAT scores for 2004.

2.2.2 The Reasons for the Selection of Criteria

An acute Trust in England offering non specialist services

Acute Trust

There are a number of reasons to focus this research within acute Trusts in the NHS. These are:

- As a researcher, I bring with me my knowledge and experience of FM within the NHS. This knowledge and experience is largely based within the acute sector.

The acute sector is the area of the NHS that provides secondary care usually in response to an acute need, either elective or emergency; the resulting healthcare is traditionally provided in a hospital setting. As I will further explain in later chapters, my knowledge and experience is to be used as an integral part of this research; therefore I felt it most beneficial to the NHS to be researching within the sector where my knowledge and experience is most relevant.

- The acute sector is the area within the NHS (perhaps second to Primary Care) that most people will recognise as an entity. This will mean that the content of my research would appeal to, and be useful to, a greater audience (both within and without the NHS) than if it were focusing on a more specialist, complex and less known area of the NHS.
- The acute sector is the area where the impact of the Patient Environment upon the health of the patient is gaining recognition, and the importance of that impact is starting to be understood.
- The acute sector Trust Star Ratings[16] and the elements relating to FM are also attracting public and political attention. Thus, I feel it is the right time for the acute sector to hold a dialogue around the lessons that might be learnt from the Trusts that are receiving recognition (albeit low key) for the achievement of good and excellent standards of Patient Environment from the Department of Health.

Trusts in England

The NHS in Wales and Scotland is different from that in England, particularly since the introduction of the Scottish Regional Government and Welsh Assembly. Although high level Government policy may be common throughout the United Kingdom, structures, interpretation and implementation of policy can be different in the four nations (for example, funded personal care in Scotland). With these potential differences in mind, it is appropriate to take only the English Trusts that are working to the same Department of Health guidance and are within centrally governed communities, thus providing findings relevant to the large group of non specialist acute Trusts in England.

There are many debates within the NHS around the differences between acute Trusts (e.g. urban and rural catchment areas, the effect of poverty on disadvantaged

[16] See Chapter , Section 1.5.2

communities, etc.). However, I decided that all acute Trusts would be used as the foundation for identifying the research group, and that the external factors that might impact on results should be explored as part of the desk based research[17].

National and regional NHS structures (e.g. Strategic Health Authority areas) are also an important and accepted consideration when looking at the NHS. However, for this study to have true impact it needed to look across the whole of England, rather than selecting one geographical area or region, which could then be claimed as atypical.

Non Specialist Services

I felt that studying the group of acute Trusts offering non-specialist services was more appropriate as the majority of acute Trusts within England manage general (non-specialist) hospitals. Thus these Trusts have the greatest impact on the Patient Environment and face the challenges of seeking higher volume throughput and increasing demands for health specialism.

Increased number of patients using hospitals are being evidenced by increases in bed usage and increases in day surgery, with waiting lists for treatments being reduced as a requirement of the NHS Plan (2000). This has also resulted in additional staff being recruited, again increasing the total number of people using hospitals which impacts on the building programmes and the requirements for upkeep if standards are to be maintained.

Against this backdrop of extra activity, clinicians are being encouraged to become more specialist, for example the practice of general surgery is reducing in favour of specialist surgery (for example, urology, hands, breasts, etc). This is challenging because clinicians are required to have a certain volume of throughput in order to maintain their skill level and smaller hospitals may have difficulties in providing that volume for specific specialties.

On another note, funding for specialist acute services may be derived in different ways than for the non-specialist Trust, for example, more complex surgery brings higher tariff rates and 'famous' hospitals bring high charity activity, donations and television or film

[17] See Section 2.3

income. The complexity of specialist services and additional income will impact on how the Trust spends its money on environments, the age of the environment, the standards applied (for example hygiene standards for open-heart surgery), length of stay (for example slower turn-over of beds results from taking sicker patients with more complex needs) and the technology available for use. This affects the expenditure of both capital and revenue funding – thus affecting the building and fitting out of environments and their on-going upkeep. These differences would inevitably impact on the research findings, and allow the discussion to become focussed on finance and its impact, rather than the wider and more holistic picture around the Patient Environment.

In addition, if acute Trusts offering non specialist services were studied, the findings would be useful to the large group of general acute Trusts, and would potentially benefit a wider section of the population who use their local NHS services provided by their local hospital. Thus I determined to exclude the specialist Trusts from the potential Research Group.

Green Patient Environment Action Team (PEAT) scores from 2001 to 2003 and Good or excellent PEAT scores for 2004

I decided that the PEAT standard for the Patient Environment would be the most appropriate to use when measuring the Patient Environment. There are a number of reasons for this decision:

- There were clear standards for each element of the patient environment. These standards are set by the Department of Health (originally by NHS Estates and more latterly by the National Patient Safety Agency), and were drawn up in consultation with NHS Trusts, thus making them a recognised mechanism for measuring standards;
- The standards dealt with all elements of the patient environment and do not recognize differences in roles and reporting structures. For example they include areas of nursing responsibilities, do not focus only on the built environment, and include the services that form the immediate patient environment, such as linen and cleanliness of toilets;
- There were clear and objective scoring mechanisms, although these may not be perfect. (It is worth noting that there was a lack of belief in the objectivity in the scoring mechanism as Trusts were given 24 hours warning of the inspection visit and 'targeted cleaning and maintenance' could take place. When the external inspection was superceded by internal inspection the responsibility for

objectivity passed to the Trust and efforts were made by most Trusts to try to ensure this, for example, inclusion of non-Trust members such as volunteers in the inspections etc);

- Audit teams were made up from a number of people from different backgrounds (for example FM managers, estates managers, infection control nurses, executive directors and non-executive directors, etc.) and these people could be from other organisations within and without the NHS;
- External audits and verification visits took place;
- Patient representatives were included;
- Information was routinely reported to Trust Boards;
- Scores were calculated by a third party, NHS Estates or the National Patient Safety Agency, giving a sense of objectivity;
- The PEAT scores used for the research were published on the Department of Health Web Site, and available to the general public;
- Scores against the standard were available from the inception of the initiative up to the commencement of my field research and thus proved consistency in delivery over time.

At the peer reviews that took place during my research, some peers have voiced their feeling that the standards and their measurement have fallen into disrepute over the period they have been in use. They feel that they favour the more affluent or the smaller trusts and that scoring mechanisms have become politicised. However, when I asked whether a better alternative was available, there was general consensus that this was a national system of standards and scoring, indeed the *only* national system, and it was recognised and understood within the NHS and was therefore the appropriate system to use.

2.2.3 The Steps Taken to Identify the Trusts

The following description shows the steps taken to identify the Trusts that would form the research group using the selection criteria laid out above.

Step One – Identification of Acute Trusts

A list of acute Trusts in England was obtained from the NHS UK website 2005.

Step Two – Identification of Acute Non Specialist Trusts

All acute Trusts offering non-specialist acute services were then extracted. The nature of the Trust was established firstly by the name of the Trust (e.g. Great Ormand's Street Hospital for Children being a specialist Children's Trust). All Trusts, including the self evident, were then checked against the Trust's web site to establish what services they delivered. This information was further checked against Binley's Directory of NHS Management (2004/05) which gives information on the types of Trusts and the services provided. From this information an initial list of acute non-specialist Trusts was compiled. This search resulted in the identification of 183 Trusts.

Step Three – Identification of Highest PEAT Scores 2001 to 2003

This initial list was then searched for Trusts that had the highest (green) PEAT scores for the first and second inspection in 2001 (April and September) and then again in 2002 and 2003. This search resulted in the identification of 21 Trusts.

Step Four – Identification of Good or Excellent PEAT Scores 2004

In 2004, the PEAT scoring methodology changed from a traffic light system of red, amber and green, to a poor, average, good and excellent score – thus introducing four quartiles of measurement rather than three. The published results for this year were checked for Trusts having excellent scores at all their hospital sites. These results were then checked against those Trusts previously identified as having green PEAT scores between 2001 and 2003. (This study does not study fluctuations in standards, it looks at those Trusts that have consistently achieved high standards). Only one Trust met this criterion. This was felt to be too small a study to be meaningful and the criteria were widened to include both 'good' and 'excellent' scores in 2004. This was appropriate as the Department of Health accepts an 'excellent' or a 'good' score as an acceptable standard for the patient environment when awarding the star rating to a Trust. I then checked these results against those Trusts previously identified as having green PEAT scores between 2001 and 2003. There were16 Trusts that met the criteria, forming an acceptably sized group to study (See Figure 2.1).

2.2.4 *Naming of the Research Group Members*

Each Trust in the group was issued a personal identification number and name in order to ensure anonymity, thus facilitating any sensitive[18] discussions that may take place during the course of the research and protecting any confidential information given[19].

Identification Number	Identifier Name
1	Bourdin
2	Rhodes
3	Harriott
4	Stein
5	Oliver
6	Smith
7	Ramsay
8	Williams
9	Whitingstall
10	Lawson
11	Slater
12	*Martin*
13	Garcia
14	Rosengarten
15	Blumenthal
16	Carrier

Figure 2.1 Trust identification number and name

The numbers were to be used to identify any paperwork that might pass between the Trusts and me. The names were to be used to make identification simple while writing the thesis, and enhance the reading quality of the document and are the surnames of celebrity chefs, taken from books sitting on my kitchen bookshelf.

It came to my attention when checking the type of Trust (see Section 2.3.1), that I had included Martin that was a specialist Trust and did not therefore meet the criteria used for selection. The Research Manager from the Trust, who contacted me to say that they were a specialist Trust and did not therefore meet the criteria, verified this and I removed Martin from the Research Group.

2.3 Desk Study of the Trusts Within the Research Group

It is sensible to believe that a number of external influences might offer an FM department an advantage in providing a successful Patient Environment. Indeed,

[18] See Chapter 4 for an account of the sensitivities that emerged later in the study

although this desk research had already been undertaken by the time the conversations with the FM Managers took place, the FM Managers later called attention to the question of these influences, claiming that they were helped by a certain factor, perhaps the size of the Trust, the affluence of the population or the situation of the hospital[20].

In an effort to understand whether a pattern of influences existed that might facilitate the delivery of high standards of Patient Environment by the FM Managers within the Research Group, I progressed my study by carrying out some desk research on each of the Trusts. I also wished to establish some background information on each Trust so that I had a little knowledge upon which I could base any further enquiries.

The advantage of this methodology was that the desk research was unobtrusive and did not involve the Research Group, who would be unaware of the ongoing research. It would also be quick and inexpensive and could allow for a need to illustrate change across time if required. The disadvantages lay in the problem of interpretation (for example, links between wealth and good health in a community) and that the desk research would be limited by the number of topics to which I could gain access and thus show the 'public' face of the Trusts[21]. However, the advantages of carrying out this initial research outweighed any of the disadvantages.

I used information published on the National Statistics website, NHS websites, Binley's Directory and other such published public information to carry out the research on the Trusts. My examination of this information does not constitute a piece of work that will show statistical significance, but is merely a comparison of situations.

In order to understand any advantages that the Trust characteristics might offer to the FM management team, I looked at:

- The type of Trust
- The size of the Trust
- The number of hospitals in the Trust
- The age of the Trust

[19] It has been agreed by my Supervisor and the University Ethics Committee that I can provide the examiners with a list of the names of the Trust in the Research Group should they require it.
[20] See Chapter 5 for an account of these conversations
[21] See Chapter 6 for further discussion on this topic

- Geographical spread

(Further explanations on these choices is given within Section 2.3.1)

I then considered any advantages that the Trusts within the Research Group might enjoy from the population within its catchment area. These I considered in terms of:

- The population size and density
- The age profile of the population.
- Economic activity
- The affluence profile of the population
- The health profile of the population

(Further explanation regarding these choices is given in Section 2.3.2)

2.3.1. The Trust

The Type of Trust

One of the criteria when setting up the Research Group was that they offered non-specialist acute services. (My reasons for this decision are laid out in Section 2.2.2). This means there were no influences on this group from differing service portfolios as they were identified from the group of acute non-specialist Trusts across England.

The Size of the Trust

The size of the Trusts within the Research Group were relevant to my desk based study since a large Trust may have more resources or more skills to bring to bear on the Patient Environment, than a smaller Trust. However, it may be possible for a smaller Trust to achieve more ownership and teamwork across the organisation because of its size.

It was also suggested by some of the FM Managers in the Research Group that the size of the Trust had a bearing on their success. They felt that the size of their Trust made the job 'do-able', and doubted that larger Trusts would be so successful.

In order to ascertain the size of the Trusts I used the information published by the NHS Commission (2006). This information allocates acute Trusts into groups according to their size. The groups are:

- Acute Specialist (not relevant to this study due to the criteria used to identify Trusts)
- Acute Teaching (not relevant to this study due to the criteria used to identify Trusts)
- Large acute
- Medium acute
- Small acute

By using the listing I was able to assign each Trust in the Research Group to a designation of large, medium or small. (See Figure 2.2)

Another traditional method for establishing the size of an acute Trust is to look at the total number of beds. I was able to ascertain this information by study of websites of the Research Group and use of Binley's Directory of NHS Management (2004-5). As an additional indicator of the size of the business, I took the annual income of each Trust for the year 2004/05; this information was contained in Binley's Directory of NHS Management and published on Trust websites within their Annual Reports. These three measures give a good indication of the size of each Trust within the Research Group.

The results listed in order of number of beds, (see Figure 2.2) show that the Trusts making up the Research Group are spread across the large, medium and acute categories, with bed numbers between 354 and 1,192, and incomes of between £52M and £202M. Given the spread in size (designation, bed numbers and income), I believe that size is not a deciding factor when considering the consistent delivery of high standards of Patient Environment by this particular group of Trusts.

Number of Hospitals in the Trust

I might suggest that a Trust with only one hospital to maintain should be able to achieve higher standards than Trusts where resource and attention is spread across more than one site. Conversely, I might argue that a Trust with more than one hospital has more opportunity to use the resources flexibly or more efficiently, and therefore had an advantage over Trusts with single sites.

Name of Trust	Designation of Size of Trust	Number of Hospitals	Number of Beds	Income 2004/05 £000 per annum
Lawson	Small Acute	1	354	68,189
Oliver	Small Acute	1	433	83,419*
Smith	Small Acute	1	445	58,253
Carrier	Small Acute	1	465	98,527
Bourdin	Small Acute	1	498	92,162
Blumenthal	Small Acute	1	501	90,622
Stein	Medium Acute	1	600	111,965
Harriott	Medium Acute	1	620	107,688
Williams	Small Acute	2	630	52,100
Ramsay	Medium Acute	1	632	106,599
Slater	Medium Acute	1	754	99,021
Rosengarten	Large Acute	2	883	180,570
Garcia	Large Acute	3	1020	202,217
Rhodes	Large Acute	2	1168	178,487
Whitingstall	Large Acute	5	1192	184,586

Figure 2.2 Size designation, number of hospitals, bed numbers and annual turnover of Trusts in the Research Group, ranked by bed numbers
*Oliver turnover figures only available for year 2003/04

Using the Trusts' websites, I was able to check the number of hospitals that operated within each Trust. Again, I was able to make a further check using Binley's Directory of NHS Management. Using this information, Figure 2.2 shows the number of hospitals in each Trust. The information does not consider the use of space on sites that are not attributed to the Trust (for example, a clinic in a Primary Care Trust property), as these are not sites which will be owned by the acute Trust and will therefore not be included in any of their reports.

Whilst there are a number of single site Trusts – 11 out of 16 – the remaining 5 Trusts have between 2 and 5 hospitals per Trust. Thus, I feel that there is sufficient evidence to show that Trusts within the Research Group are able to attain excellent Patient Environments regardless of the number of sites owned by the Trust.

In later conversations, some of the FM Managers in the Research Group who worked at Trusts that had only one hospital site said that if an FM manager had only one hospital to concentrate on, s/he would be more focussed and therefore more successful. The above findings do not support this contention.

The Age of the Trust

Another factor that I felt warranted consideration was whether Trusts had been stable legal entities, or whether they had been reconfigured and new management structures had been installed during the period of my research. If the Trusts had been

reconfigured and new management teams had been installed, it is possible that the new organisational or management structures might have been instrumental in the delivery of high standards. A search of the Trusts' websites, Binley's Directory (2004-05) and a Health Services History (2006) website gave the history of the Trusts. The findings are shown in Figure 2.3. During the period of research, the Foundation Trust legislation was brought in by the Government. Figure 2.3 also includes the date of inception for those Trusts within the Research Group that now have Foundation Status.

The findings show that 13 out of 15 Trusts in the Research Group were formed during the period 1991 to 1994. This was the period when NHS Trusts were being formed following the passing of the NHS and Community Care Act 1990, with the first NHS Trusts being set up in 1991 and others following over a three year period. However, the later formation dates of Whitingstall (1998) and Oliver (2000) indicate that these two Trusts have been subject to merger or reformation since the inception of NHS Trusts. This shows that the majority of the Research Group has enjoyed relative stability in terms of organisational identity, with Oliver and Whitingstall being the exceptions.

Name of Trust	Date Trust Formed	Date of Foundation Trust Status (NHS Monitor 2005)
Blumenthal	1991	N/A
Bourdin	1992	N/A
Carrier	1993	04/2005
Garcia	1992	N/A
Harriott	1993	01/2005
Lawson	1991	N/A
Oliver	*2000*	*N/A*
Ramsay	1993	08/2006
Rhodes	1992	04/2005
Rosengarten	1992	04/2004
Slater	1992	N/A
Smith	1992	01/2005
Stein	1994	04/2004
Whitingstall	*1998*	*N/A*
Williams	1993	N/A

Figure 2.3 Formation of NHS Trust and date of Foundation Trust status for Trusts within the Research Group

Another change that has taken place since the inception of NHS Trusts that needs to be taken into consideration is the formation of Primary Care Trusts. These organisations often resulted in combined Acute and Community Trusts giving away certain parts of their business so that the Acute Trust became more focussed on the acute needs of the population and Community services were provided by Primary Care. This is true of Smith Trust, and means that although the Trust has not become a new organisation, it has been through considerable structural changes. This is highlighted in Chapter 5 The Conversations with FM Managers when Smith talks about the effect of this downsizing and how it has contributed to its success.

The information shows that whilst stability might be a contributing factor to success, the changes at Oliver and Whitingstall indicate that it is possible for success to be delivered even when organisational identity is being challenged and Smith's history shows that success can be maintained during a period of significant organisational change. So, whilst stability might assist in the delivery of high standards of Patient Environment, it seems that high standards can still be delivered during periods of change.

Since the inception of PEAT in 2000, barring Whitingstall's changes to organisational identity, the only change to organisational identity is the gaining of Foundation Status by 7 of the Trusts. The significance of this is that these Trusts had to meet a range of criteria of success, of which PEAT scores were one, before they could apply for Foundation Trust status. Furthermore, it is the successful management team that make the application and take the organisation into new ways of working. This differs from the situation found in the case of a merger between Trusts, when there is very often a new Chief Executive and considerable change within the Top Team.

It is interesting to note that during the later conversations some of the FM Managers in the Research Group had expressed an interest in stability, feeling that it contributed to their success. Furthermore, some of the FM Managers reflected further on the link between Foundation Trust status and their ability to maintain a high standard of Patient Environment. However, although many of the Trusts have existed as a single entity for a length of time, thus giving a feeling of stability, the level of change evident in the research shows that it is possible to deliver high standards of Patient Environment even through these periods of considerable organisational change that inevitably bring instability.

Geographical Spread

Whilst looking at some of the possible contributing factors, I also felt I should deal with one raised at one of my peer reviews. There was a feeling that PEAT was very political, and that there may be an element of 'one in each area' to satisfy the political agenda. From work in identifying the Research Group I knew that this was not the case, with the absence of Trusts in the London and North East Regions disproving the political spread theory. However, in further considering this point of view, and knowing where the Trusts were located, I questioned whether the opposite was true; were there areas of the country where successful Trusts predominated? To understand whether the Research Group members were evenly spread around England, or predominately grouped in one area, I allocated members to the Regions of England as defined by the National Statistics Office (Census 2001). As can be seen in Figure 2.4, there are no Trusts falling into the North East or London Regions, while a group of 5 Trusts fall into the South West of England and 3 Trusts appear in the West Midlands group with the remainder are spread across the other Regions. In order to try to gain an understanding of the groupings, I also checked the total number of acute Trusts in each Region (NHS UK 2006).

The spread of Trusts may indicate a high level of achievement in the South West and West Midlands, but this picture changes when it is considered alongside the total number of Trusts in the Regions. For example there are 5 successful Trusts in the SouthWest which appears to be a high number, but there are 39 Trusts in the region, with this region having more Trusts than any other in England. I do not therefore believe that there are significant groupings of Trusts delivering high standards of Patient Environment in certain Regions nor a politically orchestrated spread of such Trusts across England.

Region	Total number of Trusts in Region	Trusts in Research Group	Regional Total divided by Research Group
North East	8	Nil	0
South East	14	Oliver	14
East Midlands	8	Harriott	8
East of England	18	Bourdin, Ramsay	9
Yorkshire and Humberside	15	Smith	15
North West	29	Stein, Whitingstall	15
South West	39	Lawson, Slater, Garcia, Rosengarten, Blumenthal	8
West Midlands	20	Rhodes, Carrier, Williams	7
London	32	Nil	0

Figure 2.4 Geographical Spread of Trusts within the Research Group

2.3.2 The Population

Having looked at some key organisational characteristics for each of the Trusts in the Research Group, I also felt it important to understand the population that they served. It may be that a certain size or profile of population resulted in a successful Patient Environment, for example, if the population is more affluent (and therefore healthier), they may make less use of the hospital, and consequently the Patient Environment suffers less wear and tear? Maybe providing good environments in inner city hospitals serving a more densely populated area is more difficult? Maybe older populations use their hospitals more and are more demanding of better standards because they are more reliant on services?

In order to look at these and other questions in more depth I needed to ascertain the population served by each Trust and some demographic detail for each. At this point I must be clear that this research is not intended to be an in depth study of the profile, or health, of the population within the Research Group. It is a high level view taken to identify any similarities that might impact on the Trusts' ability to achieve the desired standards.

A Trust will draw its patients from a catchment area determined by the purchasing patterns of the Primary Care Trusts (PCT's), who mainly buy non specialist acute services from their local Trust. By identifying the catchment area for each PCT, it became possible for me to identify the Trust catchment area. The information for this exercise was taken from the NHS website 'NHS in England'. This allowed a search to be carried out by selecting the Strategic Health Authority (SHA) for the area in which the Trust is situated. From this the major purchasing PCT's for each Trust were identified by selecting maps on the NHS website and cross referring to the PCTs' websites, I defined the catchment area for non-specialist acute Trusts within the Research Group. This methodology does not allow for seasonal migrations such as holidaymakers and migrant workers. I established the population profile for each catchment area in terms of:

- Population size and density
- Age
- Employment
- Affluence
- Health

Population Size and Density

Figure 2.5 shows the size of the population within the catchment area of each Trust. It shows the smallest Trust as serving a population in the region of 146,000 people and the largest serving a population in the region of 1,861,000, with the other Trusts ranged between. Thus the figures show that there is no correlation between the size of the population and the success in standards of Patient Environment demonstrated by this group of Trusts.

Name of Trust	**Size of Population**	**Population Density Number of people per hectare**	
	000's	By PCT	Overall mean figure
England			*3.77*
Bourdin	382	PCT 1 – 1.53	
		PCT 2 – 4.05	2.79
Rhodes	1,861*	PCT 1 – 41.71	
		PCT 2 – 48.91	
		PCT 3 – 21.20	
		PCT 4 – 36.44	
		PCT 5 – 11.19	
		PCT 6 – 39.32	
		PCT 7 – 24.38	
		PCT 8 – 6.16	
		PCT 9 – 4.98	26.03
Carrier	310+	PCT 1 – 2.33	
		PCT 2 – 2.06	2.20
Stein	233	PCT 1 – 1.97	
		PCT 2 – 9.24	6.59
Harriott	286	PCT1 - 25.55	
		PCT 2 - 2.27	13.91
Oliver	225	PCT 1 – 43.29	43.29
Smith	205	PCT 1 – 0.82	0.82
Ramsay	311	PCT 1 – 2.55	
		PCT 2 – 1.37	
		PCT 3 – 5.22	3.05
Williams	438	PCT 1 - 8.24	
		PCT 2 – 2.33	
		PCT 3 – 2.06	4.21
Whitingstall	308	PCT 1 - 1.41	1.41
Lawson	146	PCT 1 - 0.71	0.71
Slater	178	PCT 1 - 11.36	11.36
Garcia	501	PCT 1 – 1.99	
		PCT 2 – 0.86	
		PCT 3 – 1.99	1.61
Rosengarten	341	PCT 1 – 1.66	
		PCT 2 – 3.83	
		PCT 3 – 0.61	2.03
Blumenthal	368	PCT 1 – 0.81	
		PCT 2 – 1.84	
		PCT 3 – 2.23	1.63

Figure 2.5 The population numbers and density of Trusts within the Research Group
*other hospitals outside the Research Group share the same catchment area

The population density for each PCT area is shown separately as this gives more information than the mean of the PCT's areas within a Trust catchment area (although these are also shown). Some Trusts are in very rural areas and serving small population groups, for example, Lawson serves a population of 140,000 with a density of only 0.71, the lowest in the group. Several Trusts appear to have a centre of population but also serve the rural areas around that centre, for example, Harriott has a mean population density of 13.91, with one PCT area having a population density of 25.55 and their second having a population density of 2.27. Rhodes and Oliver clearly have some catchment areas with very high density.

By comparing the different catchment areas I could see that the Research Group contained a wide spectrum of sparce, dense and combined populations, deriving from catchment areas comprising of rural, town or inner-city locations. This discounts the idea that a certain type of location offers the Trust within the Research Group an advantage in delivering high standards of Patient Environment, although the later conversations with the FM Managers at these Trusts showed that they believed that geography could contribute to their success.

The Age of the Population

I then considered the age of the population as an older population may access health care services more frequently than a younger one. Conversely, younger populations may access a different spectrum of health care services, for example, maternity services or paediatric care. The findings of this examination are shown at Figure 2.6.

Trust ID	Mean age	Variation from English mean	Median age	Variation from English median
England	*38.60*		*37.00*	
Blumenthal	43.50	+4.9	44.33	+7.3
Bourdin	37.77	-0.8	36.50	-0.5
Garcia	42.09	+3.5	43.00	+6.0
Harriott	40.32	+1.7	39.50	+2.5
Lawson	42.19	+3.6	43.00	+6.0
Oliver	38.16	-0.4	37.00	0.0
Ramsay	42.91	+4.3	44.00	+7.0
Rhodes	37.49	-1.1	36.11	-0.9
Rosengarten	42.00	+3.4	42.33	+5.3
Slater	41.86	+3.3	41.00	+4.0
Smith	40.71	+2.1	41.00	+4.0
Whitingstall	40.52	+1.9	40.00	+3.0
Williams	39.07	+0.5	38.67	+1.7
Carrier	39.69	+1.1	39.50	+2.5

Figure 2.6 Mean and Median Age of Trusts within the Research Group

Using the Neighbourhood Statistics website (Age Structure - KS02), I ascertained the mean and median age of the normal resident population of the area at the time of the 2001 Census. The Neighbourhood Statistics website defined the mean age as the sum of each person's age last birthday, in single year counts, divided by the number of people, and the median age as the middle value when all ages are arranged in order from the youngest to the oldest.

Whilst it would appear that a number of Trusts are serving a population that are a little older than the mean and median for England, there are still Trusts within the Research Group that have populations with age means and medians that are the same or below the England figures. Therefore, I do not believe that the age of the population has a significant impact on the Research Group.

The Affluence of the Population

Higher levels of affluence are known to result in lifestyles that in turn bring better health. This might result in less call for health services and thus less demand on local hospitals. This could extrapolate to the standard of Patient Environment in that less use would result in standards being more easily and cheaply maintained. A more affluent society may also have an expectation of higher standards of Patient Environment. In order to establish an indicator for affluence, I looked at the National Census 2001, using the information regarding Approximated Social Grade (UV50) in order to understand the Socio Economic Classing of the catchment areas from which the Research Group were taking their patients. I took a base of all people aged over 16 within each PCT catchment area. These were then divided into AB, C1, C2, D and E Socio-Economic Classes, thus falling into the following categories:

- AB: Higher and intermediate managerial / administrative / professional
- C1: Supervisory, clerical, junior managerial / administrative / professional
- C2: Skilled manual workers
- D: Semi-skilled and unskilled manual workers
- E: On state benefit, unemployed, lowest grade workers

Trust	PCT	All People (16 +)	AB		C1		C2		D		E	
		Apr01	Apr01	%	Apr01	%	Apr01	%	Apr01	%	Apr01	%
	England	*38,393,304*	*8,520,649*	*22.19*	*11,410,569*	*29.72*	*5,780,577*	*15.06*	*6,538,308*	*17.03*	*6,143,201*	*16.00*
Garcia	PCT 1	125,685	22,588	17.97	37,817	30.09	24,308	19.34	20,138	16.02	20,834	16.58
	PCT 2	126,066	19,154	15.19	37,789	29.98	24,376	19.34	22,283	17.68	22,464	17.82
	PCT 3	148,731	25,207	16.95	46,572	31.31	26,401	17.75	25,373	17.06	25,178	16.93
	Total	**400,482**	**66,949**	**16.72**	**122,178**	**30.51**	**75,085**	**18.75**	**67,794**	**16.93**	**68,476**	**17.10**
Rosengart	PCT 1	95,549	18,405	19.26	33,339	34.89	14,200	14.86	13,290	13.91	16,315	17.08
	PCT 2	102,213	21,544	21.08	33,104	32.39	14,446	14.13	18,167	17.77	14,952	14.63
	PCT 3	73,046	13,503	18.49	22,003	30.12	14,909	20.41	11,481	15.72	11,150	15.26
	Total	**270,808**	**53,452**	**19.74**	**88,446**	**32.66**	**43,555**	**16.08**	**42,938**	**15.86**	**42,417**	**15.66**
Blumentha	PCT 1	66,608	14,514	21.79	21,218	31.86	11,451	17.19	9,096	13.66	10,329	15.51
	PCT 2	105,251	20,656	19.63	34,127	32.42	17,513	16.64	15,776	14.99	17,179	16.32
	PCT 3	121,433	27,309	22.49	41,343	34.05	16,377	13.49	14,762	12.16	21,642	17.82
	Total	**293,292**	**62,479**	**21.30**	**96,688**	**32.97**	**45,341**	**15.46**	**39,634**	**13.51**	**49,150**	**16.76**
Slater	**Total**	**142,682**	**31,532**	**22.10**	**47,263**	**33.12**	**22,348**	**15.66**	**19,831**	**13.90**	**21,708**	**15.21**
Rhodes	PCT 1	157,909	18,814	11.91	41,045	25.99	26,469	16.76	37,247	23.59	34,334	21.74
	PCT 2	172,937	20,424	11.81	36,610	21.17	24,691	14.28	48,482	28.03	42,730	24.71
	PCT 3	124,677	29,379	23.56	39,140	31.39	17,494	14.03	18,769	15.05	19,895	15.96
	PCT4	67,636	8,704	12.87	16,544	24.46	11,446	16.92	16,652	24.62	14,290	21.13
	PCT 5	156,376	42,608	27.25	48,356	30.92	20,149	12.88	22,361	14.30	22,902	14.65
	PCT 6	276,328	55,822	20.20	76,256	27.60	38,426	13.91	53,427	19.33	52,397	18.96
	PCT 7	196,286	29,491	15.02	47,434	24.17	38,027	19.37	42,624	21.72	38,710	19.72
	PCT 8	126,839	31,991	25.22	36,727	28.96	20,520	16.18	20,901	16.48	16,700	13.17
	PCT 9	142,413	26,384	18.53	37,498	26.33	26,662	18.72	30,241	21.23	21,628	15.19
	Total	**1,421,401**	**263,617**	**18.55**	**379,610**	**26.71**	**223,884**	**15.75**	**290,704**	**20.45**	**263,586**	**18.54**
Harriott	PCT 1	78,695	13,698	17.41	20,552	26.12	13,328	16.94	16,150	20.52	14,967	19.02
	PCT 2	134,933	23,937	17.74	34,284	25.41	24,242	17.97	26,968	19.99	25,502	18.90
	Total	**213,628**	**37,635**	**17.62**	**54,836**	**25.67**	**37,570**	**17.59**	**43,118**	**20.18**	**40,469**	**18.94**
Bourdin	PCT 1	114,948	29,310	25.50	34,831	30.30	16,562	14.41	18,264	15.89	15,981	13.90
	PCT 2	181,085	49,150	27.14	54,722	30.22	29,370	16.22	25,085	13.85	22,758	12.57
	Total	**296,033**	**78,460**	**26.50**	**89,553**	**30.25**	**45,932**	**15.52**	**43,349**	**14.64**	**38,739**	**13.09**
Ramsay	PCT 1	72,102	9,548	13.24	20,638	28.62	13,302	18.45	14,473	20.07	14,141	19.61
	PCT 2	79,893	13,227	16.56	23,774	29.76	14,140	17.70	12,653	15.84	16,099	20.15
	PCT 3	96,572	15,529	16.08	27,109	28.07	18,119	18.76	17,082	17.69	18,733	19.40
	Total	**248,567**	**38,304**	**15.41**	**71,521**	**28.77**	**45,561**	**18.33**	**44,208**	**17.79**	**48,973**	**19.70**
	PCT 1	121,191	35,316	29.14	35,441	29.24	15,272	12.60	16,979	14.01	18,183	15.00
	PCT 2	63,890	12,924	20.23	16,999	26.61	10,160	15.90	12,984	20.32	10,823	16.94
Stein	**Total**	**185,081**	**48,240**	**26.06**	**52,440**	**28.33**	**25,432**	**13.74**	**29,963**	**16.19**	**29,006**	**15.67**
Whitingstal	**Total**	**240,404**	**47,975**	**19.96**	**71,454**	**29.72**	**40,632**	**16.90**	**41,675**	**17.34**	**38,668**	**16.08**
Smith	**Total**	**159,792**	**42,832**	**26.80**	**50,663**	**31.71**	**24,271**	**15.19**	**20,720**	**12.97**	**21,306**	**13.33**
Oliver	**Total**	**174,446**	**35,796**	**20.52**	**52,535**	**30.12**	**29,718**	**17.04**	**29,936**	**17.16**	**26,461**	**15.17**
Williams	PCT 1	100,363	17,619	17.56	26,489	26.39	21,441	21.36	19,617	19.55	15,197	15.14
	PCT 2	87,703	18,804	21.44	23,725	27.05	16,181	18.45	15,450	17.62	13,543	15.44
	PCT 3	156,563	41,541	26.53	46,976	30.00	22,639	14.46	22,303	14.25	23,104	14.76
	Total	**344,629**	**77,964**	**22.62**	**97,190**	**28.20**	**60,261**	**17.49**	**57,370**	**16.65**	**51,844**	**15.04**
Lawson	**Total**	**116,203**	**18,227**	**15.69**	**35,268**	**30.35**	**23,226**	**19.99**	**20,497**	**17.64**	**18,985**	**16.34**
Carrier	PCT 1	87,703	18,804	21.44	23,725	27.05	16,181	18.45	15,450	17.62	13,543	15.44
	PCT 2	156,563	41,541	26.53	46,976	30.00	22,639	14.46	22,303	14.25	23,104	14.76
	Total	**244,266**	**60,345**	**24.70**	**70,701**	**28.94**	**38,820**	**15.89**	**37,753**	**15.46**	**36,647**	**15.00**

Figure 2.7 Socio Economic Class Groupings of Trusts within the Research Group

I then grouped this information according to Trust catchment areas. Full details are shown in Figure 2.7, which shows that the population for each Trust has a different socio-economic profile. Smith has the highest percentage of AB's, at 26.80%, with Bourdin at 26.50% and Stein at 26.06% (the percentage for England being 22.19). Smith then has a lower percentage in Class E at 13.33 as does Bourdin at 13.09%. Interestingly, Stein has a high percentage of AB but with 15.67% of the population in E they are close to the percentage for England that is 16%. Ramsay has the lowest percentage of AB at 15.41% and the highest percentage of E at 19.7%. Harriott has the second highest percentage of E at 18.94 and Lawson has the second lowest AB at 15.69.

However, whilst these figures are interesting, and provide more background on the profile of the catchment area of the Trusts within the Research Group, they indicate that there is not a consistent theme of affluence or deprivation, if socio-economic class is accepted as a indicator of these states.

Economic Activity

It is well accepted within the NHS that employment brings better health[22]. Therefore I felt it would be of interest to look at the employment rate of the populations under consideration. I turned again to the National Census 2001 for this information. Unfortunately there was insufficient data shown for Employment Rate (percentage of population employed) against PCT area. In the absence of this data, I used the data relating to Economic Activity (UV28).

Figure 2.8 shows the usual resident population aged 16 to 74 who are economically active. All people who were working in the week before the Census are described as economically active as are people who were not working but were looking for work and were available to start work within 2 weeks. Full-time students who are economically active are also included. Those classed as economically inactive are:

- Retired;
- Student (excludes those students who were working or in some other way were economically active);

[22] I quote from the Independent Inquiry into Inequalities and Health (Acheson 1998), '...unemployment and stressful or hazardous working environments are potentially major risks for health for the population of working age and their families.'

- Looking after family/ home;
- Permanently sick/disabled;
- A person who is looking for work but is not available to start work within 2 weeks; and
- Other.

I then calculated the % of those people who were economically active within the All People Count to allow a general comparison.

	All People	**Economically active**	
	Count	***Count***	***%***
England	*35,532,091*	*23,756,707*	*67*
Blumenthal	862,663	553,114	64
Bourdin	276,279	199,208	72
Garcia	359,707	226,983	63
Harriott	194,140	124,892	64
Lawson	104,737	68,629	66
Oliver	161,867	112,114	69
Ramsay	220,398	138,104	63
Rhodes	1,314,254	836,626	64
Rosengarten	604,369	386,539	64
Slater	127,132	86,354	68
Smith	147,371	104,468	71
Stein	169,784	112,899	66
Whitingstall	222,820	141,144	63
Williams	320,439	221,178	69

Figure 2.8 Economic Activity of Trusts within the Research Group

The results, laid out in Figure 2.7, show that there is a spread of economic activity between the Trusts, with 5 out of the 14 Trusts being above the percentage figure for England with Bourdin being the highest at 72% of its catchment area being economically active. 9 Trusts, or 64% of the Research Group, were below the percentage for England, with Garcia, Ramsay and Whitingstall all having the lowest levels of economic activity at 63%.

I do not believe there to be any consistency of economic activity amongst the catchment areas; therefore there is no shared impact on the Trusts within the Research Group.

I felt it would also be of interest to see how people within the catchment areas of the Research Group Trusts viewed their own health. Again I used National Census 2001 information - General Health UV20 (this shows the usual resident population by a self-assessment of their general health over the 12 months before the Census) and Limiting Long Term Illness UV22 (a self assessment of whether or not a person has a limiting long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age).

I considered that this information may reflect populations that did not feel they enjoyed good health and consequently had greater dependency on their local hospitals, which in turn created a demand for higher standards. However, they may also cause greater wear and tear on the Patient Environment by their more frequent use, thus creating a situation whereby the Trust finds it more challenging to deliver high standards of Patient Environment.

Figure 2.9 shows a spread around the percentage figure for England. For example, Bourdin is above the national average for good health with 72.32% of people saying they are in good health, and above the average for England for poor health - 13.66%. Oliver is above the average for good health and fairly good health and below average for poor health, while Harriott is below the average for good health and above average for fairly good health and poor health.

	Good Health	Good Health	Fairly Good Health	Fairly Good Health	Not Good Health	Not Good Health
	Count	%	Count	%	Count	%
England	*33,787,361.00*	*68.76*	*10,915,594.00*	*22.21*	*4,435,876.00*	*9.03*
Blumenthal	249,544.00	68.28	86,733.00	23.39	31,264.00	8.33
Bourdin	276,790.00	72.32	79,139.00	20.85	25,643.00	13.66
Carrier	216,668.00	69.89	68,417.00	22.16	24,713.00	7.96
Garcia	329,992.00	65.81	119,880.00	23.92	51,395.00	10.27
Harriott	167,040.00	62.42	67,911.00	25.40	32,600.00	12.18
Lawson	98,137.00	67.00	35,009.00	23.90	13,327.00	9.10
Oliver	157,322.00	70.08	50,202.00	22.36	16,977.00	7.56
Ramsay	199,928.00	64.20	80,142.00	25.84	30,820.00	9.96
Rhodes	1,239,400.00	66.66	431,900.00	23.21	190,092.00	10.13
Rosengarten	234,378.00	68.80	77,999.00	22.94	28,264.00	8.26
Slater	121,366.00	68.26	40,932.00	23.02	15,503.00	8.72
Smith	146,789.00	71.62	42,873.00	20.92	15,294.00	7.46
Stein	164,714.00	70.34	47,787.00	20.71	20,375.00	8.95
Whitingstall	206,445.00	66.99	70,194.00	22.78	31,556.00	10.24
Williams	303,293.00	69.10	97,273.00	22.27	37,506.00	8.63

Figure 2.9 Health of the Population of Trusts within the Research Group

Thus by using the populations' view of their health as an indicator of the population's interest in the standards of the hospital and the volume of throughput in the hospital, I am able to dismiss perceived ill health as a shared external influence on my research group.

2.4 Conclusions

I have carried out a high level investigation of the main external influences and Trust characteristics that could influence FM Management Teams and the Trusts within which they work, and have not found any evidence that would warrant further and deeper investigation. Therefore, I concluded that the external influences and Trust characteristics were not creating advantages for the FM Managers within the Research Group that would assist them in delivering high standards of Patient Environment. The possibility of extremes making the environment more difficult to sustain has not been excluded, for example, the conditions that may occur in London (such as density, diversity, staff competition), or extreme affluence (bringing with it challenges such as staff competition, charitable donations). Otherwise there is nothing common to my sample or nothing to obviously distinguish them from a random set of Trusts other than their ability to achieve a high level of PEAT score on a consistent basis.

Given this lack of external influences and Trust characteristics, the question remains as to why the FM Managers within the Research Group have consistently delivered high standards of Patient Environment over the period of the research. This leads me to consider whether it is the way in which the FM teams are managed that allows the achievement of these consistently high standards. NHS Estates (1996) identified that the FM manager (whose role at that time was about managing the site) should become the FM leader who works with his/her team to create an environment. Consequently, evidence of leadership skills rather than or in addition to management skills could be making the difference in the Trusts within the Research Group who consistently deliver high standards of Patient Environment. So I ask the question: Is it leadership by the FM Management Team that enables the consistently high standards of Patient Environment to be delivered?

In order to further develop the thinking around leadership it is important to clarify the language of leadership and how the FM Managers within the Research Group may

portray this. In order to start building this clarity of language I move on to review the literature around leadership, and in particular the literature which reviews leadership within the NHS, or the public sector.

Chapter 3 Underpinning Knowledge

3.1 Introduction

Figure 3 signposts the reader to the position that Chapter 3 Underpinning Knowledge takes in the research route.

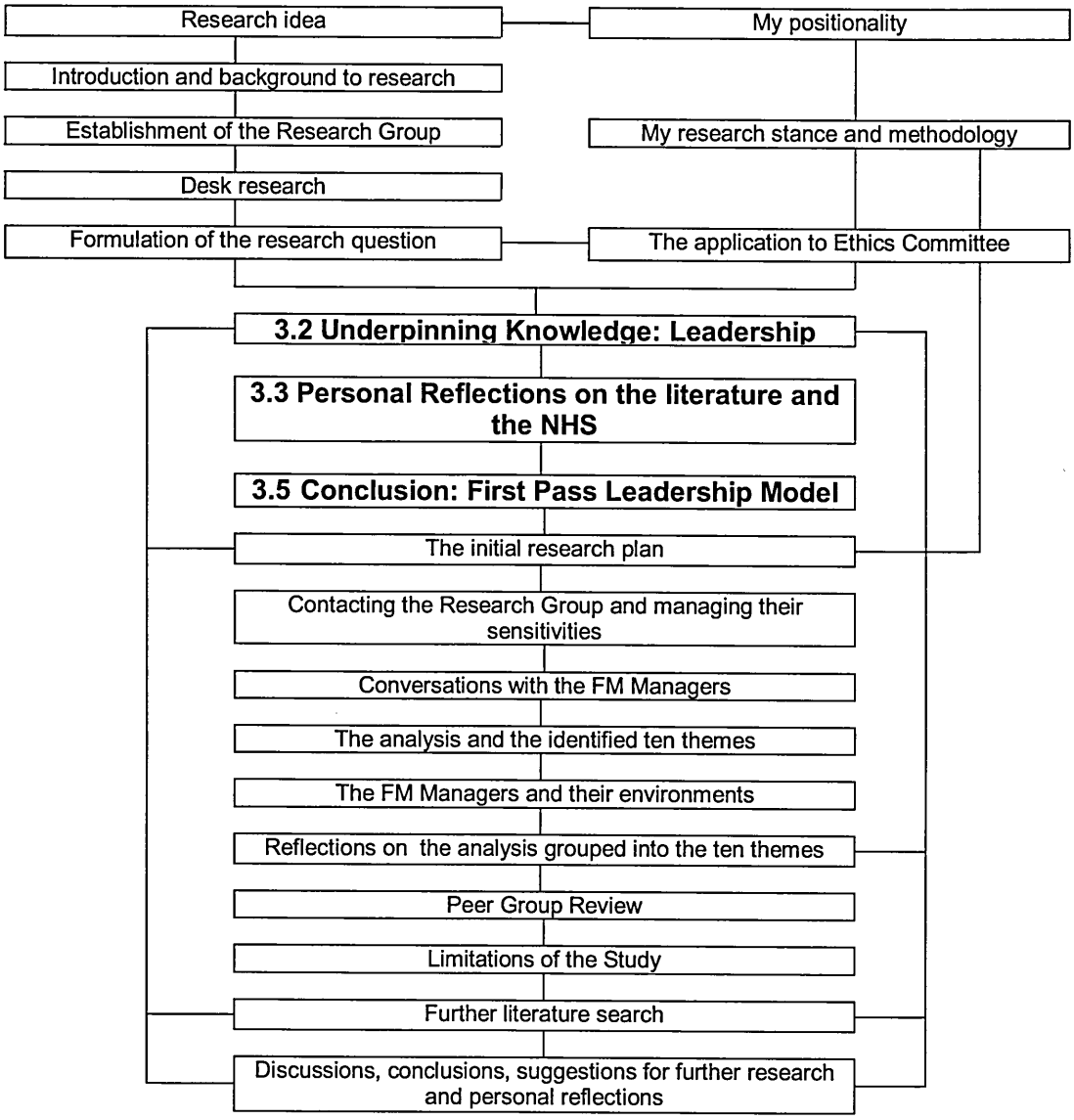


Figure 3 The Thesis set out in the Research Pathway

Before I could proceed with any meaningful research with the Managers within the Research Group it became important to clarify the understanding around leadership; a much discussed topic. Once this understanding was established it became possible to

understand how this was (or was not) being portrayed by this group of FM Managers. To start building this clarity of understanding, I moved on to review the literature around leadership, and in particular the literature which reviewed leadership within the NHS, or the public sector.

This chapter is therefore concerned with the underpinning knowledge relating to leadership. This underpinning knowledge will provide clarity of understanding upon which to build further research into the FM Managers within the Research Group.

3.2 Leadership

The health-care delivery system in many countries, and certainly in England, has been hugely challenged during the last two decades and unprecedented levels of change continue to be demanded (Griffith 2000, Chow-Chua and Goh 2002). It was recognised that the NHS Plan (2000) formed perhaps the most radical change to the NHS since its inception and that effective leadership was the key to delivering this change, and in turn this change would result in improved patient care and better working practices. This drive for radical change through leadership resulted in demands to identify and develop the necessary skills in managers' style and attitude (Flanagan 2004, Humphris 2004) that would help them evolve to the new ways of leading. Much time and effort has been expended (both outwith and within the NHS) assessing what is needed, by whom and how. In amongst all this activity, I set out to understand the underpinning knowledge that exists around leadership, in so doing I focus on knowledge that might be applicable to the public sector and in particular the NHS and FM managers.

The old management models, based on managing the status quo and technical expertise, where senior managers are seen as lacking in creativity and innovation can no longer meet the requirements of the changing NHS (Cook 2003). This need to change means new and more flexible ways of working need to be introduced by a new style leader who motivates and inspires, fosters positive attitudes and thus creates a sense of contribution and importance with and among employees. This requires fundamental changes in the NHS culture through a leadership which is evident everywhere, enacted in day-to-day behaviours by everyone, with those in senior positions leading by example (Crisp 2000, Hogan et al. 1994, Alimo-Metcalfe and Alban Metcalfe 2003). When writing the NHS Plan (2000), the Government perceived difficulties in realising this new leadership model and undertook to set up a new

Leadership Centre[23] to support the NHS in developing its managers. However, this initiative was not to stand-alone and many researchers have been involved in exploring the underlying attributes and behaviours of leaders who successfully perform these contemporary leadership roles, both before and after the launch of the NHS Plan (2000).

This multitude of different theories, directions and concepts (McCall and Lombardo 1978) makes assessing the literature around leadership no easy task; the challenge is where to start. With this in mind, and to provide some focus for my literature search, I have taken a step away from my inductive approach to the research, setting myself some delineation within which to work. In this way I will be able to form a foundation for my field research with the FM Managers within my Research Group, rather than trying to build my research on wealth of disparate thoughts around leadership, however interesting. Thus, I ordered my enquiry into the following subsections

- Personal Attributes
- Manager or Leader, Reality or Rhetoric
- Leadership Styles
- Emotional Intelligence in Leaders
- How Leadership Affects Performance
- Leadership in Context

3.2.1 The Personal Attributes of Leaders

Bennis (1992) tells us that all leaders are different, but all leaders are concerned with vision, and the goals to achieve that vision. This requirement for the achievement of vision calls for the ability to inspire others and a desire for responsibility that brings a need to make difficult decisions, and thus the ability to be able to make sense of difficult choices (Radford 2003, Gardner and Stough 2000, Golman et al 2002). This need is of particular importance, and indeed becomes a strategic issue in the NHS, as the solution so often requires equal importance to be placed upon context and content (Hood and Lowry 2004).

[23] The Leadership Centre works with leaders at all levels of the NHS, from front line leaders to those in the most senior positions

It is important to understand the attributes of the leaders who are expected to inspire others; I started with the work of Bennis and Nannus (1985) who set out to define the personal attributes of a leader by spending time with 99 Chief Executives. This work was of particular interest to me as many of the early studies of leadership took place in corporate America but in this case 39 of the Chief Executives studied were in the public sector. They found that the attributes of leaders in the private and public sectors were the same. It is worthy of note that Bentz (1985) spent time with Chief Executives, but working within a private U.S. organisation, and identified very similar attributes.

The attributes identified by Bennis and Nannus (1985) were:

- Management of attention – the ability to get others to listen to their intentions and focus on their agenda and visions. It is important for the leader to be focused on attention as the things that leaders pay attention to will catch the attention of their followers (Loughran 1992);
- Management of meaning – the ability to communicate and encourage feedback from receivers. Whilst a leader needs the ability to manage language in all its forms (Musson and Cohen 1999) including stories and legends, a leader also needs to have the ability to recognise that meaning also takes the form of non verbal language such as the decorations or symbols that reinforce loyalty - for example, flags, logos, the built environment and the value statements (Handy 1995). Indeed much of the cultural web (Johnson and Scholes 1995) found within an organisation is made up from items that are used to communicate the desired culture of an organisation in verbal and visual forms;
- Management of trust – wholesale acceptance of leaders by followers. This requires constancy of views, commitment, reliability, integrity, stability, predictability. Trust is developed over time, through repeated interactions;
- Management of self – leaders are likely to have strong egos and positive self-image, they need to know their strengths and weaknesses and they need to continue to nurture these. They also need to manage their strong personalities in a positive fashion;
- The Wallenda factor – leaders constantly look for challenges, concentrate on winning and enjoy taking calculated risks. They see failure as temporary blips that can be resolved.

A more recent study carried out among 1,900 public sector managers by the Chartered Institute of Management (Charlesworth et al. 2003) found that the top three personal attributes sought from today's public sector leaders are:

- clarity of vision (66%) – highlighted in Section 3.2.1 The Personal Attributes of Leaders and expanded upon by Bennis and Nannus (1985) when they talked of the ability to focus followers attention on the vision (management of attention);
- integrity (52%) – management of trust;
- sound judgement (50%) – again highlighted in Section 3.2.1 Definitions of Leadership;

with the top three skills listed as:

- communication (63%) – management of meaning;
- engaging employees with the vision (62%) - management of attention, management of trust;
- creating an enabling culture (60%) – management of meaning.

Alimo-Metcalfe and Alban-Metcalfe (2003) looked though a different lens at the same subject when they looked at what NHS employees expected from their leaders. They found the big issues to be:

- an ability to find new approaches and solutions and resolve complex problems;
- a willingness to develop staff;
- a leader who shows genuine concern;
- empowers his/her team;
- is accessible;
- is a strategic thinker;
- encourages change;
- has personal leadership qualities including a charismatic nature and exceptional communication skills;
- acts with integrity;
- is a good networker.

Although a certain level of interpretation is required, it is interesting to set the three pieces of work alongside each other (see Figure 3.2), as the first is the result of research in the private and public sector, the second is research on leaders across the public sector and third is the perceptions of employees within the NHS. There are distinct similarities between the models, although the two public-sector-only models do not put as much importance on managing self or taking risks. Alimo-Metcalfe and

Alban-Metcalfe (2003) use language such as new approaches, problems and solutions rather than vision; this is possibly the interpretation of the more reactive, fire fighting stance of the NHS which needs to change (NHS Institute for Innovation and Improvement 2005). As Harvey Jones (2003) pointed out at the NHS Confederation Conference, an organisation cannot chase numerous priorities at a time, it needs a clear vision and sense of direction.

From 2002, NHS Estates were running leadership development centres for FM Leaders; these centres are now provided by the private sector. Observations of NHS FM leaders take place whilst they role-play in a variety of situations. These observations are then graded against a set of criteria that are seen as the key skills for leaders. Figure 3.2 shows these criteria mapped against the Bennis, the Chartered Institute of Management and the Alimo-Metclafe models. When this matching is studied, it can be seen that a close correlation exists. However, I cannot see evidence of candidates at the NHS Estates Development Centre being measured against the Wallenda factor, which calls for leaders to constantly look for challenges, concentrate on winning and enjoy taking calculated risks. This echoes the lack of emphasis placed on risk by both the Chartered Institute of Management and Alimo-Metcalfe and Alban Metcalfe 2003). I discuss the topic of risk taking in Section 3.3 Personal reflections on the relevance of the literature to the NHS.

A model of leadership has been designed by the NHS Leadership Centre (2004) that highlights leadership attributes within three clusters: Personal Qualities; Setting Direction; and Delivering the Service (Figure 3.1). The model is shown mapped against the work of Bennis, the Chartered Institute of Management, Mecalfe and Mecalfe and the NHS Estates Development model in Figure 3.2. Although subject to my interpretation, the NHS Leadership Centre model does not show an emphasis on the Management of meaning and the Management of trust and I discuss this point in Section 3.3 Personal reflections on the relevance of the literature to the NHS.

Personal Qualities	Setting Direction	Delivering the Service
Self belief Self awareness Self management Drive for improvement Personal integrity	Seizing the future Intellectual flexibility Broad scanning Political astuteness Drive for results	Leading change through people Holding to account Empowering others Effective and strategic influencing Collaborative working

Figure 3.1 Leadership Attributes after the Modernisation Agency and Leadership Centre (2004)

Management of meaning is a key competence of a leader, with effective communication being seen as a key tool for the effective leader who uses language to interpret vision and views and translate them into meaning for their followers. Price (2006) also underlines the importance of communication, saying that society will expect leaders of the future to communicate far more about their decisions. He quotes one of his interviewees, Alexander Baker, as saying,

> *'The role of the internet subverts traditional leadership forms and gives power to individuals who rely on information which the internet itself provides.'*

In this new world where individual power is growing, skill with language opens the door to influence and control and gives energy and direction to the staff groups (Spinks and Wells 1993, Musson and Cohen 1999). This focus is to be paid more than a passing glance, indeed Handy (1994) calls for leaders with missionary zeal; he sees leaders as mobile characters who are always travelling in order to constantly talk and listen to followers. The leader who listens to his/her followers can draw on the wealth of knowledge and experience that exists within an organisation. But language and listening needs to broaden into understanding before the leader can sell their ideas to followers, or help them change their paradigm and thus see a different solution (Appleyard 2003, Covey 1992).

The ability to build and retain trust is key to effective leadership with openness, integrity, loyalty, fairness, and ability being key to the existence of trust between follower and leader (Clark and Payne 1997). Linked with this is the leader's willingness to care about their followers, when these forces combine high levels of trust result and followers become more receptive to new ways of thinking and improved methodologies. Leaders need this united and harmonious environment characterised by trust in order to lead and they must unite the group in a common and trusting culture (Fairholm and Fairholm 2000). If unity is not achieved leadership degenerates into management and control, power politics and compromise, thus lack of trust is seen as one of the key reasons why so many change programmes fail (Beer and Nohria 2000, Institute for Innovation and Improvement 2005). I discuss the topic of trust and its impact on the NHS in Section 3.3 Personal Reflections on the Relevance of the Literature to the NHS.

Bennis and Nannus, 1985	Chartered Institute of Management, 2003	Alimo-Metcalfe and Alban-Metcalfe, 2003	NHS Estates Development Centre 2002	NHS Leadership Centre 2004
Public and private sector	Public sector	NHS Employees	NHS	NHS
Management of attention	Clarity of vision Engaging employees with the vision	Is a strategic thinker An ability to find new approaches and solutions and resolve complex problems	Strategic management Knowledge management Achieving Goals	Effective and strategic influencing Holding to account Political astuteness Broad scanning
Management of meaning	Communication	Exceptional communication skills	Communication	
Management of trust	Integrity Sound judgement	A leader who shows genuine concern Is accessible Acts with integrity A willingness to develop staff	People Management Managing Relationships	
Management of self		Is a good networker Has personal leadership qualities including a charismatic nature	Personal Style	Self belief Self awareness Self management Drive for improvement Personal integrity Intellectual flexibility
The Wallenda factor	Creating an enabling culture	Empowers his/her team		Leading change through people Drive for results Seizing the future Empowering others Collaborative working

Figure 3.2 Comparison of Four Leadership Models after Bennis and Nannus 1985, Chartered Institute of Management 2003, Alimo-Metcalfe and Alban-Metcalfe 2003, NHS Estates Development Centre 2002, NHS Leadership Centre 2004

3.2.2 Manager or Leader, Reality or Rhetoric

A case is made within the literature for there being a separation between the role of the manager and that of the leader, laying out the difference between the two roles (Bennis 1992, Adair 2003). Figure 3.3 presents a synopsis of this thinking.

Potok (1972) puts forward a case in which he argues that managers are trapped by the system they work within, but leaders are motivated to change the system and in order to do so free themselves from the norms of the group, recognising the system as artificial and thus changeable. This thinking starts to promote the idea that not only is the work of the manager and the leader different, but that of the leader is 'better' than that of the manager, one good, one bad - one new style, one old hat. The call to abandon managers in favour of leaders is taken up, with the proposed advantages being good business sense and a clear indication that the methodologies used by

leaders would reduce the unacceptably high rates of stress amongst NHS employees (Alimo-Metcalfe and Alban-Metcalfe 2004).

Manager	Leader
Administers	Innovates
Copy	Original
Maintains	Develops
Focuses on systems and structures	Focuses on people
Short range view	Long range perspective
Asks how and when	Asks what and why
Eye on the bottom line	Eye on the horizon
Imitates	Originates
Accepts status quo	Challenges status quo
Classic good soldier	Is his own person
Does things right	Does the right thing

Figure 3.3 Manager versus Leader after Bennis 1992

However, there are challenges to this idea of manager versus leader. There are also those who suggest there is a right and wrong time for a leader and that people desire a leader when faced with uncertainty and ambiguity which makes them feel anxious and uncertain. Indeed research has found that groups of people who were faced with a crisis (for example turnaround situations) rated the charisma of the leader as more important than those in a more settled environment (Gemmill and Oakley 1997, Meindel 1995). Others argue that the visionary and mission setting aspects of leadership must be linked with management techniques in order that organisational purposes are achieved and that a leader in the NHS will split their time between leadership and management issues. Often leaders state the vision and walk away, as though their jobs were done. Although the leader must trust his/her team and 'get out of the way' to allow them to perform at their highest and most proficient levels, the leader must ensure that team members are informed as to how to best put their skills and knowledge to work within the organisation and lead by example (Wing 2005). A case is put forward that suggests that the splitting of management and leadership is a social defence that saves us from needing to confront the demands of today's organisational challenges. Social defences can have a great impact on individuals and impair the functioning of organisations at the same time, as they allow people to turn away from the realities they face (Argyris 1990).

Another challenge to the fundamental concept of leadership being right for business purports that the stereotypic leader is a liability as leadership advocates swift decision making, with evaluation and analysis seen as procrastination. But having made a hasty decision, the problem is then compounded by persistence that locks the leader

into the decision, however badly things turn out. This means that losing courses of action are pursued with no economic justification (Drummond 1991).

There is a view within the NHS that those leading NHS modernisation will need good management skills as well as excellent leadership qualities to make sure they can lead and deliver real change for patients. This means that leaders will need to recognise that they will need to effectively manage leaders and lead managers (Leadership Centre 2006, Fritchie 1997).

3.2.3 Leadership Styles

Much literature is given over to the identification of specific styles of leaders. In 1979 Bass published his seminal work introducing the concepts of transformational and transactional leadership and since then work has been undertaken to develop these ideas (Burns 1978, Bass 1985, Bass 1999). Heroic and charismatic leadership styles are also talked of (Yukl 1993, Bolman and Deal 1991), although I am unable to see a great difference between these and the transformational leadership style.

Bass (1998) went on to develop a six-factor model of transactional and transformational leadership. Other early work saw a simple model of transformational and transactional leadership existing on a continuum with the former seen as the more successful leadership style (Leithwood et al. 1996). Later the work was re-examined and a need to broaden the approach to the styles was established. I found reservations in the literature raised over the emphasis on the transformational style of leadership that could encourage authoritarian forms of organizations as it promoted undue conformity, and thus suppressed dissent. Alternative works look at transactional leadership, and recognise the need for leaders to be followers and followers to be leaders, the acceptance of multiple visions and the need for negotiation, conflict resolution, debate and free speech (Tourish and Pinnington 2002). This thinking by Tourish and Pinnington (1992) heralded the acceptance of a four-factor model of leadership: transformational; contingent reward; management by exception; and passive leadership (Avolio, et al. 1999, Den Hatrog et al. 1997).

This requirement to observe the needs of the organisation, rather than to believe in the more simple approach of one ideal leader fitting all, is further emphasized by the thought that the leader needs to work within the context of his/her environment and adapt behaviours accordingly. This adaptation of behaviours echoes the more usual

incremental change found in organisations. This style is seen as more beneficial for organisations, allowing them to build on the skills, routines and beliefs of those in the organisation. In this way change can be efficient and smooth, allowing time for the commitment of those in the organisation to be won (Feidler 1976, Johnson and Scholes 1993).

3.2.4 Emotional Intelligence in Leaders

We have looked at the attributes of leaders, and in so doing seen that such attributes as those that build and maintain relationships with others are key. This points to the idea that leaders may have a set of attributes that are softer skills. Golman (1996) talked of leaders having a set of traits one might almost call character – Emotional Intelligence. He suggests that emotional life can be handled with differing levels of skill, and like any other skill requires its own unique set of competencies. According to how adept a person is at managing their emotional life dictates as to why one person thrives in life while another of equal intellect does not. He claims that Emotional Intelligence is a higher level ability, determining how well we can use what other skills we have.

Not all literature supports this concept; some see it as a marketing concept, or as a brand name for a recognised set of competencies (Steiner 1997, Davies et al. 1998, Woodruffe 2001, Luthans 2002). However, there remains much interest in the topic (Dulewicz and Higgs 2003) and I feel it worthy of attention. Not least because of the early observations made by Bentz (1985) who noted that executives promoted to the highest levels at Sears had independence, self-confidence, and emotional balance amongst their attributes.

Mayer and Salovey (1997) lay out a model of Emotional Intelligence that has four branches:

- *Managing emotion*, the ability to regulate or change emotions in oneself or others, for example, disguise one's anger, excite others about a piece of work;
- *Understanding emotion*, knowledge of emotional vocabulary and how emotions combine, progress and transit from one person to another. (Sy and Cote 2003);
- *Using emotion*, the ability to harness emotions to guide information processing, use of positive emotions to enhance creativity and unpleasant emotions in specific problem solving;
- *Perceiving emotion*, being able to identify emotions in others.

A silo focus approach by employees can impede collaboration. It is argued that emotionally intelligent individuals may not only co-operate better, but also foster collaboration in others. Emotionally intelligent individuals are able to accurately perceive the emotions of others, such as interest and anxiety, thus helping build strong relationships; such perception is necessary for empathy and empathy enhances the quality of social relationships (Eisenberg 2000). Emotions can be used strategically as self-presentation strategies (Clark et al 1960). Emotionally intelligent individuals can build trust (already discussed as a key attribute for a leader) by suppressing unpleasant emotions that damage relationships, for example anger. They develop better relationships and richer social networks thus improving cooperation with others in their department or across departments. They are capable of exhibiting corporate behaviours that build increased trust, rapport, and cooperation. These behaviours result in improved links between different functional and geographic areas and thus increased coordination. However, the case is made for not over controlling feelings (emotions and moods) as they are needed to aid decision making, whilst recognising that intense emotions interfere with decision making, too great a reduction in emotion can equally lead to irrational behaviour (George 2000, Damasio 1994).

Many years ago Stogdill (1948) carried out research in an attempt to identify the personality descriptors for leaders. He included amongst these mood and emotional control. This theme (emotional stability) has been carried forward in the Big Five Model used by the more recent personality psychologists (Digman 1990, Goldberg 1993, Hogan and Hogan 1992, McCrae and De Costa 1987, Passini and Norman 1966).

It is claimed that great leaders work through the emotions of others and our attention is drawn to the fact that leaders have always played a primordial emotional role, suggesting that the original leaders, for example, tribal chieftains, earned their place in large part because their leadership was compelling. In any group the leader has the power to sway each person's emotions. If people's emotions are pushed towards enthusiasm, productivity soars and if towards anxiety, they are thrown off stride and productivity falls. However, in order to ensure a healthy workforce the leader must be certain that the emotional labour employed by each employee when delivering the desired behaviour is not too high, or problems that generate dissatisfaction and stress will arise (Mann 2005). Leadership can work to everyone's advantage if the leader has the competencies of emotional intelligence (Rosete and Ciarrochi 2000), that is, how

leaders handle themselves and their relationships (Golman, Boyatzis and McKee 2002).

In 2001 Palmer et al. challenged the concept of Emotional Intelligence. They said that how and to what extent it accounted for effective leadership was unknown and popular claims were misleading. They then set out to try and understand the difference in levels of emotional intelligence between transactional and transformational leaders (Lowe and Kroeck 1996), but were unable to find conclusive evidence.

Despite Lowe and Kroeck's inconclusive study, other studies were able to show a direct correlation between leadership success and emotional intelligence competency levels when using the Multifactor Leadership Questionnaire and the Swinburne University Emotional Intelligence Test on a group of Senior Managers (Gardner and Stough 2002). They found leaders with emotion intelligence were:

- happier and more committed to their organisation;
- achieve greater success;
- perform better in the workplace;
- take advantage of and use positive emotions to envision major improvements in organisational functioning;
- use emotions to improve their decision making;
- instil a sense of enthusiasm, trust and co-operation in other employees through interpersonal relationships.

This positive correlation between emotional intelligence and transformational leadership was echoed in the works of Sivanathan and Fekken (2002).

If leaders require this mixture of softer emotional intelligence skills coupled with a set of harder, more easily seen or quantifiable attributes, can a leader be developed, or are they born with the emotional intelligence that they need? The literature supports the view that leaders are developing their skills and learning new things all the time (Bennis and Townsend 1997). Leadership traits are not static, but are dynamic and modifiable, with some organisations having had success in training leaders in some aspects of leadership, particularly to become more charismatic, dynamic, enterprising and confident (Avolio and Bass 1990, Sivanathan and Fekken 2002, Stein and Book 2000, Dukerich, et al. 1990, Barling et al. 1996; McElroy and Stark, 1992; and Micha et al. 1992). The emotional intelligence debate suggests that if leaders have high levels of

emotional intelligence they will create a can-do attitude in others, as their behaviours influence others to see change as desirable (Kenmore 2004).

3.2.5 How Leadership Affects Performance

All this discussion around leadership, leadership attributes, styles and emotional intelligence are surely meaningless if there is no benefit to an organisation. However, benefits are not easily and uniformly identified; the key benefit to one organisation may be different to another. Benefits may be competitive advantage to the private sector while to the NHS they represent achievement of targets, enhanced patient experience and improved health within a given population (The Hay Group 2006). But benefits there must be.

With old styles of command and control leadership dying away as technology changes the way we think, the capacity of leaders to create an organisation capable of generating intellectual capital (ideas, know how, innovation, knowledge and expertise) becomes key. This idea of leaders generating competitive advantage is a strong theme, with leaders bringing enhancements to an organisation's performance and success (Bennis and Townsend 1997, Day and Lord 1988, Smith and Cooper 1994, Thorlindsson1987).

Many of the studies (for example, Bennis and Powell 2000) prove that leadership characteristics are associated with enhanced team performance, but perhaps more importantly research into incompetent management shows that there is a loss in productivity. This growing body of evidence supports the belief that leadership is an important concept to business if it is to maintain, or improve, its viability (Hogan et al 1994, De Vries 1992 and Shipper and Wilson 1991).

3.2.6 Leadership in Context

Most adults carry with them the potential energy to behave in a variety of ways. Whether they behave in these ways depends on the kinds of motive or needs they have and the characteristics of the environment in which they find themselves (Altman and Hodgetts 1979). Leaders need to be able to understand and satisfy these motivators within their followers, as leaders cannot operate in isolation.

Culture (Schein 1990) can be defined as referring to the patterns of development reflected in today's system of knowledge, ideology, values, laws, and rituals. It is a metaphor derived from the agricultural idea of cultivation and requires an

understanding of the symbolic significance of organisational life. The internal environment of the organisation is often termed as culture. Culture is seen as:

- how things are done around here – written and unwritten rules, the rules are rarely discussed, usually shared by all or at least most. what has achieved good results for the team in the past, thus the rules are set or reinforced;
- Metaphors and signs exist and have a shared meaning;
- Stories and legends exist and are rehearsed.

(Morgan 1986, NHS Institute for Innovation and Improvement 2005)

The organisational culture will dictate and influence how an individual behaves. Humans hold two kinds of theories of actions, the first being their espoused theory composed of their beliefs, values and attitudes and the second being their theory-of-use which is the one they actually use when they act. Humans are programmed in their heads to avoid embarrassment or threat and use their theory-in-use to retain control in these situations and will use their theory-in-use to save their own and others face. These behaviours form an organisational defence pattern and restrain the individual from practising according to their beliefs, values and attitudes. However, behaviours caused by theories-in-use can be modified by leaders who create a learning organisation, and through that modification of behaviours, cultures can be changed. Leaders need to be aware of this if their change programmes are to be successful (Argyris 1990).

It is suggested that one of the reasons that there is a lack of focus in the literature around leadership might result from the subject being studied in isolation of the organisational context. Pure leadership models are designed without due consideration to the organisational variables that will impact on the leader and the way s/he employs their skills (Edwards and Gill 1993). This pure form of leadership cannot survive in practice, as the relationship between the leader, his/her leadership approach and the organisation's culture is inextricable, with the leader being part of that culture. The cultural web bonds the beliefs and assumptions of the organisation and its people to the day to day actions of that organisation. Once recognised and understood by the leader, the cultural web is a useful tool with which s/he can understand the way in which their thoughts and actions can be guided and constrained by the culture they find themselves working within (Alimo-Metcalfe and Alban-Metcalfe 2003, Johnson and Scholes 1993). It should also be recognised that not only must questions of leadership be asked within the context of culture (the internal environment), but also taking

account of the external environment. Much of the leader's work will be concerned with changing an existing culture, or creating a new culture, so that his/her vision can be realised. This is not the work of bold marches but of long marches (Abernathy 1998) that require followers to be enlisted and put their creativity and imagination into the change. A leader can set the direction, but the change must be owned and guided by the people within the organisation.

3.3 Personal Reflections on the relevance of the literature to the NHS

Recognising my positionality[24], I approached the literature search as both a leader and a follower within the NHS, hoping to find reassurance that the development of leaders can shift the paradigm and help the ailing NHS move forward to a more positive future, but worried that these conversations have been held before within the NHS. In 1989, during the conversations over the formation of NHS Trusts, the concept of leadership was embraced by the NHS as the new saviour (Stewart 1989), and now those calls are being made again, but to herald a different change and some 15 years later. There is little point to the conversations if the NHS do not move on from the vision of the NHS Plan (2000) to make the real changes that can improve performance (Obolensky 1996, Stata 1995) so turning the rhetoric into reality.

The literature search stimulates an image of the leader taking up responsibility (and I would suggest that responsibility entails the moral and ethical issues facing the leaders of today) for guiding an organisation (and within this I include its people) through a minefield of dilemmas and difficult choices towards an overarching vision. We can see this image emerging in Figure 3.2 The Comparison of the Four Leadership Models. The model is further refined in the light of my work, see Figure 7.1.

The context within which the leader works within the NHS is important as it has a plethora of stakeholders each with differing and strongly held ideals, is in great change, and has set itself multiple priorities (Harvey-Jones 2003). The literature shows that the leader needs to be able to work with their followers, including those working within the NHS and its stakeholders, to form and communicate a convincing vision for the organisation. The leaders then need to take up the responsibility for the organisation and guide it through a minefield of dilemmas and difficult choices to make the vision a

[24] See Chapter 1

reality. Given the large, complex and internally competitive nature of the NHS, and the leader needs to recognise the importance of gaining and holding followers, particularly as the NHS is increasingly requires its leaders to influence across teams and across organisations, thus requiring more complex communication behaviours. Given this context I feel the management of meaning to be of particular importance, warranting special emphasis (Smircich and Morgan 1991, Meindl 1995).

The definition of Bennis and Nannus (1985) highlighted one of the leadership attributes within the Wallender factor as risk taking. Risk is not highlighted specifically in the public sector models (Chartered Institute of Management, Alimo-Metcalfe and Alban-Metcalfe, NHS Estates Development Centre and NHS Leadership Centre). However, these models call for enabling cultures, new approaches and leading change through people and seizing the future. Elements of risk taking will be necessary in order to attain these, therefore I believe the lack of attention given to the skills required to take managed risks to be a fundamental oversight and will result in leaders who are not encouraged to develop the necessary risk taking and survival skills that are required if radical change is to brought about in the NHS. This could result in changes not happening as leaders continue to avoid taking risks, or it could lead to unmanaged risk taking with the possibility of interruption in services due to unforeseen consequences. As leaders start to challenge the status quo and look for radically different ways of working, skills in stakeholder management become paramount; leaders will need to ensure that appeasement of stakeholders is replaced by an open dialogue which results in agreement over the implementation of the vision. Thus real change will be delivered.

The literature speaks of the need for trust between leader and follower and how it needs to be built up and maintained over time. The NHS change programmes will fail if that trust is damaged at any time in the process. Leaders need the skills to both recognise this and understand how to build and maintain this trust with their followers, each of whom may have differing personal values and agendas, and thus require a different approach. They also need to ensure that they invest time and effort in ensuring that trust is maintained, remembering that it is their everyday actions that demonstrate their trustworthiness. A leader who demonstrates competency in managing a situation and fairness of judgement gains trust, even if this means a difficult issue has to be faced and one individual suffers sanctions. The complexity of the NHS often means that the effects of unwritten rules are not clear and visible (NHS

Institute for Innovation and Improvement, 2005) and the leader needs to recognise that not only are their overt messages a measure of trustworthiness, but also their unspoken messages count too. I was therefore interested to note that whilst the NHS is calling for leadership skills that inspire and energise, the NHS literature is still using old metaphors that are legacies from command and control language such as 'driving' for results and 'seizing' the future (NHS Leadership Centre). Old metaphors strengthen past wisdom and knowledge, and therefore old cultures. This makes it difficult for followers to trust in the integrity of the message and thus the leaders. In comparison the language of leadership might be that of 'designing' for results and 'growing' for the future. Trust is an important issue for the NHS, if it is to achieve the radical change that is required there must be trust between followers and leaders.

Whilst considering the context of the NHS and the trust which needs to be built by the leader, I am interested by the ideas on leadership styles. I think that transactional leadership styles, with acceptance of multiple visions and the need for negotiation, conflict resolution, debate and free speech, may be more appropriate for the NHS. The NHS' need to provide leadership to the professions (Kennie et. al. 2002) coupled with its risk aversion (Connor 2001) makes large scale change methodologies such as process re-engineering less attractive and incremental change more acceptable. I believe that transactional leadership would be very appropriate within the FM management teams, as the diverse portfolio of services call for very differing workforces with differing motivations. This workforce includes those with high levels of qualification and professionalism, for example the chartered engineer, and those entering the field with little formal education or experience of the NHS. Whilst a leader will have one vision for FM, of necessity, the vision for these staff groups needs to be expressed and communicated in a way that is unique for each service and workgroup. Taking up the responsibility to lead a group of professionals (Middlehurst and Kennie 1995, Kennie et al 2002) is very different to the responsibilities of a group of part time workers and the leader would need to be able to encourage debate and free speech by all in order to ensure that all followers hearts and minds are won.

It is, however, important not to loose sight of the real reasons for the change, that is the need for increased efficiency as the acute sector of the NHS moves towards Foundation Trust status with the greater emphasis on a business focus, that is legally constituted; well governed; and financially viable (National Library for Health 2005). Thus the performance of the teams becomes paramount. The leadership literature talks

of how the leader can impact either positively or negatively on the productivity of his/her followers. The NHS can develop this theme of productivity by looking at the leaders impact on patient care that translates into well being and ultimately the lives of those in its care.

If NHS leaders recognise the reality, which means that easy answers, quick fixes and magic bullets are harder to find and pathways to success increasingly complex and ambiguous, they will realise that growth and innovation emerge as the key drivers for the future (Jonash 2005). They will see that they need to spend their time both leading managers and managing leaders, and that, by embracing both leadership and management skills and behaviours, they can build the excellent teams that the NHS needs for the future (Krantz and Gilmore 1990).

I am concerned that the NHS will pin its hopes for transformation on the magical idea of a leader and turn its attentions to the transformational leader who is parachuted in to make a 'quick fix'. I am also concerned it will try to turn managers into leaders in the same way as it tried to turn administrators into managers in the 1980's, and in twenty years time we will still be discussing why leaders have not offered the route to salvation for the NHS. I found the thoughts around the social defence of leadership particularly sobering. However, like others who have expressed some nervousness around the leadership theory (Smith and Cooper 1994, Bazerman 1990, Straw and Ross 1978, Calder 1977, Miner 1975 and Perrow 1972), I am convinced to continue looking by those who claim increases in productivity or performance when leadership is adopted (Wing 2005, Falk 2003, Ozaralli 2003, Finnie and Early 2002). I can see a place for leadership as described in the literature in the NHS, however, I leave the topic of leader versus management with the belief that leadership and management should walk hand in hand. Leadership can only be one element in a manager's contribution to the NHS reforms and to focus on this to the detriment of other management activities will ensure leadership a place on the long list of management fads. (Hewison and Griffiths 2004).

This literature review has shown that some of the key skills of leadership are managing and directing an organisation, influencing their followers and harnessing their efforts towards the common vision. All this has to be achieved within the prevailing culture and context. Figure 3.2 can be further rationalised by allocating all the attributes of leadership laid out in this chapter to re-present the models within three headings taken

from the Bennis and Nannus 1985 model. See figure 3.4 for a first pass model of leadership.

THE LEADER		
Management of attention	**Management of meaning**	**Management of trust, self and risk**
Good networker/relationship manager Focuses on people Politically astute Collaborative Empowering Holding to account Influencing/inspiring Knowledge management Exceptional communicator Creates enabling culture Accessible Finds solutions to difficult/complex situations/problems	Clarity of overarching vision Engages employees in vision Understands prevailing culture/context Broad scanning Seizes the future Finds new approaches and solutions Guides	Emotionally intelligent Looks to take responsibility Challenges status quo Integrity Sound judgement Self disciplined/style in context Has genuine concern Charismatic Appropriate personal style Takes appropriate risks/a risk taker Learns by mistakes Sees mistakes as blips Intellectually flexible Results focussed/wants to win

Figure 3.4 First Pass Leadership Model (after Bennis and Nannus 1985, Alimo-Metcalfe and Alban-Metcalfe 2003, Chartered Institute of Management 2003, NHS Estates Development Centre 2002 and the NHS Leadership Centre 2004)

3.4 Conclusion

In summary of the exploration of the leadership literature, I offer Figure 3.4 above as a first pass model of leadership that reflects the literature critique and my reflections as covered in the above sections. It is based on the works of Bennis and Nannus (1985), Alimo-Metcalfe and Alban-Metcalfe (2003), the Chartered Institute of Management (2003), the NHS Estates Development Centre (2002) and the NHS Leadership Centre (2004) as discussed in Section 3.2.1, and extends to the further discussions around personal attributes, leadership styles, emotional intelligence and performance, particularly within the NHS. It also includes reference to how leaders need to work within the context of their organisation, its culture and the external environment.

This model provides a platform of understanding to take the reader into the following chapters that will discuss the research undertaken with the FM Managers in the Trusts that form the Research Group. Chapter 4 Research Methodology, moves on to discuss the research methodology that I will be using to look at the FM Managers in the Research Group. The methodology that I establish will be looking to draw from the conversations with FM Managers and their Environment a comparison between the rhetoric on leadership shown above and the reality of the FM manager working within the NHS non-specialist acute Trust and consistently delivering high standards of Patient Environment.

Chapter 4 The Research Methodology

4.1 Introduction

Figure 4 signposts the reader to the position that Chapter 4 The Research Methodology takes in the research route.

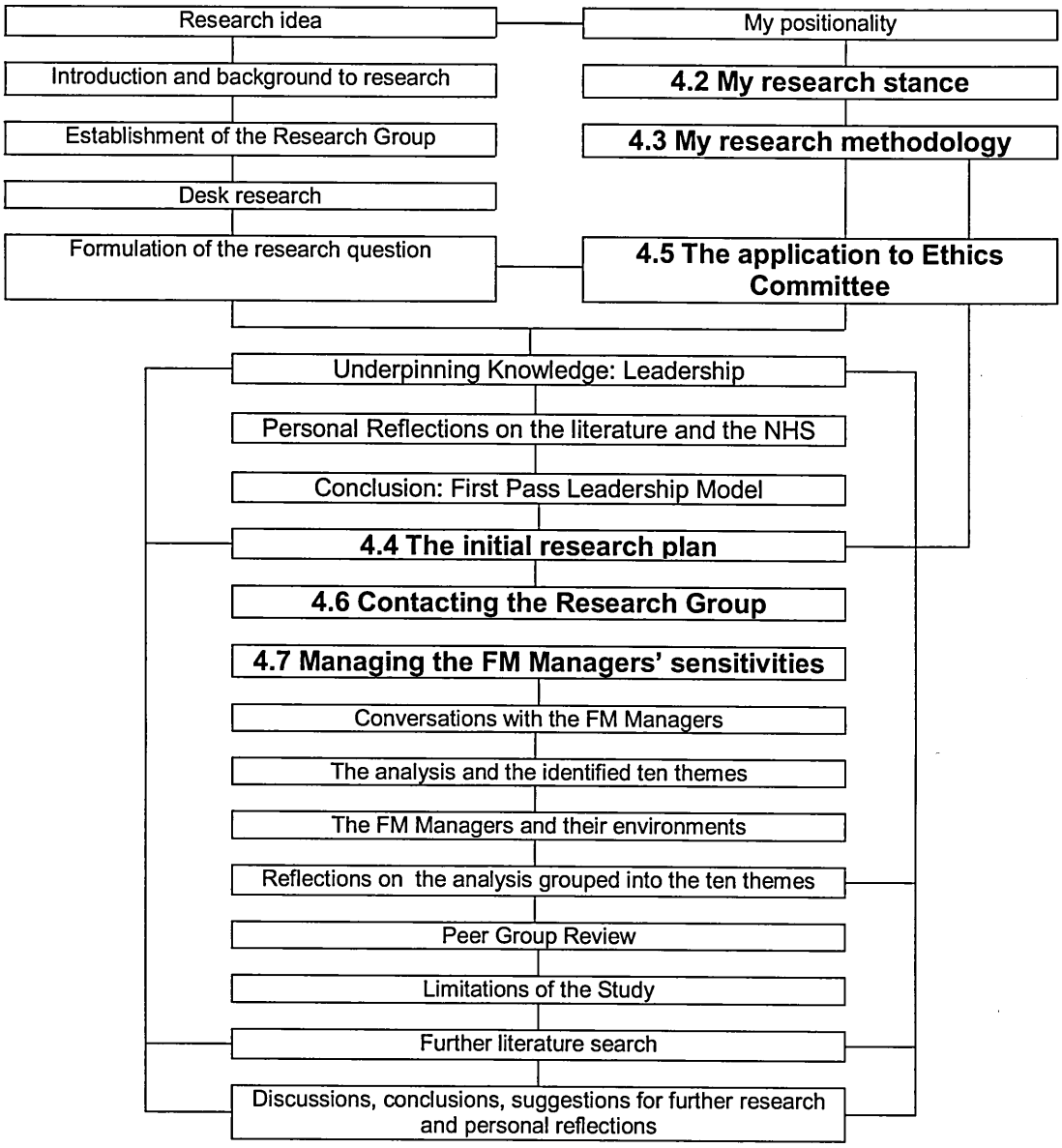


Figure 4 The Thesis set out in the Research Pathway

My investigation of the main external influences and Trust characteristics that could have influenced the FM Management Teams and the Trusts within which they worked did not show any evidence that warranted further and deeper investigation. Therefore, I

concluded that the external influences and Trust characteristics did not create advantages for the FM Managers within the Research Group that would have assisted them in delivering high standards of Patient Environment. This encouraged me to think that the high standards delivered by the FM Departments within the Research Group may be delivered because of the manner by which these teams are led. In order to clarify the understanding around leadership I reviewed the underpinning knowledge relating to leadership and in particular the literature around leadership within the NHS or the wider public sector. This chapter provided clarity by proposing a first pass model of leadership that could be used as a foundation for this study.

However, before any field research can take place, a robust research methodology needs to be formulated. This chapter is therefore concerned with that methodology in some depth, laying out the methodology to be used and the background around that choice, it plans how the methodology should be put into practice and deals with the early practicalities of getting started.

4.2 My Research Stance

Social Science studies usually follow one of two routes, deductive and inductive. Deductive methodology uses systematic protocols and demanding standards of scientific rigour, and requires precise models and hypotheses for testing. Such quantified methodology means that deeper meanings within the research may be lost. Inductive methodology uses analysis of subjective accounts and places emphasis in theory grounded in empirical observations. It takes account of the subjects' meaning, the researcher is not seen as an expert and it allows the researcher to acknowledge their role and impact, using this as a benefit to the research itself.

I recognised quite early in my work that the inductive approach would be most appropriate stance for my research (Cresswell 1998, Glaser and Strauss 1967, Cassell and Simon 1994). My considerations included:

The type of research question

My research question needed to give me the flexibility and freedom to explore a phenomenon in depth as all the related concepts had not been identified, and the relationships between the concepts were poorly understood and conceptually undeveloped. My initial inquiry (paraphrased as: why were some Trusts able to deliver consistently high standards of Patient Environment) started as a broad, open ended,

evolving and non directional question which stated the purpose of the study in general terms. This approach to stating the question gave me the ability to become more focused and narrow my question as the research process unfolded (Strauss and Corbin 1998, Strauss and Corbin 1990 and Cresswell 1998). Cresswell recommends that a researcher reduce his/her study to a single over-arching question and several sub-questions, but cautions that drafting the central question will often take considerable work because of its breadth and the tendency to form specific questions based on traditional training. My personal challenge was to keep the question as broad as possible at the start of the research and not to bring pre-conceived ideas from my experiences of the NHS into play at the early investigative stages. Thus by undertaking a careful analysis of the main external influences and Trust characteristics that could influence FM Management Teams and the Trusts within which they work, I was able to ensure I avoided the trap of making assumptions regarding the cause of the high standards too early in the study.

The impact of the researcher

I recognise that the impact that a researcher makes whilst interpreting in the inductive fashion can be seen as controversial by some; alternatively the researcher's epistemology can be seen as a valuable part of the exercise (Johnson and Duberley 2000). I believe that no matter how hard the researcher tries to stay objective, they are a part of the picture and cannot therefore fail to have an impact[25]. They ask questions, answer questions asked of them, and sometimes share their own experiences. This is not only true of interviewing, it happens in other research methods such as observations (Seidman 1998). The researcher then works with the material selected from these interviews; they interpret, describe, and analyse it. Though they may be structured and work hard to keep as close as possible to the participants' meaning-making process, researchers remain part of the process and therefore influence that process. I believe that this highlights the dangers of applying positivist criteria such as objectivity, (for example, a belief that there is a freedom from bias), to a non-positivist paradigm. I also believe that the researcher's experience and knowledge of a culture, a system or a process can bring a depth of insight not possible if their impact is denied. Therefore, I believe that, when used appropriately, the researcher's impact can add value to the study. These views are underpinned by my positionality.

[25] This was not my position at the point I entered the DBA. Previously I had not had occasion to think about how my ontology and epistemology might impact and made the assumption that is 'adequate' systems or methodologies were used then a 'true' end point would occur.

My positionality

During the period of the research I have come to recognise that I have tendencies towards the thinking of an ironist. An ironist can be defined as someone who is able to re-describe her own world and identity in new words, reaping the potential for regeneration, whilst simultaneously never quite sure of herself, never able to deny the fragility inherent in re-descriptions (Tietze et. al. 2003). By understanding this definition and using it to understand my positionality, I realise that that anything might be made to look 'good' or 'bad' by being re-described. This has helped me recognise and work with the impact that I have made as a researcher on this study as I have described and re-described the conversations with the FM Managers within the Research Group and my observations of their environment. Whilst I made every effort to use a rigorous methodology and reach some real conclusions that would make my research of interest and of use to others in the NHS, I have taken interviews with FM Managers, analysed and re-described them, and thus inevitably made some impact upon them. I also had doubts over the vocabulary I chose to demonstrate my findings to the reader, as I did not think that I had the ability to depict the realities of the NHS any more accurately than any other researcher. My confidence in my work could be swayed by the opinions of others, as my positionality is such that I see that new ideas can always supplant the ones I perceive to be fact at that moment in time. Again robust methodology has stood me in good stead here and allowed me to defend my stance and my findings to my own satisfaction, and that of my Supervisor. I feel that my findings will be of interest to others because my ontology has been formed by being a member of the population from which Research Group is drawn and, because of this, I brought with me opinions and experiences of the NHS that are valuable to this study.

There is a need to present detailed views, so the research needs to grow and develop over time

After carrying out the desk-based research on the Trusts within the Research Group, I had come to suspect that the delivery of consistently high standards of Patient Environment were due to the way in which the FM Management Teams went about their business. Therefore, I wanted to hear their detailed views on leadership and I needed a methodology that would allow me to look closely at what the FM Managers in my Research Group would tell me. I also recognised that my views, and therefore the research, would develop as the interviews with the FM Managers unfolded.

In order to study individuals in their natural setting

If the study was carried out away from the natural setting it could lead to contrived findings that were out of context. I wanted to see the FM Management Teams in their work settings so that I could see if the reality of behaviour and symbolism fitted the rhetoric I would hear, albeit within a small snapshot of time.

The researcher has an interest in writing in a literary style

I very much wanted my thesis to be recognisable and appealing to those working within the NHS, therefore I needed to write the document persuasively, and in a way that gave the reader the experience of being there. This was an important consideration to me at all times; I wanted to ensure that the end result of this study could be used for practical improvements as well being a rigorous piece of academic writing. Not only did I want the NHS to benefit from my work, this need for practicality is part of my epistemology and formed part of my decision to travel the DBA road rather than taking the more traditional PhD route.

There is a concern with the collection and analysis of written or spoken text

In order to ensure that qualitative research is robust, sufficient time and resource must be spent on extensive data collection in the field, and detailed data analysis of text information. I felt that I had the necessary time and resource available to me to allow the detailed study required, particularly following my decision to resign from my position as Director of FM and work part time within the NHS during the second half of my DBA programme[26].

The audience are receptive to this style

In my experience members of the NHS relate more to relationships, conversations and experiences of colleagues, than factual evidence, thus making the qualitative route more appropriate for the setting and my objectives (see discussion on literary style above).

The researcher's role as an active learner who can tell the story from the participants' point of view, rather than as an 'expert' who passes judgement on participants

As hinted at earlier, my epistemology and positionality as an ironist does not allow me to step comfortably into an 'expert' role. I see my true value as a facilitator of information, putting forward thoughts and ideas that can start a conversation, which

may well mean other opinions surface that are seen as more appropriate than my own. Starting the debate is more important to me than being seen as the expert. Seeing practical improvements is my end goal. At the time of the interviews with the FM Managers I was very much a participant in the NHS FM scene, and as my Trust did not appear within those in the Research Group I could hardly put myself forward as an expert. I was much more interested in finding out what these FM Managers could do and identifying where I could improve my own practice, and thus using this study as a means to improve my own performance as well as offering a learning opportunity to others in the NHS.

The fact that the human actions are dictated by their values, beliefs, attitudes and intentions

Human actions and thoughts have an internal and individual logic that needs to be understood in order to gain meaning; consequently, using the external logic of quantitative research is inappropriate in this particular situation. I firmly believe that attempting to understand values, beliefs, attitudes and intentions is important in this particular study, as leaders must involve their ethics and feelings in their work in order to truly be a leader. These thoughts have been underlined by the literature discussed in Chapter 3 Underpinning Knowledge.

4.3 My Research Methodology

Having made the decision to adopt a qualitative stance, I was then faced with a decision over which methodology I would adopt. I started looking for a research methodology that would offer me a sensitive, but fairly structured way to begin researching my area of interest. I felt that a more structured approach would enable me, as an inexperienced researcher, to carry out some good quality research. A methodology that allowed sensitivity would allow the delicate nuances of the topic to be uncovered as the research progressed.

In pursuit of such a methodology, I turned to Creswell's (1998) 5 traditions of inductive research (Biography, Phenomology, Grounded Theory, Ethnography and Case Studies). He selected these, as they are popular, frequently used, require a rigorous approach and have systematic procedures for inquiry.

[26] I talk more of this career change in Chapter 7 when discussing my personal reflections

Initially, I planned that my methodology would be based around the Grounded Theory approach (Glaser and Strauss 1967) as it allowed the development of a theory with four interrelated properties: the theory must fit the substantive area in which it will be used; be readily understandable by laymen; be sufficiently general; and allow the user partial control over the structure and process of situations as they change over time. As the use of the Grounded Theory method has evolved, there has been criticism of its methodology due to the positivist, structured nature of the method. This resulted in the method being taken forward in conflicting directions, although the method continues to be permeated with positivism and objective underpinnings (Guba and Lincoln 1994) that may result in the nuances and complexities being lost. I quickly came to realise this meant that a pure form of Grounded Theory would not allow me the depth and breadth of qualitative research that I sought. However, as a novice researcher, I saw benefit in the structured approach of Grounded Theory.

Although I saw the interviews as the main source of data, I wanted to build in my observations of symbols, unspoken language and body language. I also wanted to include the examination of any documents relating to the organisations. This meant I would need to find a way to allow this additional information to be bound in alongside the analysis of the inteviews. With this in mind, my research method had to allow the freedom to move away from a pure approach of the methodologies in order to allow a greater in depth understanding to grow during the research, informed by several media, to include conversation, signs, symbols and unspoken language. I decided to take King's (1994) advice and allow the research to develop as my work unfolded, thus leaving room to accommodate any surprises and for my methods to develop alongside the research.

I decided that my research would be based upon both interviews and observations (two of the four basic forms of information in qualitative research (Cresswell 1998)) rather than simply on the content of the interviews. This would, through providing a context to each conversation, offer insight into the unspoken message. I would also include evidence from documentation where appropriate, another of the basic forms of information mentioned by Cresswell.

In hindsight, the decision not to use a pure form of the methodology turned out to be wholly appropriate. As the research began it became apparent that I was not going to

be able to use a tape recorder during some of the interviews, as some were conducted as a tour of site. At other times I was offered more candid views if the recorder was switched off. This meant that I found myself reliant on good note taking, either carried out during the conversation, or immediately after. I needed to be able to incorporate into my research the interviews held in this way, along with some of my thoughts around these situations. I also became aware of the wealth of unspoken language such as signs and symbols that surrounded me in these situations. A camera would have been useful to capture the wider environment, although the sensitivity of using this within a hospital and the subject's reaction to such a request would need to have been addressed.

4.4 My Initial Plan

My next step was to draw up my initial plan and then to test it to evidence the advantages and disadvantages (Gill and Johnson 1996).

4.4.1 The Plan

Step One – Carry out a series of interviews with the FM Management Teams within the Research Group:

These interviews were to cover any areas of leadership that the FM Manager wanted to discuss, information about the Trust and details of the FM Manager as an individual. Although allowing the FM Manager to freely choose the content of the conversation, I planned to ensure that every FM Manager had covered three main topics: personal attributes and skills; use of processes and information; and observations on consistently delivering high standards of patient environments.

I saw the advantages of the interview as the ability to elicit sensitive information at a time of great change in the NHS and to get individuals' views, not facts or dogma, wherever possible. I believed that I would gain a greater insight through more informal interviews than if I used questionnaires and/or structured interviews, as the FM Managers would be able to control the interviews themselves and include their points of importance and/or enthusiasm. I also wanted to be certain that I acted ethically and respected the contributors to the research (Rowley 2003)

Step Two - Look at the wider environment of the FM Management Team:

I planned to look at the less overt messages of symbols, signs and unspoken language and to use this information to further inform the findings from the interviews. The advantages of this approach were that it would provide me with a rich source of qualitative data; it would be unobtrusive and show the more informal aspects of the FM Managers' work world, allowing me some further interpretation of the FM Managers' perspectives. I needed, however, to observe the impact that I may bring to the research at this point as the meanings given to symbols by the researcher are not necessarily the meanings inferred by organisational members (Rafaeli and Worline 1999).

Step Three - Analyse the information through categories and themes, thus leaving room for interpretation:

I planned to use the analytical tools from the Grounded Theory approach, codes and categories, to analyse the interviews and my observations of the wider environment in order to understand key themes. I proposed to allocate each comment made by the FM Manager during the interview to a category. I would then group the categories across all the interviews and highlight the main themes deriving from the categories. I would work with my comments on the FM Managers' wider environment in the same way, looking for evidence of the themes that I had identified from the FM Managers' interviews.

Step Four – To compare my findings with the model of leadership that resulted from the literature search:

In comparing the findings with the literature search, I would look for a match or comparison that showed that the FM Managers had similar views to that expressed in the literature, or issues or thoughts that they raised that were not covered by the literature. As will be seen in Chapter 6 Reflections Limitations and Future Research additional thoughts were raised and I returned to the literature for evidence of further underpinning knowledge.

Step Five – To draw up reflections upon the analysis and draw conclusions from the study

As my intention was to have as deep an understanding of the participants as I could in the time I had, I decided that the advantages of this initial plan outweighed the disadvantages. The greatest disadvantage that I saw was that I could easily jump to conclusions when analysing the data. However, I felt this was partly mitigated by my

desire to include a high level of quotation as part of a careful analysis and the inclusion of an initial set of reflections. I felt that these activities would give me a full and rounded set of information upon which to base my conclusions. Thus I moved on to test my plan.

4.4.2 Testing the Plan

In order to do this, I carried out three trial interviews with colleagues in senior FM management positions. I then categorised the interviews and looked for themes; this proved to be a satisfactory, if challenging, methodology and became the one that I would use throughout my research. I realised that I was dealing with a series of sub-conversations (the interviews) that fitted together to make up one overall conversation, with each interviewee participating in the conversation. At this point I stopped thinking of these interactions as interviews, albeit unstructured, and thought instead in terms of conversations. This realisation impacted on the way that I decided to present the findings[27].

During the testing stage I did not carry out any formal observations regarding the wider environment, but simply started to note what type of things I might be looking for. This was largely due to the fact that the test conversations were carried out in an ad hoc way that meant they followed other meetings, or took place around other events. This meant that only one test was carried out in the workplace of the interviewee. During the one test conversation that took place at the FM manager's site it was clear to me that there was a wealth of additional information that was available regarding the wider environment that could inform my study. This reinforced my determination to carry out the research in the FM Manager's workplace and not to be deterred by difficulties such as travel time and travel and accommodation expenses.

4.5 The Application for Favourable Ethics Opinion

Before research can be carried out in the NHS, the researcher has to apply for, and receive, favourable ethics opinion from the NHS Research Ethics Committee. I have included a pen sketch[28] of my experiences in making my application as I feel this to be

[27] See Chapter 5 for a discussion on the presentation of the analysis
[28] My story telling (see Chapter 6 for discussion around story telling) will show images of the 'old' NHS set against the backdrop of a research study that deals with the 'new' NHS

of interest to the reader given the call for change through new ways of working in the NHS[29]. This is particularly so in that the Department of Health (2001) formally recognises the relationship between the contribution of research to the efficiency and effectiveness of the content, planning, delivery and monitoring of health and social care, and the part that the NHS Research Ethics Committees have to play in this.

I approached the Trust Research Manager at my then employing NHS Trust to ascertain how this application should be made and, upon her advice, completed an application document which was to be submitted to the Local Ethics Committee. The application form was structured to favour quantitative research and writing the submission was challenging as I would not be testing a question in the positivist manner, but attempting to create knowledge through understanding the meaning of phenomena. As I have laid out in Section 4.2 My Research Stance, I wanted to use the inductive approach in order to gain a subjective meaning of social actions, rather than embrace the positivist approach of applying the methods of the natural sciences to the study of social reality. This meant that at the time of completing the form I was still in the very early stages of forming a full research question. The application also called for copies of the documentation to be used as part of the research (for example questionnaires) and again my chosen research methodology did not fully fit with this approach.

It transpired that I would need to make an application to one of the Regionally based National Ethics Committee as my research would cover Trusts around England, rather than in one region, and a second submission was required. As the Ethics Committees were re-organised over the period of my submission the second submission was to be made via the Ethics Committee web site, rather than by paper copy. However, the new application form still leant towards positivist styles of research. I was disappointed that this was the case, as I felt that the review that took place prior to the re-organisation might have identified the bias towards a particular methodology or approach and provided an opportunity to create more balance.

Before the Ethics Committee was prepared to consider my application, I was asked to resubmit the section containing the detail of my research as it was seen as unclear. I attempted to clarify my position by including some additional information on my

[29] See Chapter 1 for information on the NHS Plan 2000 which calls for radical change

methodology. Many months after my initial submission I received an invitation to attend an Ethics Committee to be held in Leeds at which to defend my application.

The Committee convened in a very nice hotel, conveniently placed near to the main line station. After gaining entry through a receptionist, I took the lift to the floor where the Committee was meeting, where I was greeted at the lift door by the organiser of the event. I was asked to take coffee and to wait in a large foyer, populated with very small groups of chairs and tables, outside the Committee room. I was told that I would be called into the Committee room when I was required. One other person was waiting in the foyer – we made no effort to greet each other and sat alone in the little islands of seats on separate sides of the large foyer. The organiser did not speak to me again until she called me into the room where the Committee was meeting, some 40 minutes later.

Apparently the panel on that day was small, as it was held on the day after the bombings in London and several panel members had been unable to travel. However, it comprised of some 20 people, both clinical and lay. They were seated around a large table that took up most of the room. There was one spare seat at the table and the Chair stood as I entered the room and instructed me to sit at this seat. He introduced himself by name and clinical status and started to give his point of view on my application. He also represented the written views of absent colleagues. None of the other Committee members were introduced to me, and there was little opportunity for me to look at my paperwork or make meaningful answers to his questions. Members of the Committee seemed to be surprised that the application in front of them was not of a clinical nature. A few members underlined the points made by the Chair whilst others did not seem interested in the content of the application.

The Chair stated that the Committee was not happy that I proposed to study only FM managers in Trusts with successful PEAT scores and felt that I should also study failing FM managers in order to establish the difference and thus prove my hypothesis. Although I explained that my study was not concerned with proving the 'right' way to lead, but merely to discover the discourse of the successful FM managers, the Committee was unable to accept that this was a valid approach. A favourable opinion was only given upon a letter from my Supervisor at the University being lodged along with the application (see Appendix 1). The reservations of the Committee were

recorded. This seemed to me to be a further indication of the positivistic stance of the Ethics Committee.

The Chair was also concerned that the information was of a sensitive nature and he required that a consent form be signed before the research started at each Trust. I was surprised by this at the time and felt it to be rather unnecessary, however sensitivity did surface, and in the early stages of the research. I feel that my lack of understanding over the sensitivity was indicative of my research naivety and was a lesson for me to learn.

I was asked to further modify my application, and to include examples of the documentation to be used at the interviews (for example, consent forms, letters inviting Interviewees to interview etc). Following this resubmission, and several months later, I received a letter telling me that my application had been successful and that I could proceed with my research. The letter informed me that I was required to notify the Research Manager at each Trust where my research was to take place, but that no further permissions were necessary.

My observations on the limitations placed on my research by the process and duration of the application for favourable opinion is set out in Chapter 6 Limitations and Reflections.

4.6 Contacting Trusts within the Research Group

Upon receiving the favourable opinion from the Ethics Committee, I made contact with the Research Department at each of the Trusts in the Research Group, giving notification of the nature of the study, of the Ethics Committee opinion and the intention to start research at their site. I received communications from most of the Trust Research Departments telling me not to proceed with the research until I had their permission and asking me to send in copies of my Ethics Committee application and liability statements from my employing organisation, and asking me to fill in various forms and paperwork.

ID	Identifier Name	Withdrawn	No permission granted/ no reply	Invitation to visit
1	Bourdin		x	
2	Rhodes			x
3	Harriott			x
4	Stein			x
5	Oliver			x
6	Smith			x
7	Ramsay		x	
8	Williams		x	
9	Whitingstall		x	
10	Lawson			x
11	Slater	no site access allowed		
12	Martin	Specialist Trust		
13	Garcia	delayed		
14	Rosengarten		x	
15	Blumenthal		x	
16	Carrier		x	

Figure 4.1 Results of contact with Trusts within the Research Group

I also received notification from the Research Manager at Martin that the Trust was a specialist acute Trust and therefore did not fit the criteria of being an acute Trust offering non-specialist services. This fitted with the findings of my desk research[30] and I removed Martin from the Research Group. Slater gave me permission to use a postal questionnaire but would not allow me to visit their site or speak to their FM Management Team, this meant I could not progress my research with this Trust as this approach did not match my research philosophy. Garcia gave permission after a very long delay; unfortunately the research was completed by that time and the opportunity to be included had been missed.

4.6.1 Contact with FM Management Teams within the Research Group

Research was undertaken to find the contact name for the person who was responsible for FM within the 13 Trusts now making up the Research Group. Again Binley's Directory of NHS Management (2004/05) and the Trusts' web sites proved very useful, as did the Health Estates and FM Association (HEFMA[31]). A name was sourced for each of the Trusts and I approached the 13 FM contacts. This resulted in invitations to visit six of the Trusts - Rhodes, Smith, Oliver, Stein, Harriott and Lawson Trusts in

[30] See Chapter 2

[31] This is the association for NHS managers working within FM. Its activities are largely carried out on a Regional basis and its main focus is on networking. Other associations provide professional networks for individual areas, e.g. engineering, estates, catering etc.

order to talk to key members of the FM Management Teams. A summary of the position at this point is shown in Figure 4.1.

4.6.2 Selection of the FM Managers

I left FM Managers within the Trusts to decide whom, within their management team they wished to put forward. I requested meetings with their Director, Senior Manager, and/or Operational Managers in order that I could understand whether the conversations were multi-layered or particular to one level of seniority. Arrangements were made to talk to twenty-two FM Managers who operated at Director, Senior Manager and Operational Manager level; the levels of the FM Managers at each Trust are shown in Table 4.2. The conversations at each Trust were planned to take place on one day, consecutively and arranged to last one hour, although in practice several ran over the time allowance. When a conversation overran I made no effort to bring the conversations to a conclusion, as new information was being made available to me throughout.

Trust Identifier	Director	Senior Manager	Operational Manager	Total Interviewed	Total Interviews
Smith	1	3	0	4	3
Lawson	2*	3*	2*	7*	4
Stein	1	2	1	4	3
Harriott	1	1	0	2	2
Rhodes	0	1	1	2	1
Oliver	1*	1*	1*	3*	3
Total	**5**	**12**	**4**	**22**	**16**

Figure 4.2 Levels and numbers of FM Managers (* includes FM Managers from Contractor's team)

As can be seen from the schedule (Figure 4.3) some of the interviews were to take place on a 1:1 basis and some as a 2:1, for example, the Senior Manager at Rhodes invited his Operational Manager to join the conversation, as did one of the Senior Managers at Stein. Lawson provided an opportunity for me to talk to the contractor's management team and they chose to hold their discussion as a group. At Smith the Director and one Senior Manager opted for a joint conversation, while other Senior Managers chose a 1:1 approach. Thus, it was planned that twenty-two FM Managers would contribute to the research through sixteen conversations.

Trust Identifier	Interview 1	Interview 2	Interview 3	Interview 4
Smith	1 Senior Mgr	1 Senior Mgr	1 Director 1 Senior Mgr	N/A
Lawson	1 Director	1 Senior Mgr	1 Ops Mgr	1 Director* 1 Senior Mgr* 2 Ops Mgr*
Stein	1 Director	1 Senior Mgr	1 Senior Mgr 1 Ops Mgr	N/A
Harriott	1 Director	1 Senior Mgr	N/A	N/A
Rhodes	1 Senior Mgr 1 Ops Mgr	N/A	N/A	N/A
Oliver	1 Senior Mgr*	1 Ops Mgr*	1 Director*	N/A

Figure 4.3 Schedule (* includes FM Managers from Contractor's team)

However, each conversation was planned in the same way in order to ensure that an underpinning structure was applied to all the conversations no matter how many participants. I would explain to the FM Manager(s):

- why their Trust had been identified as part of the Research Group;
- that I was seeking to establish why their Trust fell into that group of high achievers;
- that some initial desk research had assisted me in formulating the idea that it might be the way that they led their team(s); and
- that the conversation was to cover any areas of leadership that the FM Manager(s) wanted to discuss, information about the Trust and details of the FM Manager(s) as individual(s).

CONVERSATION GUIDE
Why the Trust met the Research Criteria, namely: • **Acute** • **Non specialist** • **Green peat score from 2001 – 2003** • **Good or excellent score for 2004**
My Statement: That some initial desk research had assisted me in formulating the idea that it might be the way that they led their team(s). During the conversation I was particularly interested in hearing their views on how they led or managed.
Areas that must be covered: What were their personal attributes and skills; What processes and information did they use and why; Their observations on how they consistently delivered high standards of patient environments

Figure 4.4 Conversation Guide

Figure 4.4 shows the prompt sheet which I planned to use during the conversations to ensure that the conversations, whilst free flowing and open to the FM Managers views and thoughts, started on the same note and covered the three main points of interest. I declined any invitations from the FM Managers to discuss my research before the

conversation in order to ensure that I did not introduce themes to the conversation that would not have arisen otherwise.

4.7 Managing the FM Managers' Sensitivities

Whilst carrying out the conversations it became evident that several of the FM Managers were sensitive about the conversation we were to have and the possibility that they would make statements that could be attributed to them. Whilst they wanted me to have a true account of their observations, they were keen that the information was presented in a way whereby they could not be identified, either by other members within their Trust, by people reading the thesis, or by other participants in the study. On two occasions I was asked not to use the tape recorder, one FM Manager saying that s/he would tell me the 'real story' if I turned off the tape recorder. They felt that blame could be apportioned and retribution would follow if they did not reflect the organisational view.

As previously stated in Section 4.3 Research Methodology, I had planned to identify each Trust with a code name and then allocate each participant within that Trust a code name. It became apparent to me that, once the Trust code name was known, it was possible to work out the identity of an individual, despite also assigning a code name to each individual. This has resulted in my identifying only the Trust by a code name, and using this single code name for all comments made by any FM Manager at that Trust. In order to ensure fair representation of views I have quoted each participant individually, thus several views from the same Trust are recorded where more than one FM Manager has made comments on the same topic, even when the comments may appear identical.

I used this approach, as it was not possible to drop the code name for the Trust and code each FM Manager, as this invalidated the desk research. I felt the desk research to be an important part of the study, not least because some of the FM Managers saw part of their success as due to some of these external contributory factors.

Two more areas of identification to be eradicated from my text were geographical locators and company names of contractors. The geographical location was important as the information on PEAT scores is available to the public. My research methodology clearly sets out the criteria used to identify the Trust and thus it is

possible pinpoint the initial research group. Identification becomes a little bit more difficult after that, as some Trusts chose not to be included in the research. But some Trusts stand-alone in a large geographical area so are easily identified by quotes by the FM Managers that contain the names of neighbouring Trusts. These names have been removed, with codes such as 'xx' and 'yy' employed in place of the name. Secondly, the names of contractors had to be removed, as again it would be possible to narrow down the Trusts in the initial listing by matching Trust name and contractor's name, information easily gained. These I replaced with simple expressions such as 'the contractor'.

It is worthy of note that out of the twenty-two people that took part in the conversations, only three of these were women and were based at one Trust. Whilst this study in no way considers the differences between the genders and the possible differences in their approach to leadership, nor seeks to follow feminist research methodology, it is important to note this lack of gender balance and the impact it might have had on my research. It would be interesting to understand why I spoke to so few female FM managers, particularly when the areas that provide many of the FM services are traditionally areas that employ high numbers of females. However, the topic is outside of the scope of this research.

I discussed the sensitivity of the FM Managers with colleagues who have carried out research in the NHS, with similar experiences. For example, a colleague told me that s/he held focus groups and was given a consensus opinion. Later, several individuals stopped her/him in the corridor each saying that they did not agree with the view expressed at the focus group and offering her/him an alternative view. When together, members of the group had felt the need to 'toe the party line' in case they 'paid the price' for their differing views.

Whilst I recognised that the prevailing culture within the NHS would inform the behaviour of the FM Managers, I attributed many of these sensitivities to the situation in which the NHS found itself at the time I was carrying out the research. Many Trusts across England were declaring large financial deficits and cutting back on both clinical and non-clinical staff. As we can see from the comments made during the conversations, many FM Managers were involved in finding cash savings from their budget, or dealing with the extra controls put in place to manage deficits. In addition to this Primary Care Trusts and Strategic Health Authorities were being restructured and

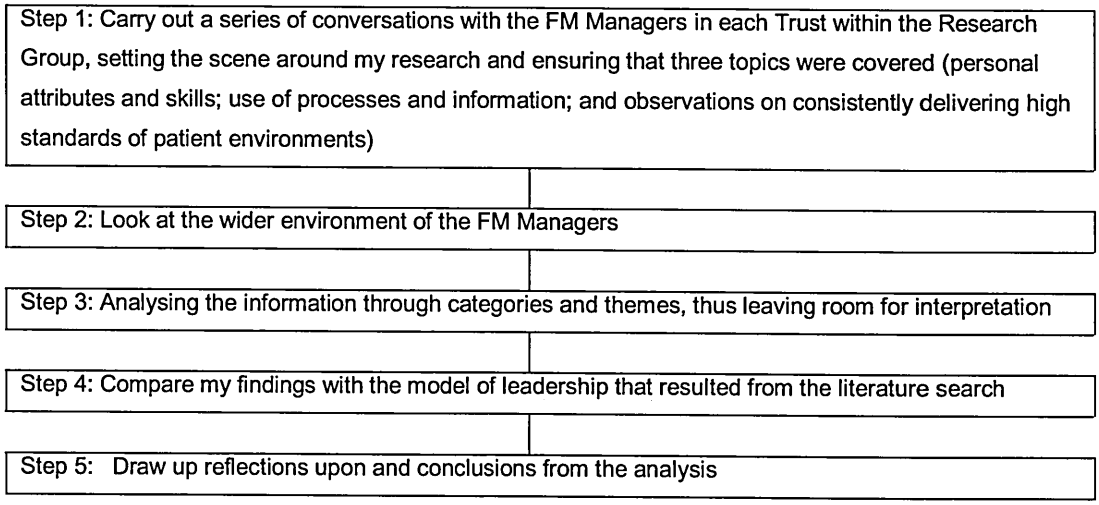
the number of jobs reduced in these areas, thus creating a large pool of managers seeking employment within the NHS. I think it is understandable that people would be sensitive to this situation and may feel the need to be careful about what they were saying. It is all credit to the twenty-two FM Managers in this study that they retained their commitment to their work at such a difficult time, and were prepared to be open and honest about their thoughts and feelings during their conversations with me. In the next chapter (Section 5.3.1 Analysis Methodology) I identify the ten themes that FM Managers conversations focused on. My observations above helped to underline to me the strength of the themes of Confidence, Pride and Commitment and Personal Development which I identified from their conversations

4.8 Conclusion

This chapter has laid out my research stance and looked at the methodology that I will be adopting for my research. I show how I decided to use a hybrid approach to my qualitative research, drawn from the theories of Grounded Theory , but giving me the flexibility to allow my study to unfold as I work on my research question.

I have also discussed the Ethics Committee application and the approaches made to the Trusts within the Research Group and the FM Managers at the six Trusts who participated in the research. I then detailed the plan to talk to twenty-two FM Managers at Director, Senior Manager and Operational Manager level through sixteen meetings and dealt with some of the sensitivity issues raised by those FM Managers.

The plan for the research has been identified as five key steps:



Having given the reader a comprehensive overview of the approach and methodology to be taken and the planned activities of the research, the next chapter moves on to report on the conversations that I had with the FM Managers within the Research Group, the analysis of those conversations and my reflections on their wider environment.

5.1 Introduction

Figure 5 signposts the reader to the position that Chapter 5 The Conversations with the FM Managers takes in the research route, while Figure 5.1 gives additional detail on workflow.

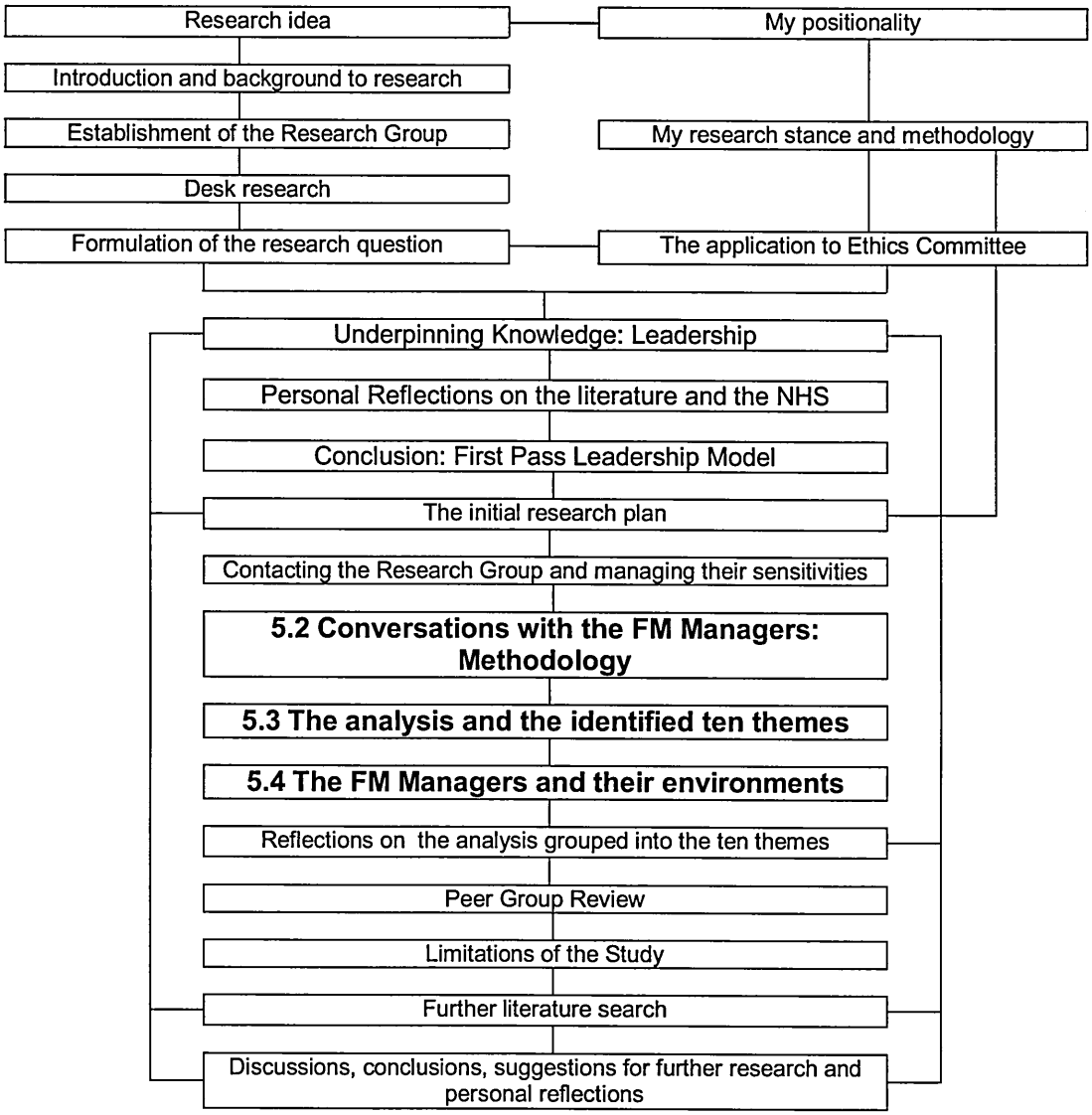


Figure 5 The Thesis set out in the Research Pathway

In Chapter Four The Research Methodology, I addressed the need to establish a robust research methodology by looking at my research stance, my chosen research methodology and my research plan. I also talked about my application for favourable

ethics opinion, discussed how I made contact with the Research Group and how the resultant access to twenty-two FM Managers during sixteen meetings had been gained. I also discuss how I needed to review my methodology to accommodate their sensitivities, and indeed why this sensitivity might have existed.

5.2 Methodology

I planned a five-step plan to the research and in this chapter I look at the first three of these steps, namely: a series of conversations with the FM Managers in each Trust within the Research Group; reflections on the FM Managers' wider environment; and, analysing the information through categories and themes. The methodology relied on a number of iterations at this point, and in an effort to show the reader how this fitted within the research pathway I have shown a more detailed figure of the research pathway for this stage of the work (See Figure 5.1).

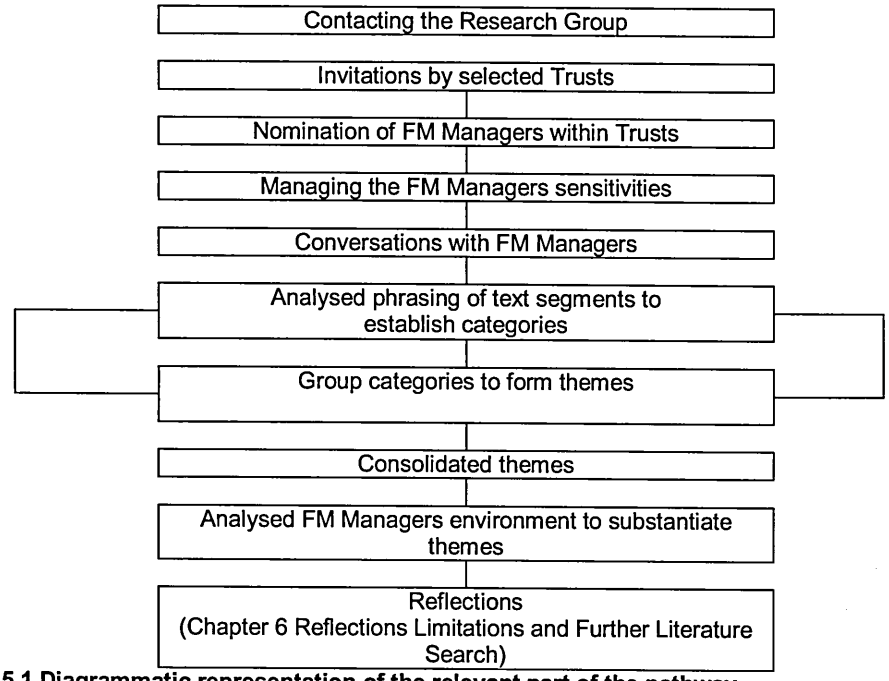


Figure 5.1 Diagrammatic representation of the relevant part of the pathway

Having completed the conversations with the FM Managers my first task was to transcribe the text in a verbatim style and break up the conversations into segments (phrases, sentences or words) in order to allow the analysis of the content of the conversations. This I did using a spreadsheet, cutting and pasting text segments into rows on the spreadsheet. See Figure 5.2 for a short example of text segments.

We were three star, but that is all gone now
Our Chairman is very good, she's from the oil industry
Our Chairman is clearly a business woman, she has certainly bitten the bullet re the financial position. She is much more demanding regarding this, she's really going at the Directors and the NED's are following that lead
I am integrated with the Exec Directors - I have a relationship with the HR Director, we worked very closely when the TUPE arrangements were taking place. They were very supportive. Now the A4C issues are bubbling away
There is a corporate expectation that Facilities will achieve
We became a three star trust and have maintained that ever since
We are seen as a successful Trust. Staff know they work for a successful Trust, 3 star, no job cuts and not financially hard up. They listen to the news and deep down this is important to them
The local community work in the hospital and are related
They have a stake in the community
There is a lot of ownership in the hospital
I don't get tired and worn down because I have a short memory, I have a sulk and then I bounce back quick. I sulked at A4C, I was thoroughly miserable. You get knocks that means you get pats on the back too

Figure 5.2 Identification of text segments from the conversations

I analysed the text segments from each conversation looking for commonalities, by which to define categories of text segments. I then re-examined the segments of text assigning them to one of these categories. At first I found this very confusing, ending up with long lists of categories with only one or two segments of text in each category. I re-iterated this procedure several times before recognising that I could consolidate the categories reducing overlap and redundancy, for example, the site/ its size and/or position. Subsequently I grouped together the categories to form themes, starting to create the model of the Ten Themes of Leadership[32].

Figure 5.3 shows the process of inductive analysis (Thomas 2006) used to identify text segments, create categories, allocate text segments to categories, reduce overlap and redundancy among the categories, and form themes. I also include within this figure an example using one of the themes, luck and contributory factors, to show how I progressed the analysis (9 other groupings were made to form a total of ten themes).

Although Figure 5.3 shows this as a linear and tidy activity, it proved to be a messy and rather difficult affair, with many frustrations and iterations. Following the advice of Lofland and Lofland (1995) I analysed each group of interviews as I completed my visit to each Trust in order to avoid the feeling that I was facing a monumental task. However, whilst this had the advantage of ensuring that the analysis was dealt with in a timely fashion, I only felt that I could see the whole picture when all the conversations

were completed. This called for further iterations and minor adaptations to the categories. Eventually I settled on the categories shown in Figure 5.4. In hindsight I feel I might have reduced the number of categories that I used even more, by providing one more general category rather than several specific, or by considering the introduction of sub-categories within categories. For example, when categorising information around the PEAT initiative I used FM Managers commitment to PEAT; PEAT and the FM Team; PEAT initiative; PEAT initiative and star ratings; Top Team support for PEAT; and, PEAT inspection team. I might have used PEAT as the category and then had sub-categories within that. This issue arises as the categories do not stand alone, but are interdependent. However, in writing the thesis it is necessary to show the categories and themes laid out as a linear arrangement, simply to allow the reader to understand the analysis that has been undertaken. The interdependence is played into the later write up of my observations, reflections and conclusions.

Once I had formed a robust list of categories, I looked for the themes that categories had in common. To do this I grouped the categories and gave them names. For example, the FM Managers talked about pride in their organisation and then about an achievement that they were proud of; these groups of categories were themed as Pride. As more categories were grouped it became evident that pride and commitment were inextricably linked and therefore a theme of Pride and Commitment emerged. Again, this work took several iterations, but eventually I settled upon ten themes that grouped all the categories in a seemingly logical manner.

I was not surprised by the difficulties I encountered in analysing the data that I had gathered. Qualitative research is diffuse and the very encouragement of the wide reaching and open ended questioning leads to many different thoughts and ideas being expressed; this is the strength of the methodology. However, all research has to be drawn together in order that conclusions can be drawn, and a more linear approach has to be adopted in order to carry out this task in an acceptable way. At this point interesting tensions arise between the wide reaching, diffuse mass of findings and the tidy, linear end point required. There is of course a danger of losing some of the quality of the findings during this drive to present a cohesive finished document that fits with

[32] See Figure 5.3

the expected research norms, and I employed a careful system of work and re-iterations to safeguard against this.

I identified and analysed two themes around FM team members and contractors' teams, and these have been shown as separate themes in this chapter. However, when I came to reflect upon the analysis, I found that there was very little difference in the FM Managers approach to teams that were in-house or contract, and my conclusion was that the FM Managers treated contractors' staff as their own and recognised them as part of the team. Thus the two themes have been amalgamated in Chapter 6 Reflections, Limitations and Further Research.

During my work on the analysis the FM Managers' conversations came alive again, and it became very important to me to show the reader the content of the conversations. I wanted the reader to experience the words in the same way as I had done. Therefore I opted to use a high level of quotation with subdued levels of editorial when reporting on the analysis of the conversations. In my text I wanted to conjure up the image of having the twenty-two FM Managers around a table each putting forward their own ideas and thoughts on each of the themes, but in no way constrained by the themes, free to express their own views. Whilst these thoughts may give the illusion of the researcher as an observer or reporter, the impact that I made as the Researcher should not be forgotten. My influence will have been felt by my categorising, coding and reflecting the comments; I have inevitably started to interpret the conversations by introducing linking and introductory words.

The Process of Inductive Analysis Used	An Example of the analysis

Initial reading of text data (many pages of text)

Identify text segments (many segments of text)

Label the segments of text to create categories (many categories)

Text segment	*Category*
'There are lots of things we have been lucky with, e.g. 105 modern wheelchairs'	Lucky
'We had a head start - domestic services had been provided by a contractor until very recently...so when PEAT came we already had a [monitoring] group there, they had been there for 2-3 years, so that was fortunate.' We have always had an in house service, we have never cut standards to the levels that others have. Cleaning staff are in house, so they feel part of the team.'	Services contracted in or out
'It is a simple site' 'The site is neat, not complicated', 'No older workhouse buildings' '...but we are lucky we have only one site to focus on' 'We are lucky, this is a modern hospital so we are not starting from scratch.' 'We are resilient, we are quite lucky, the hospital is not too big to manage like [our neighbouring] Hospitals - but then even the big jobs are do-able' 'Some of the success will be where we started, Victorian hospital versus new hospital' 'The size of the hospital allows for people to know each other by name, the supervisor will know the estates people personally.' 'The geography is what makes us successful' 'We are lucky, this is an out of city hospital, there is space and it is green - we are lucky with car parking'	Site/size/ geography
'We have freedom with finishes, for example in MRI we fitted fibre optic lights as filament lights are affected by the MRI scanner. We didn't know which firm would provide the MRI, so we had to design a box and talk to the manufacturers to get information'	Learning
'We sell Chef's special and ethnic food (we have our own ethnic chef) to other Trusts and sell some frozen food to the general market'	Innovation
'We have difficulties cleaning the courtyard windows and the cladding - it doesn't look good for patients when they look out of their ward window, they changed the regulations about working at height after the hospital was built. But we do our best.' 'Decant facilities are not available, so we have to work around things and do things more piecemeal' '...put up carparking charges' [in order to meet their budgetary gap]	Solution finding

Reduce overlap and redundancy among the categories	Lucky; Services contracted in or out; Site/size/geography; Solution finding
Create a model incorporating the most important categories	The model created was the 10 Themes of Leadership (see Figure 5.3) of which this example is Theme 3 - Luck and other contributory factors

Figure 5.3 The Process of Inductive Analysis Used Including an Example of the Analysis

Figure 5.4 shows the ten themes that resulted from my analysis, with each of the categories grouped within these themes. Section 5.3.1 The Detail of the Analysis is laid out by theme, but the categories are subsumed in order within the text so as not to impede the flow for the reader. As I have said, I tried not to place any particular interpretation or observation upon each theme, but simply tried to arrive at a point where the themes were made up from a cohesive group of categories and thus comments.

Themes		Categories	
1	Pride and commitment	Chartered status Pride in the organisation Self critical Not all have pride Long term future Needing success Pride in success Their commitment to PEAT Frustration	Mistakes External recognition Loss of pride Loss of direction Rewards for commitment Model service delivery to standards required Personal commitment
2	Personal Style	Responsibility Getting people on board Teamwork Personal style Adaptive style Accessibility Leading by example	Visual standards Time management/workload Clarity of roles Communication skills Dealing with issues Fair and honest Role model
3	Luck and other contributory factors	Lucky Services contracted in or out Site/size/geography Solution finding	
4	Opportunity for personal development	Career advancement Maturity Development opportunities Experience Mentors/coaches First qualifications Developing directors Sharing with others Formal studies/seminars New responsibilities	Financing training Training Performance Indicators Staff awards Appraisals Career development Time to develop Networking NVQ's Agenda for Change Professional Development
5	Maximising the contribution from FM Staff	First qualifications Success through people Commitment of staff Understanding staff Challenges with staff Motivation Self esteem PEAT and the FM Team Feedback/praise Awards Traditional supervisors and managers	Teamwork Integration across teams Geography/family employer Selling ideas Knowing individuals Adapting language Dealing with issues Recruitment Regular meetings/discussions Sharing information Performance monitoring Creating ownership
6	Maximising the contribution from the Contractor's Team	Performance monitoring Integration with in house staff In house versus contract	Partnering Financing change Financial impact of standards

7	Stability, experience and change	History, stories, legends Financial recovery Stability in management teams Organisational culture Experience and results Low turnover Foundation Trust status	Change and creativity Benefits of change Managing change Opportunities for change Financial pressures Value for money/benchmarking Change
8	Integration with clinical Teams	Isolation Roles to create integration PEAT initiative Modern matrons Value for money Part of overall team Ward level integration Skills and experience Partnership Relationships	Specifications Reporting against standards Service design Receiving feedback Dialogue Dealing with issues Customer desires Standards Difficulties Engaging nurses
9	Integration with the corporate agenda and the Top Team	Improved service delivery Working against integration Conversations Reporting achievements Isolation Calibre of leader PEAT initiative and star ratings Top Team support for PEAT Objectives Relationships Status Integration	Place on board Others' agendas Relationship versus structure Finance and investment Reporting results The PEAT inspection team Organisational culture Disadvantages Organisation of top team Opinions on top team Focus on outcomes and results
10	External perspective	Major stakeholder Patient Environment Positive feeling by community Involvement of patients Commitment to local community	Recruitment National bodies Pool to draw upon Patient Choice

Figure 5.4 The Themes and categories used to code conversations

In Chapter 4, Section 4.4.1 I laid out my initial research plan, explaining that I intended to look at the less overt messages of symbols, signs and unspoken language and to use this information to further inform the findings from the interviews. I felt that this would provide me with a rich source of qualitative data and show the more subconscious aspects of the FM Managers' work world, allowing me some further interpretation of the FM Managers' perspectives. Section 5.4 deals with my observations and reflections on the FM Managers and their environments. Below, I look at the manner in which the data was recorded, analysed and combined with the analysis from the conversations.

As noted in Chapter 5, the unspoken message had really started before I met the FM Managers. It started when I carried out my desk research and made my initial contact with the Trust and the FM team. Anything that struck me in particular during these interactions was recorded in my record book. To that I added observations and a record of my feelings following the site visit on the day of the conversations. In order to

ensure that I observed the Patient Environment about which we would converse I ensured that I visited public areas within each site and noted my observations and feelings about what I saw and its impact. I also made a record of my reflection of the Facilities Managers to whom I had spoken on that day. I did this as soon as possible after the meetings, sometimes in the car before leaving the site.

The Process of Inductive Analysis Used	**An Example of the analysis**	
Initial reading of reflections an observations (many pages of text)		
Identify text segments (many segments of text)		
Label the segments of text that relate to the themes	*Theme*	*Text segment from written record*
	Pride and Commitment	The FM Managers acceptance of their position in the Research Group Visible high standards – café's entrances, sign posting, car parking etc See themselves as professionals Don't want to be part of a failing Trust Very enthusiastic about working in FM Visible signs of high levels of energy and enthusiasm They would not rest until a suitable solution was found Find change exciting Want to be part of a succeeding Trust
Review the groupings of text segments that underpin the model looking for evidence of the ten leadership themes	Text segments were found to underpin all ten themes of leadership.	

Figure 5.5 The Process of Inductive Analysis Used Including an Example of the Analysis of the Reflections on the FM Managers and their Environments

Upon completion of the analysis of the conversations, I took the records of my observations and reflections on the FM Managers and their environments and looked for text segments in the same way as I had approached the conversations. This time I looked for segments that reflected the ten themes of leadership; I did not look for new categories or themes. Figure 5.5 uses one of the Ten Themes of Leadership (Theme 1, Pride and Commitment) as an example of the analysis process.

5.3 The Analysis

5.3.1 The Detail of the Analysis

Theme 1 Pride and Commitment

There was evidence of pride during conversations with the FM Managers. An FM Manager at Oliver was proud of his chartered status and wanted to use that to contribute to the Trust agenda.

> *'I am a chartered surveyor so I have something to contribute to the Estates Utilisation Group'.*

The FM Managers' pride in their Organisation was voiced as

> *'There is lots of pride here'* (Smith)
>
> *'People who work here have pride'* (Lawson)
>
> *'We are seen as a successful Trust. Staff know they work for a successful Trust' (Harriott)*
>
> *'3 star, no job cuts and not financially hard up. They listen to the news and deep down this is important to them'* (Harriott)
>
> *'It is generally recognised that it is a good hospital, people know we are an FT three star hospital and do well'* (Smith)
>
> *'We became a three star trust and have maintained that ever since'* (Oliver)
>
> *'We do not compromise on quality and design'* (Stein)

> *'Facilities Management staff know what the right thing to do is' and 'They do things that are in the best interest of the client' and 'People are passionate about what they do here.'* (Stein)

This feeling of pride in the organisation rather than individual was reflected in the comment that

> *'FM staff have a huge loyalty to the organisation and the department - not to me'* (Stein)

Stein acknowledged that they were *' very self critical'* and this may have caused them to be *'... half a mark short of excellent'* at their last PEAT assessment.

However the pride shown was tempered with practical day to day thoughts around staff and delivery issues. Rhodes recognised that not all their people would have pride in their work and said

'Many of these staff are not here for a career, they are here for the money. They try to work to their standard or a minimum standard.'

Smith recognised that they strove to do the best they could, but recognised that would not always be right and said

'but I would be the first to hold my hands up if I got things wrong.'

Examples of external recognition were offered with evident pride by the FM Managers.

'We have been written up by NHS Estates as good practice' (Smith)

'One of our sites was the development site for Better Hospitals Food, we tested the chef's special dishes' (Rhodes)

'We have a good Clinical Risk culture, we were the first to gain level 3[33] *in the UK'* (Harriott)

Lawson are facing a very difficult future, with large financial deficit and the loss of all but one of their stars. They said

'We were three star, but that is all gone now'

This situation has impacted greatly on the FM Management Team, one FM Manager spoke of the loss of direction within the Trust and told how

'[I was] really mad with myself, we lost a year..I just let the objectives roll forward, I lost sight of where we were going, my boss didn't set me any objectives...I realised that I had let things go.'

When s/he realised that this had happened, s/he recalls how s/he

'..upset all my team, I had a tantrum and sent them a stroppy e-mail, it was my fault as much as theirs, but they should have thought about it.'

Lawson recognised their personal need to be proud of their work and their Trust. They feel that there is no long-term future for them in a failing Trust. One FM Manager reported

'I thought about leaving, but where would I go - the quality of life is good around here and my children are here. I am divorced, so I cannot take

[33] See the NHS Clinical Negligence Scheme Regulations 1996 for information on the scheme (available at the Department of Health Publications and Statistics website).

them with me if I move. The geography means I would have to move a long way away.'

And another

'I am thinking about moving on - I don't want to be working in a failing Trust'.

But, however much they are struggling with the difficulties of the changing top team and the loss of the Trust's three star status, the FM Managers at Lawson still retained the culture of needing success and having pride in that success. They missed their success, saying

'There is a lack of success around - we are living in a dream'

To counterbalance their shame at the failure, they found successes that they could be proud of and talked of those. Following a report by an external auditor they found they could be proud because they were not mentioned in the auditor's criticism.

'I am proud that we are not mentioned in that report and I have told my team that'

Faced with a lack of organisational objectives they retain their sense of pride in good service delivery - saying

'I have made up my mind that we will continue to provide a good service and stay within our budget, then we can't be criticised'

They believe they can maintain pride and confidence within the Directorate and continue to deliver despite the difficulties because they felt they could breed their own successes, saying

'We think we are successful if we are told that we are'

Several of the FM Managers spoke proudly of their commitment to PEAT, it was evident that they viewed the PEAT standards as a standard to be aspired to and worked towards, not as a tick box exercise. The FM Managers expressed this commitment in several ways, saying

'At other trusts labour costs go high just before a visit. [Here] there is no additional scrub up before a visit' (Lawson)

'*We are not just paying lip service here – [our Director] is really signed up* (Lawson)

'We believe in PEAT' and 'We take the Patient Environment very seriously.' (Stein)

'We invest a lot of time and effort into the PEAT scores' (Rhodes)

This commitment to the standards meant that services were modelled around the targets, rather than an add-on, or as Harriott expressed it

'...[it's] not a wish list, we look specifically at the target'

The commitment was also expressed on a personal basis as well as a team basis, with the FM Managers commenting

'I'm interested and I want this Trust to succeed' (Oliver)

'I just want to have a good environment' (Smith)

'I like to see the changes relating to PEAT' (Lawson)

Although frustration did creep in when one FM Manager was talking of the changes to the PEAT criteria that had taken place since its inception.

'It's a shame it is changing just when we have got it sorted out' (Rhodes)

Smith told me how their commitment was rewarded by the Organisation when the Trust stars were awarded

'They tell people they have done fantastically well. In the last two years we have had an extra days leave.'

Theme 2 Personal Style

Smith told me that leadership was about

'Taking personal responsibility', 'I like to take people on board' and 'I win hearts and minds.'

Whilst Stein felt it was all down to

'Lots of teamwork.'

Harriott talked to me of leadership style, saying:

'My leadership style is fluffy', 'I see myself as a Director or leader. I have more of a directional style e.g. we made a decision about renewing boilers The engineering decision is not my job, nor is convincing the engineers of the decision made. I deal with the economic issue and then the powerful message that [my deputy] took back was that it was enough funding for one ward. We are not going to do this, because people are adverse, I can't convince the organisation it's a good idea', 'That style of management I have learnt from the people I have worked with. They are very results

driven, but more moralist here. I have taken that lead', 'I have chosen to be arms length. When something gets difficult if you are too close it gets more difficult. I don't socialise with them anymore. It gets more difficult the more senior you are' and 'I use a softer approach'

Smith also recognised that there was a certain style that brought successful interactions with others, but felt that this style should adapt, saying

'Different people need a different style, some need closer supervision, and if the implications are serious you need to take a more detailed approach.'

Harriott reflected this thought in practical terms, saying

'...[my style] has to be hard nosed to the boss, but then I sell to the team'.

The focus on a leadership style was further explained by an FM Manager at Harriott, who told me that s/he had an overall style, but that s/he used differing approaches when working with the clinical teams and the FM workgroup.

'I am autocratic overall. I enjoy the teams around me, but I am more autocratic with facilities than with the clinical teams. They are more touchy feely.'

Stein also touched on the existence of a leadership style when s/he said that s/he was

'Definitely not autocratic.'

Oliver felt that a crucial part of their management style was accessibility, saying

'A big part of our success is our Managers being accessible', 'NHS FM are fully committed to strategic issues, but we're down here and working amongst them. They can see me, they can ask me about anything and I can answer them' and 'There is no bar to people coming in to see me or any of the managers, it is possible and very easy to do this. This is our culture, if someone says they need to speak to me they would see me that day.'

Lawson echoed this thought, saying

'... my door is always open if people have problems they can come to me'

'I speak to everyone and I know all the staff whether they are contract or not.'

At Smith this desire for accessibility was reflected by an FM Manager who was telling me how supportive another of the FM Managers was *'[His/her] door is always open.'*

At Stein accessibility was further developed by visibility

'I continually walk the site' and *'It takes up a lot of time to do this.'*

Interestingly, I was walked around the site during the time I spent with that FM Manager[34].

Another theme within the leadership style conversations was the need to lead by example.

'I lead by example, absolutely, its almost a byword. We all share our [personal] mantras at the Raising Our Game training programme, this is my mantra' and *'We try to enact valuing people'* (Oliver)

'I lead by example. I don't ask people to do what I wouldn't do and I don't drop people in the deep end, I give them my thoughts and ideas, comments and suggestions.' (Smith)

While an FM Manager at Lawson liked to think that s/he was

'a role model for people.'

As Harriott pointed out,

'You need to get respect from all the staff and get them to want to work for you.'

An FM Manager at Oliver gave an example of how their personal adherence to a standard would encourage all the team to do the same

'I answer e-mail on the day and letters within two, even if it is to say that I am investigating. I always do that.'

And that visual standards were also important

'I am at great pains to always look like a Director of the Trust, so that people can see that. I never take my jacket off, not even on a baking hot day.'

[34] See Section 5.4 for more information on my reflections on the FM Managers

Stein told me that it was very challenging to have a boss who led by example.

'The boss is very time disciplined...'I can't be like that, a lot of stuff comes in', 'I should be more strategic, [I] need to do things like the energy strategy and capital replacement plan. I get involved in operational stuff and anyway I don't want to lose control and so I don't hand it over. I don't want to overdo the control, I want to share.'

Being disciplined with time was a topic of conversation for others as well. Harriott felt that it was key that work was carried out by the right person, saying

'I do all the bureaucracy and the staff focus on what they should be focussing on.'

Whilst Smith felt it was no longer as simple as knowing who should do what and when

'Policies and procedures need reviewing and updating. Finding the time is tough and delegation now not possible.'

Their response to this lack of time was

'We simplify processes to allow us to focus on the real job.'

The need for simplification was echoed by Harriott

'People complicate things fantastically, my managers say that I over simplify.'

An FM Manager at Lawson felt that a clear understanding of one's role allowed one to focus one's time

'I am involved in the planning ahead. I am not operational.'

Good communication skills were also felt to engender trust and respect and encourage better working styles. The FM Managers told me

'I like to think that I am a good communicator." (Lawson)

'I believe in communication', 'I explain why we have to do things' and 'I communicate to staff' and *'I involve everyone'* (Stein)

'I value [their] advice, s/he's good to talk to, and I can talk to [them] ... a bit like a mentor.' (Stein)

'Once you start listening you hear other things.' (Harriott)

Being an FM Manager does not only involve telling people good news. Oliver told how communication was handled without damaging morale and pride

'If the staff do well, we talk about 'you'. If there is an issue or something goes wrong we talk about 'we'. It is a collective thing.'

Stein echoed this need to be able to communicate bad news

'I believe in telling them when they get it wrong.'

The need to be seen as fair and honest was also the topic of conversation with several of the FM Managers.

'I am fair and honest and open.' (Oliver)

'You know you will get an honest answer from him - cards are on the table.' (Smith)

'I am firm but fair.' (Stein)

'I fight the corner for what is fair, and people get behind you.' (Harriott)

An FM Manager at Harriott felt that FM Team members may not be able to see that the decisions s/he needs to take are fair, as there is a bigger agenda which they may not see. S/he says that because of this s/he is

'... a pragmatic leader. The Directorate is disappointed in me as I don't always fight their corner.'

As well as having good relationships, Harriott see clarity of role as important. While there was clarity about the expectation that supervisors would

'... step away from technical stuff.'

At one point there was less clarity at higher levels

'I have had to fight to keep my Director in his job and to allow me to manage Facilities'

It seems that this has been worked through, and there seemed to be some agreement over who did what. When I asked whether the FM Manager has the vision or whether the Boss is the visionary one, I was told

'My [Boss] has the corporate targets and I have the vision of how to deliver those'

Was there lasting damage from the initial conflict? Maybe the remark

'I see no reason to go it alone now, I have learnt to play politics and to protect myself'

suggests there might be. But the explanation over roles at Harriott now seems clear.

'My deputy doesn't do the wider direction of the organisation, his/her contribution is indirect. S/he delivers the operational stuff, today and tomorrow.'

Similar conflict does not seem to exist at Stein, where there are matrices of management in place. One FM Manager told me

> *'[It's] difficult to tell where the accountability is, but [s/he] makes it work well.'*

When talking about clarity of role, an FM Manager at Harriott told me of the need to rely on others

> *'You can't supervise all the staff your self'*

This view was echoed by other FM Managers when they talking about their workload. They felt that delegation, with the space and freedom to achieve, was seen to encourage the best from people, whether that be the supervision of staff or carrying out day to day duties around the Directorate. Trust and support were also seen as important in a relationship where work was delegated, either between FM Manager and staff or FM Manager and their boss.

> *'I believe in leaving people to do things', 'You have to give people space to achieve'* , *'We have reasonable autonomy' 'I have trust in my people, I have the confidence that they will prove that trust.' and 'I offer support to my people if they need it and 'I don't like to micro manage.'* (Smith)
>
> *'I delegate a lot'* (Lawson)
>
> *'I look for opportunities to support everyone and help them do what they want to do', 'I am a back room person, my success is through the people I work with.'* (Stein)
>
> *'I told them, if they betrayed my confidence I would stop telling them things.'* (Lawson)
>
> *My boss is super, [s/he] gives me freedom to do things my way, supports me and lets me run with an idea* (Oliver)
>
> *'I get on well with my boss, [s/he] doesn't interfere. [S/he] drives the strategic direction. [S/he] is really passionate about certain things. [S/he] supports us really well and is highly regarded by the organisation.', 'My boss meets with me on a monthly basis and is always supportive, [s/he] is amazed if people don't behave honourably.'* (Oliver)

Theme 3 Luck and Other Contributory Factors

The FM Managers seemed to think that there were reasons for success that were outside of their control upon which they could not impact. They often claimed that luck

came into their success, or thought that situations outside of their control conspired to help.

> *'There are lots of things we have been lucky with, e.g. 105 modern wheelchairs'* (Stein)

Contract or in-house services were also felt to be important to the starting point

> *'We had a head start - domestic services had been provided by a contractor until very recently...so when PEAT came we already had a [monitoring] group there, they had been there for 2-3 years, so that was fortunate.'* (Stein)
>
> *We have always had an in house service, we have never cut standards to the levels that others have. Cleaning staff are in house, so they feel part of the team.'* (Smith)

The FM Managers were noticeably positive about the site(s) that they managed. Stein they said

> *'It is a simple site', 'The site is neat, not complicated', 'No older workhouse buildings', '...but we are lucky we have only one site to focus on' and 'We are lucky, this is a modern hospital so we are not starting from scratch.'*

Harriott felt their success was due to the size of their site

> *'We are resilient, we are quite lucky, the hospital is not too big to manage like [our neighbouring] Hospitals - but then even the big jobs are do-able'*

Smith said of their site

> *'Some of the success will be where we started, Victorian hospital versus new hospital'*

but also felt that size was the key

> *'The size of the hospital allows for people to know each other by name, the supervisor will know the estates people personally.'*

Whilst Lawson said

> *'The geography is what makes us successful'*

Stein also felt that location impacted favourably on their Trust, giving a practical example of what that meant in terms of PEAT

> *'We are lucky, this is an out of city hospital, there is space and it is green - we are lucky with car parking'*

The FM Managers were keen to find solutions to make things work, rather than allow difficulties to stop the patient environment progressing. For example Smith recounted how

> *'Decant facilities*[35] *are not available, so we have to work around things and do things more piecemeal'*

Oliver showed me their courtyards and pointed out the difficulties they had cleaning their bright yellow clad facades and many windows, saying

> *'We have difficulties cleaning the courtyard windows and the cladding - it doesn't look good for patients when they look out of their ward window, they changed the regulations about working at height after the hospital was built. But we do our best.'*

Smith and Rhodes both spoke of enjoying the freedom to be innovative

> *'We have freedom with finishes, for example in MRI we fitted fibre optic lights as filament lights are affected by the MRI scanner. We didn't know which firm would provide the MRI, so we had to design a box and talk to the manufacturers to get information'* (Smith)
>
> *'We sell Chef's special and ethnic food (we have our own ethnic chef) to other Trusts and sell some frozen food to the general market'* (Rhodes)

This freedom to generate income was also used at Rhodes to help fill gaps in financial plans. I was told that they would *'...put up carparking charges'* in order to meet their budgetary gap.

Theme 4 Opportunity for Personal Development

Personal Development for the FM Management Team

Personal Development was a strong theme from all. Some spoke of their own career advancement

> *'I came to the Trust as the Deputy Director of Maintenance and Capital', 'I was at [another Trust] for 18 years, then 2 other hospitals including this one' and 'I started as an electrician'* (Stein)

[35] Historically Trusts would maintain an empty ward into which to decant patients whilst maintenance was being carried out on a ward. Due to efficiencies and cost savings this practice has largely stopped.

'I used to work on quality, Chartermark and ISO 9000...I was the quality manager and then I moved to work with [my boss] then the role changed to the Facilities Co-ordinator.' (Lawson)

An FM Manager at Harriott talked of their journey up the management structure and that now s/he had matured s/he could see that getting one's own way was not always right for the business. S/he has come to recognise

'I am not the CEO or the Executive and I have to work within my sphere of influence'

The FM Managers were encouraged by their boss to grasp development opportunities

'My boss is a great supporter of training and development. [S/he] encourages me along those lines' (Lawson)

'My boss is very good about training and development' (Stein)

A new member to the FM Management Team at Oliver echoed this when s/he told me

'I get more training here than I have been used to before, it is grand.'

Experience (particularly informal experience) was seen by some of the FM Managers as a good way to develop skills in managing the political agenda, for example -

'I learn by experience... I have learnt from other managers - they have a really bad idea and it gets through...I learnt...not to rush in and to keep my gob shut.' (Harriott)

Oliver spoke of the learning they could offer their organisation as they learnt from the experience of living with a new hospital

'This is the only place we have for all our stores. It's very tiny, but it allows us to operate a just in time service. We have contingencies with suppliers just down the road...The service yard is small, everything comes through here and the domestic staff rest room is just across the yard so they have to walk across, but I guess that some hospitals would be glad to have even this. It is all good learning for when we build other hospitals.'

It seems that experience is not always a positive force in one's career within the NHS. An FM Manager at Smith told me

'I've not got a career plan. I've been here 2 years, at [xx Trust] for 2 years and before that in [yy Trust]. I look after capital design, jobs at £1M and

under, work closely with Strategic Planning. Experience and time [served] meant that you got a lot of work but were not rewarded for it at [yy Trust], so I looked for the right reward and went to [xx Trust] and then came here [in order] to stay in the NHS. Here offered opportunity.'

Mentors and line managers offered additional learning opportunities for FM Managers. These mentors and managers could act as coaches and offered their experience as part of the learning portfolio

'S/he gives me good advice' (Stein)

Aware of the continual need for additional skills, an FM Manager said

'I should be more strategic, I need to do things like the energy strategy and capital replacement plan. I get involved in operational stuff and anyway I don't want to lose control and so I don't hand it over. I don't want to overdo the control, I want to share...., but maintenance is very reactive' (Stein)

This reactive nature of maintenance got in the way of the strategic work, but s/he saw that their boss

'is very time disciplined, [but] I can't be like that, a lot of stuff comes in.' (Stein)

It seems that training and development opportunities are offered and taken right across the FM Management Team; Smith explained that their FM Director

'... has moved into new areas of the organisation and taken on Risk Management - learning as you go is development for Directors.'

This method of developing Directors was echoed at Harriott

'At least here you don't get stuck doing the same thing, for example. I project managed the FT application.'

This FM Manager also spoke of the importance of learning by sharing

'My learning comes from colleagues, and Executive Team members pool information.'

The FM Managers at Lawson were encouraged by their Director to both develop their role in order to expand their knowledge and experience and to undertake formal study

'I am doing an MBA at xx University' and 'I have taken on some additional responsibility lately, for some project management of estates. It is an area that I need to develop'

Smith also encouraged their FM Managers to take on responsibilities that were new to them. I was told about one of the FM Managers, whose

'[His/her Continuing Professional Development] is on the Health and Safety side, membership of IOSH and new Fire Regulations. S/he is responsible for the Nominated Officer Fire.'

Stein reflected this high level encouragement to undertake development, although in a more traditional way, reporting that

'If I want to go on seminars there is no problem'

At Smith, development was seen as 'keeping up to date' and the FM Managers with chartered status were encouraged to carry out the necessary Continuing Professional Development (CPD). They were also encouraged to network and access training from organisations they worked with.

'I am chartered so I do CPD, either by reading or by on line CPD facilities. I attend the sub group of HEFMA re building and attend CIOB [Chartered Institute of Building]. Also, find anything that is particular to a scheme. Constructionline also give training. Barbour index are coming in so we are trying to keep up to date' and 'I am chartered, so that keeps me up to date.'

Formal study was also encouraged at Smith, one FM Manager reported

'I did an Institute of Health diploma at Smithgate College and I got time off to go to that and the Trust funded it.'

And another told me

'I've done quite a few IT courses and some basic management courses'

Harriott reported

'Then I got to do a certificate in management studies at Sheffield College, that way I understood what management is really about and the key elements that make the job run'

This FM Manager went on to say of the MBA s/he now holds

'My MBA made me think about what I really valued and what I didn't'

Even though members of the FM Management Team at this Trust are unable to attend courses at the moment, due to the financial situation, opportunities for learning are still identified

'I take on new services to learn, now that we can't go on courses'

But, finding time to develop oneself at Harriott can be a challenge

'I struggle at the moment with personal learning, although I do belong to a learning set' and 'I have to keep the statutory role, that slows me down and stops me developing.'

The FM Managers were open to opportunities to develop, showing this through comments such as

'I would do some more studying' (Smith)

'I am motivated by learning' (Lawson)

Networking was seen as another route to personal development, with one Director saying

'I keep up a network of Directors to find out what is happening elsewhere and what is best practice. This is very necessary.' (Harriott)

'[My boss] likes us to network' (Lawson)

Personal Development for the FM Team

There was a strong theme within the conversations around training and development of FM staff, with National Vocational Qualifications (NVQ) and other basic training featuring heavily.

'We spend lots of time and effort on training. This is really driven by my boss' (Oliver)

'Training and Development has a very high profile' and 'Training here is very good' (Stein)

'There is a lot of learning on the job', 'Secondments and courses etc are also available' and 'There is plenty of in house training for staff e.g. lifting and handling' (Smith)

Agenda for Change[36] was seen as a vehicle that would enhance this focus on training, allowing staff to progress from FM posts, through to clinical work, for example Ward Domestic to Health Care Assistant

[36] The job grading system offers gateways to incremental points for enhanced skills

'[it] offers the opportunity to train staff for clinical purposes. FM could become the recruitment agency for the NHS' (Lawson)

Indeed Rhodes reported that this movement of staff from FM was already happening

'Good domestics go by the dozen into Health Care Assistant posts, especially ward housekeepers, we are always recruiting'

But it was not only the NHS that benefited from their well trained staff,

'We loose staff to security sites and all sorts.'

Stein felt that Agenda for Change would help with recruitment

'It is difficult to find staff. Agenda for Change has improved things. It has given a 20% pay uplift and we can compete with others. Agenda for Change has also given a benefit realisation.'

It was recognised that the training received may form the first qualification for some staff groups and that this could be used as another method of showing staff they were valued. In turn, the staff were interested in gaining NVQ's.

'Many staff have NVQ's - e.g. Infection Control, Support Services' (Lawson)

'There is a lot of training, NVQ and BICS, hygiene certificate, this is an ongoing process' (Rhodes)

We are heavily into the NVQ programme' (Oliver)

Supervisors and Senior Supervisors have good career progression and can take NVQ 3 and BTEC Housekeeping and training qualifications. NVQs are done quite a lot' (Smith)

However, the differences among the needs of the FM staff posed challenges, as did the need to alter personal paradigms as people developed and were promoted within the Trust

'Academic learning in management is very different, estates people want a finished formula, 2+2 =4' (Harriott)

As might be expected in times of financial restraint, budgets for training were tight and in some Trusts it was mentioned that priorities for the Organisation had to be around clinical training

'There is difficulty getting funding for training and development, we are a hospital so I guess 80% of the funding has to go to medical people. [But Facilities Management] have a budget and [our Director] is open to ideas' (Smith)

and priorities for FM were around legislation rather than personal development.

'The training budget is mainly for mandatory training' (Stein)

Stein also spoke of how they had been able to access Learning Accounts to fund NVQ's, but this was no longer an option.

Smith underlined the need for training to be linked to the business needs, saying

'Training must benefit the organisation'

In addition to budgets being allocated for staff training, resource is also made available for staff to organise and carry out training. This appeared to be the case for contractors and for Trust teams.

'[Our contractor] have a Training Officer, who liases with the Trust' (Lawson)

'We have Supervisors and Senior Supervisors that are responsible for training' (Smith)

'We have shop floor training reps' (Stein)

Not only were training budgets tight, but there seemed to be a tension between wanting to offer a substantial training package to staff and getting the day to day work done

'The Trusts will give time [for study] as long as the job is done' (Harriott)

'The Trust are not keen for us to take staff off the wards for training, this is one of the down sides of being so integrated [with the wards]. The Sister is involved in how the work will get covered.' (Oliver)

In order to maximise the training budgets, some of the FM Managers offered evidence of integration between the training offered by contractors to their staff and the training offered to Trust staff.

'Community Hotel Services attend [our contractor's] training' (Lawson)

'[Contractor's] staff train with Trust staff as well, e.g. swallowing course.' (Lawson)

This integrated approach sometimes meant that FM staff were trained with staff from clinical areas

'We have used the NHSU[37] customer care course. We now have Nursing Auxiliaries etc on that course' (Lawson)

[37] NHS University – now disbanded

Oliver spoke of taking this integration one step further, and invited others from their organisation to the site for development purposes

'Sometimes those on the leadership programme come to site. We had an HR person for 6 months. We can also offer help as a stable contract, people on the programme come to us for a week to learn certain aspects and to see things. The Programme is available to anyone.'

Rhodes felt that the training opportunities offered by the contractor to staff was a key performance indicator and reported that they

'carry out training audits etc on contract personnel by checking their records - e.g. food hygiene, equipment use'

Several of the FM Managers reported that staff are rewarded for taking part in the training programmes

'There are annual training awards' (Smith)

and Stein told of how they won a learning award the previous year, and the Department of the Year Award for Training and Development this year, along with an award from the local college.

Appraisal systems are seen as key for personal development

'I have 1:1's, appraisals, PDP' (Stein)

'The appraisal will cover where you have done well, or underperformed, also places for improvement. Maybe Government or central targets to be met' (Smith)

Smith reported that FM now carried out a team appraisal

'The team approach is an FM idea, not Trust. But this way FM achieves 75% appraisal against a Trust norm of 50%. A person can request a personal appraisal if they wish', 'The facilities approach is a team appraisal. It is fairly informal, but you do get a written account.', 'I have mine with [other members of the team...we approach it] from the communications side', 'There is a team appraisal for [my colleague] with his teams. S/he appraises Hotel Services Manager, and Senior Supervisor and Supervisor. They then do their teams using the team approach', 'We have an informal team appraisal. We do things together so it is right that we share the appraisal' and "I have not had an appraisal yet'

So was opportunity for training linked to possibilities of career advancement for the FM Managers?

'Career development is hard due to the size of the management team, however variety is possible - the Senior Supervisor acts up for the Accommodation Manager and the Supervisor as the Senior Supervisor.' (Smith)

But perhaps career development is not the only consideration?

'Here it is not about your title or your background, it is about your skills' (Harriott)

Theme 5 Maximising The Contribution from FM Staff

Whilst the FM Managers were cautious about measuring success through people, with one of the FM Managers saying of the NHS staff survey

'It is difficult to measure success, the few staff who fill in questionnaires are probably the vociferous minority' (Smith)

Maximising the contribution that staff could make was of interest. Oliver pointed out

'We work hard with our staff, they are 75% of the costs - if we don't get value from them that is a lot of money'

The staff were seen to be key in delivering the services at the standard required

'People are the secret.' (Harriott)

'We filter the Trusts needs through to the staff.' (Lawson)

'Valuing staff can make a huge impact' (Stein)

Largely the FM Managers saw staff as committed and wanting to deliver a good service

'they make an extra effort against nationally.....They [domestic staff] have a genuine drive to do the best job they can', 'We have very committed and loyal supervisors, they have always been in house, ... we have good relationships between managers and supervisors ...' (Smith)

People are passionate about what they do here' (Stein)

'98% of people want to do a good job. Lots of managers believe that staff just take the mickey. I look for good. Aggressive and nasty alike, I look for good.' (Harriott)

'There are good people who take a pride in it' (Rhodes)

The FM Managers wanted to understand their people and treat them well in order to build on that commitment and get the best from them.

'Everyone is different and sometimes you loose track. It would be good to understand even the guy changing the filter. I try to stop and talk and make him part of the team and valued' (Stein)

'I'm not sure what makes us the top 15, but treating people well makes a difference' and 'It pays to treat our staff well. We are reliant on these people, they won't do it if they just see their job as cleaning that patch' (Oliver)

'Valuing staff can make a huge impact' (Stein)

However, there was recognition amongst the FM Managers that there were areas within the FM teams that were challenging. When talking of one group of staff an FM Manager said

'[This group] are so different, there is a different culture. The shop floor are not interested... There is a barrier between [staff] and management' (Stein)

They told of a situation where work was contracted out on an interim basis so that funding could re-routed from non pay budgets to pay in order to create a job. An FM Manager said

'The interim message did not get through, so they thought their work was being contracted out. They thought that was to de-skill them for Agenda for Change...We had the same with the office staff, we freed someone up for a project and they thought we would get rid of them when the project finished.' (Stein)

The issue of keeping staff motivated and valued was spoken of

'Jobs here are not well paid and the jobs are not nice to do' and *'Maintenance is tedious.'* (Stein)

Harriott felt that FM staff saw themselves as

' bottom of the heap.'

Stein felt that staff self esteem was further eroded as recognition was not given by everyone in the Trust

'Staff don't get much thanks' (Stein)

'Very variable, some [customers] appreciate, some do not' (Stein)

and reflected Harriott's view by saying

'there are classes in the NHS - porters are lowest and estates staff are sometimes seen in that group' (Stein)

The FM Managers saw PEAT as a vehicle to introduce variety into jobs and to ensure they were given praise and recognition

'It gets them away from the humdrum' (Lawson)

'PEAT scores helped to raise the self esteem of the work group'. (Oliver)

'We get a lot of praise.' (Stein)

They spoke of being careful to give feedback after the PEAT inspection took place and to praise their staff when the PEAT results are received, indeed they felt that feedback throughout the year was important

'Quite a bit of feedback is given to them' (Smith)

'We compliment the good practice.' (Rhodes)

Lawson felt that not only directly employed staff should be recognised, but their contractor's staff must also be given their share of the praise

'When we get a PEAT score its about thanking [our contractor's] staff as well'

The necessity to keep the contractor on board was spoken of by Rhodes, who said

'We keep the contractor on board with regular meetings, plenty of monitoring and don't let things slide'

Many of the FM Managers spoke about how they built upon the feedback and praise by putting together schemes to recognise individuals and groups more formally. Oliver organise a Christmas Party at which they can recognise their staff. Long Service Awards, NVQ certificates and other such awards are presented at the Christmas Party. They spoke of the difficulties in engaging their staff in this way as

'We have a big ethnic group as we are the first port of call for people coming into the country'

'We have an Asian community and a Kosovan group. We employ these people and they are very good and very reliable.'

To make their Christmas Party work

'Our Asian ladies need to have chaperones so that they can come. We also lay on coaches and play Bhangla music. It is hard to engage the Asian community, we are very pleased we have managed to do that with this party'.

Hidden benefits have been discovered from this approach, with the FM Managers feeling that the hospital was now accepted as a good place for Asian females to work.

Long service was seen as a key factor to success by most of the FM Managers as it brings stability, experience and integration to the teams. Lawson reported that their contractor has a long service award for their staff at which nominated staff

> *'...have a day out and the CEO attends, with an award ceremony and a disco. The next day they go to the awards ceremony'.*

However, it is not only long service that is rewarded. For example, at Lawson the FM Managers run an Employee of the Month award scheme. The ward staff or the staff supervisor can nominate an employee to be put forward for the award. An extra element of competition has inadvertently been introduced by this activity

> *'There is competition between the zones to be the best - e.g. employee of the month'*

Although Smith do not have formal award schemes, they also report on an element of competition existing between teams to achieve the best standards:

> *'They [the domestic staff] are competitive I think'.*

Several hundred staff transferred from Oliver to the contractor in 1999-2000, thus presenting a different need. When the present FM Management Team had taken over their team, they had

> *'...inherited the whole lot from the Trust. The silo mentality continued and we had to do something about it....we had to work hard at breaking down the silos, the philosophy became we can't blame each other we all work for [the same firm] now.' And 'We like them to realise that this is their hospital and they can affect the way things are done'*

They spoke of trying enhance the sense of teamwork and value by including staff in the decision making process.

> *'We have a staff group where they can all put their views forward, I am really pleased the staff are getting involved and are committed. It's what we wanted', 'We involve the staff as much as we can, when we were planning new ward kitchens we asked the staff what they needed, it changed the design a lot', 'A porter suggested we put coin operating mechanisms on the wheelchairs because we had such a problem' and 'I try*

to give them ownership of their area, we don't try to upset that [the relationship between staff and ward] we want our people to be integrated.'

They felt that productivity had increased greatly since staff had become involved. The measurement used to prove productivity gain was sickness levels

'Our sickness levels have fallen hugely from about 18% to around 4%, I am sure it is because we involve the staff so it becomes more than a job.'

Lawson called this involvement 'ownership', saying

'We are giving [the staff] ownership'.

explaining how, when they contemplate changes such as bringing in new equipment, they

' use feedback forms ... We don't just implement - e.g. microfibre, all the staff have tried it'

When I asked them, 'what did you mean when you said that you had given ownership to the staff?' Their answer was

'We have 4 zones of 5ish wards (although one has 2 wards and deparments and linen services). They are responsible for all soft FM matters. Nursing staff can go to the zone co-ordintor even if all three services are involved. So even if it is a catering matter, the zone co-ordinator comes back to catering and takes the solution back to the ward.'

They reported that since they had introduced the zone scheme productivity had increased, again the measurement of productivity was sickness levels and retention-

'The sickness and retention figures have been good' and 'Sickness was high but it is lower now'

Smith had worked closely with their staff over a number of years now and felt that now the benefits were being felt through

'staff having ownership.'

They felt that

'Pats on the back are there, that's really important if you want loyalty and commitment.'

However, they felt that sometimes encouraging staff to become involved was not easy, because management behaviour got in the way. This thought was echoed by Lawson, who felt that

'Traditionally, Trusts do not treat people well, so they do not come forward [with ideas]'

Rhodes had needed to change the culture of their supervisory team in order to move forward with their chosen approach

'Problems with old supervisors were trained out or removed'

Harriott also reported difficulties at supervisory level

'We hear from supervisors that are too busy to manage the staff'

Stein echoed this theme of difficulty with changing the approaches of supervisory staff. They told me of their flexible working system within which some of the staff can work 4 long days. This system had proved to increase productivity, but the managers had difficulty coping with the new system. They said that it

'increases productivity, but managers don't like it as it is difficult to manage. There is no supervision after 5pm, [the managers wonder] are they hanging about?'

Harriott also had difficulties with supervisory and management staff. An FM Manager reported

'I need to introduce a problem into their head because they don't see it, they say we've always done it like that. Especially in soft FM.'

S/he explained that in order to get managers and supervisors to see a problem s/he has to

'sow seeds of problems, e.g. chargehands had not got responsibility, now they have gone and we have [staff] *who think for themselves.'*

Smith said

'Sometimes we can miss the useful idea because managers don't like staff to have input'

Lawson (who use contractors for their soft FM services) reported that they had had to re-look at how they worked with their Contractor and their Contractor's staff.

'The traditional 'monitor' has left, There is no clip board approach now'

Now

'Staff go straight to the Trust with ideas as well as to [the contractor]'

'Staff are not thinking that [Contractor] equals profit. They understand that the hospital gets it [any savings made].'

Harriott felt strongly that difficulties within teams need to be faced up to -

'I was ... young [and] in the laundry and they made my life a misery and I ran around doing everything. Some times the truth is needed, I'm a person

as well. People try to use organisational change to avoid having the tough conversation'

However, it seems it is not only the supervisory team that are difficult to change, Stein report that they have problems where a group of staff that

'..need to be multi skilled, but the shop floor are not interested'

but within another group, there is

'...not so much of a gap between [these staff] and management'

They feel the difference in the second group is

'[they] are [educated to] degree level, and they often work really closely to patients'

Stein felt that investing time into recruitment of staff was a key element in ensuring that teams were able to deliver across the range of standards (both technical and personal) and fit into existing teams

'I take lots of time over recruitment, I am clear about what I want. A technical wizard is no good if the personality is flawed', 'It is important to get the right person' and *'I accept that people need construction skills, but I need the right people with similar ideas.'*

The integration of the FM Team was seen as another 'must do'. As reported above, Oliver felt the need to remove silo thinking between the team, and now happily report

'The PALS [Patient Advisory Liaison Service] person said you're like a family here, you're so supportive to each other' and 'We are a comfortable crowd.'

They feel that taking time and effort to build between the managers and their people was important. An example given was

'We would rather the porter reported that s/he had smashed into the door, then we can send someone to repair it.'

The Stein team seemed to work very closely together, despite there being no formal FM structure. Here Hotel Services is separate from Estates, and then,

'1.5 years ago the Trust split capital and maintenance'

I asked if the groups were very integrated. The reply was

'10 years ago we all stayed in our own box. Now there is maturity.' And 'Hotel services and estates have to achieve [PEAT scores] together'

The reason for the difference in their structure is because the

'CEO wanted clearly defined roles when s/he split capital and maintenance'

I asked why the Estates Department and Hotel Services worked so closely together when they were not part of the same team (i.e. not in an FM Team). I was told

'I work closely with Hotel Services Manager. Why? Personalities... we are in the same directorate... because we are not in Facilities there is no jostling for position. We respect each other's management skills. I often see two managers within FM jostling for one job. That is not happening here at the moment, but I don't know what will happen in the future.'

When I asked if it mattered that the teams weren't joined together to make a Facilities Team I was told,

'No it doesn't matter, it is a similar management structure anyway. This way is more manageable', 'The ... Director says there is no idea of joining FM together. They are too busy now the private contractor has gone', 'It's a different structure... It fitted in well when there was lots of building work going on - we build what the Trust wants, this way advice to planning works well and it keeps day to day things separate' and '... this structure is better for the period of time when we have so much capital work going on, it allows me to focus.'

But it seems that this closeness might not be so easy at Smith. One FM Manager said

'We are in separate buildings and we are very busy and reactive. We are more closely linked to Capital Planning than to operations.'

However, they did work together to maximise their contribution to the customer. An example given was

'If we are trying to get some work done on the electrical load, we might incorporate operations work into a scheme if we can.'

Meeting regularly with members of the management team and with staff was a shared theme. This was done whether it was an all in-house team or whether contractors were employed.

'There are regular diary meetings' (Stein)

'There is a monthly FM meeting across the whole team. It is open house to ask anything. It is fairly easy to find things out', 'Facilities Meeting - we have a team brief meeting, we might give an update at this meeting', 'It's important that [the management team in Facilities Management] keep in

touch and know what it is going on. A necessity that we work together and understand the impact of our roles on each other. We share information and work together. Things run smoothly and there are no hiccups.' and *I'd rather know things even if they don't impact on me* (Smith)

We have monthly team talks. We have a daily relationship with our people, so it almost makes team talks meaningless, but we do it' (Oliver)

'[Yy] meets with me and [Xx] once a month (Lawson)

This theme around meeting to share information and give updates extended to the PEAT process. Stein explained that even before PEAT was introduced they had

'a meeting with the contractor (which included the Managing Director) already in place, this included clinical staff.'

And now they

'meet regularly over PEAT'

and to ensure integration between hotel services and estates

'Estates are part of the PEAT inspection team.'

'The building manager goes as [s/he] has PEAT as part of their objectives'

Smith told me that they hold

' a monthly PEAT inspection which the Senior Supervisor has responsibility for organising. We generally pick poor performing areas, but it is fairly random'

and to ensure integration

'An estates officer will go round as part of the PEAT inspection.'

Performance Monitoring featured in many conversations, because whilst the staff are important

'... we are a business, not here for people's moral and social well being.' (Harriott)

Therefore, it was felt

'We need to know if the staff are deviating from what they should be doing.' (Oliver)

Harriott looked to their managers to explain their performance, saying

'I ask my team, what do they contribute.'

Lawson explained that they established areas where performance had fallen by looking for trends

'for example I kept getting an action 'retrain chefs' and really it was a performance issue.'

They explained that in addition to their own monitoring

'Incidents and complaints come to me. [The Contractors] have to complete a form as to how they will remedy and then I make sure it is done'

It was hoped that problems would be dealt with at team level before they were raised by or with the management teams. The FM Manager explained that

'The zone co-ordinator reports estates issues to [person a], who is the designated estates person for PEAT. If things don't get done [person a] will chase them.'

Rhodes gave some examples of their approach to performance

'We name and shame', 'We say, these are the standards and you are expected to work to this' and *'We work with a bit of stick and carrot.'*

However, they spoke of being considerate when dealing with their staff's performance

'We went to another Trust when tendering and they posted their scores on a notice outside the ward, we didn't want to be so public, but we circulate the information widely'

Smith have

'... an electronic job management system to measure our performance'

'the system is just for estates.'

They explained

'We look at performance on a weekly basis and a 13 week basis' and *'We look to see if our jobs are done within 24 hours, 3 days, 7 days or 7 days plus. Our goal is to hit 65% responded to in 24 hours. We may not complete a job of course, we may need spares etc. This information is used in Facilities Management and shared with staff and supervisors etc.'*

Stein took a strong line with contractors who did not perform to the level expected of them, saying

'Bad performers get kicked off'

It may be a little difficult to decide which manager is accountable for which contract, and can therefore make this decision, as

'The budget is still shared between me and [xx].'

Perhaps the structure helps in making that decision as the FM Manager who is sharing his budget reported to the Human Resources Director but has

'professional accountability to [the Estates Director], I tell him everything that goes on.'

Maybe decision making is easier for those who are clear about what is expected of them

'I have got operational responsibility for the contract.' (Lawson)

Or there is scarce resource, and everyone is under pressure -

'We have four levels of management in our structure from supervisor to me, so that is very flat and everything has to be done by those in that structure.' (Oliver)

Thoughts around this lack of clarity or others unrealistic expectations were voiced at Smith, when the FM Managers said

'We are often given artificial timescales, this does not give the best end result', 'There is a perceived view that schemes do not come in on time, despite why - e.g. the heaviest recorded rainfall in August' and 'We do some work for the PCT. They had a scheme that had lots of problems [because] we don't have time to do the research into the fabric and the information is not always available.'

Teamwork was important; Smith offered the following views

'If we don't work together something will fall through the middle', 'We're a good team, s/he is very good with the colour schemes and s/he is very good with lighting' and 'Success? Being a team.'

Of teamwork, Stein reported very simply

'We went to the pub every Friday night.'

They also told of a time when team-work was not so simple and how they changed this

'Maintenance and capital traditionally don't get on, here they work reasonably well together, [xx] has some new staff in, they are from industry, they are good personalities to have around. One of [xx's] team is on secondment, s/he had been here for a number of years. There was lots of tension. [Now] ...we are starting from scratch.'

When I asked them if there was a special technique to forming their teams, perhaps teambuilding sessions, I was told

'No we don't do special team building, we just work together and talk about things'

They thought that when contractors were involved it was more difficult to form a team, particularly when there were problems to face

> *'But we establish the problem, and extend to others when we are singing from the same hymn sheet, [this is when] we would approach the contractor. The contractors and our points of view are poles apart'.*

Oliver said

> *'The [staff] talk, know one another and there are friendships. I really believe this is an important thing.'*

Lawson reported that the geography of their Trust helped,

> *'Everyone knows everyone around here, we employ families'.*

and if you were not part of a family employed at Lawson, there was always local sports to bring you together.

> *'It is a real community around here, many of the staff are [sports enthusiasts]. If you come here on a day when the [xx] and the weather is good, the hospital looks half closed.'*

Many of the FM Managers spoke to me of the need to sell ideas to staff members. Getting to know the staff as individuals was seen to be a way of doing this, with an FM Manager at Harriott telling me

> *'I think you need to understand the qualities of the people below you and recognise they are not clones. Then you can work out how you can use those skills.'*

S/he said that once s/he had come to understand the team s/he had to motivate his people to see where they had to take action. The strategy, as s/he was new to the position at that time, was to

> *'..ask why, I was ignorant, I could ask.'*

S/he feels that

> *'Everyone of my managers thinks they have full control, and in their view is valued and they do it right.'*

although in reality, s/he could see that s/he was the ideas person in the team.

An FM Manager at Stein commented *'I like to know my staff.'* S/he felt this gave him/her an insight into how best to work with them.

Harriott spoke of how s/he has to sell ideas that s/he does not always agree with

'I used to ask for a rethink when I did not agree with the decision, then I would sulk. But now I just go off and think about how to sell the decision.'

S/he feels s/he needs to deliver because

'My boss is very focussed on targets and expects a plan and process to achieve the targets'

Harriott recognise that it can sometimes be hard for staff within the NHS to relate to the decisions being made. I was told

'This reactiveness to finance can demotivate carers.'

and the business like approach can be difficult for FM staff. One FM Manager felt that their role had to compensate for that difficulty

'given the environment ..[my role] is to provide a buffer between the organisation and that business reaction and the staff... I introduce change in the way they can relate to and I sell it to staff as a benefit to patients.'

Lawson felt that sharing everything with the FM Management Team was the best way to deal with getting the messages across, relying on trust and loyalty from the team in return when dealing with confidentiality.

'I used to have a Wednesday morning meeting with my staff, I would come from the Board and tell them everything, even the confidential bits'

However, as times became hard and the Trust started to struggle with its agenda and lost its three star rating, the FM Manager reported

'I found I was just getting so negative, I came back and told them that no decisions had been made, or that they had gone off at a tangent.'

And a decision was made to discontinue the meeting. However, following the reflection

'I said to my people, we are not going to get any direction or objectives from my boss, so we have to set them ourselves... We might bring the Wednesday meetings back together, we'll have to see what the team thinks about that.'

However, in the absence of a clear Corporate Agenda, they continue to adapt the FM agenda into a language that shows staff how each idea relates to them. They say

'We bring every idea to how it relates to them as staff. This is our style.'

Oliver agree that converting language is an important part of integrating agendas, but they also show staff how the organisational values relate to them. They then reward their staff members for demonstrating their understanding and commitment.

> *'Our organisational values are very middle class, so we have rewritten them into [our Trust] language - e.g. we describe what a 'can-do' attitude is, why 'smart' is important. The best two or three exponents of our values get awards at the Christmas Party. They get a certificate. It is so well received, they were so pleased to be recognised and valued.'*

Theme 6 Maximising The Contribution from the Contractor's Team

There is a constant conversation within the NHS as to whether in house or contract services are better. This is reflected in the FM Managers comments:

> *'I don't think in house performs as well, but others wouldn't agree'* (Stein, NHS Employee)
>
> *'In house costs will be higher at the sites you research'* (Lawson, Contracted Employee)

Many of the comments above have been offered by both FM Managers employed directly within the NHS and by contractors working within the NHS. The following comments examine the interface between the Trust and their chosen contractor(s) and their staff.

Smith staff are happy to work with contractors, saying

> *'Trust staff are happy to work with contractors, [in the areas in which we use them] they can be there in 5 minutes' and 'We can also use consultants if the workload is heavy'*

but they are careful in selecting the contractors they use

> *'We only use experienced hospital contractors, we use Constructionline to select our contractors'*

They do not use contractors to provide soft services, telling me that

> *'Over ten years there has been a big reduction in the numbers of staff, this may have stopped contracting out services. One of the sites was out to contract [in the past, but is now back in house].'*

Rhodes felt that using a contractor to provide their hotel services suited their situation, as the staffing situation was difficult

'.. it is hard to recruit in [one of our areas], it is a rich area and there is competition with the shopping complex' and '.. the contractor can motivate the staff better and get rid of staff if they need to.'

Conversations around measuring the impact of staff delivering to standards seemed to be more overt who those who worked with contractors. Rhodes monitor their contract

' in line with National Standards for Cleanliness'

and have a financial penalty system as part of their contract agreement

'We have financial penalties attached to the contract, which work in steps...94% achievement of standard is 2% off budget, then 4 and 6%, but we have not needed to use those [4 and 6%].' (Rhodes)

Achieving the 94% standard was seen as important and they said that they had

'waived the penalty a couple of times, but then decided to get tougher' and *'If we fall below a certain % we will penalise... We have penalised about 1/3rd of the months.'*

They felt this penalising of the contract attracts the contractor's attention to improving poor areas as

'We have the £'s badged to specific areas' and *'the scores point the contractor to the point that poor scores equals costing them money.'*

There is often a perception that contracted services are subjected to quite different rules as regards monitoring of standards. Both Lawson and Rhodes have responsibility for contracts at one site and in-house teams at another. They monitor both sites in the same way, and this has been useful to show the contractors concerned that they are fair to both teams.

'In house and contract - both monitored exactly the same', 'The contractor has experienced audit at the in-house site, and says that is just as tough' (Rhodes)

Lawson felt that their contracted services were

'..ahead of the in-house community team'

As mentioned in the previous section, integration across FM was an important theme, and this theme extended itself to how Trusts work with contractors where these were employed as part of the FM Team. Disjointed working or conflict between Trust staff and contractor's staff was seen as a risk to the delivery of high standards.

Lawson said of potential problems between their staff and their Contractor's staff,

'If there are any problems between the Zone Co-ordinator and [the estates representative], I will step in.'

Rhodes carry out

'Joint monitoring between the Trust and the contractor. It is very rarely we fail to agree with the contractor on monitoring' but *'If the monitor and the contractor can't agree it is escalated to the Senior Manager, [decisions] must be by agreement, but we don't have argument if you can't agree.'*

The financial impact of bad monitoring results, and thus on the profitability of the contract, becomes evident when it is explained that

'With the size of the contract, we only need to loose 1 or 2 points of efficiency and we have paid for the monitoring team.' (Rhodes)

and thus the risk of conflict is high between the in-house team and the contractor's staff.

I asked Lawson how their Contractor reacted when the Trust established different monitoring results to those established by the Contractor's tem. There did not seem to be any great conflict around that in the FM Managers eyes, as

'they know it is fair.'

They explained that they had an in house team in a neighbouring part of the NHS, saying

'that is a good measuring stick.'

Smith explained that when they were working on a capital scheme

'..external contractors will discuss with estates operations. They are given the opportunity to comment and get involved in commissioning a scheme. They try to get involved as they do not want to pick up the pieces. Sometimes even craftsment come and are asked for comments. They would want larger plant rooms. It helps being in the same building so that we can discuss things. We try to discuss feasibility with them.'

Lawson are very seriously involved with partnering with their Soft Services Contractor. They

'asked for proof of partnership working and best value when we tendered'

The Contractor at Lawson explained to me that their Organisation was piloting partnering at three contracts, one in the South of England, one in the North and

'we have a partnership with [Lawson] '

Lawson explained that the Contractor was paid

'.. a profit up front, guaranteed' and *'we have an open book arrangement, and there is a profit share of any savings.'*

They also agree a savings target in line with the Trust Financial Plan[38].

'We have a savings target because of the Trust financial position, we have agreed with [the contractor] a range of service reductions. e.g. reduced office cleaning', 'They have achieved their savings targets to date', 'the financial position of the Trust affects [the contractor] as they have to make savings - e.g. waste segregation, small clinical waste bins and larger black sack bins' and '[the contractor] helped us save by introducing pouches'

Objectives are then set jointly for the in house team and the Contractor

'I have my objectives set at my Development Review. They are also set for [the Contractor's] staff', 'We decide together where to invest and where to save money. If there is no money to do something, we find a way to do it. e.g. reduce office cleaning', 'No initiatives go beyond the contract price, we are joined at the hip', 'At this Trust, decisions are given a joint message, at many Trusts they say it is the contractors decision' and 'we set objectives for three years, these were set at the beginning of the contract.'

Their monitoring system is based upon the European Quality Foundation Model and thus, the Trust continued to be interested in their Contractor's staff. When I asked if their Contractor's staff would know about the partnership approach, I was told

'It is part of their induction, newsletter, and they know that decisions have to be made at the Partnership Board, for example, pay rises', '[The Contractor's] staff are seen as part of the Trust. I treat the Contracts Manager as part of my team' and '[The Contractor's staff] have won Trust awards and one of the staff has been the [Contractor's] Employee of the Year'.

[38] Every Trust is required to have a Financial Plan which shows how it will finance its services, including any service changes required, and make any cash releasing targets set by the Treasury. FM Managers are involved in delivering this plan as they are required to reduce the FM expenditure or increase volume throughout the year.

However,

> *'The management and the relief teams are sometimes written off as being [the Contractor], but not the regular ward staff... we have work to do on that'*

It is felt important at Lawson that Contractor's staff could not be identified as being different, and examples were given of trying to ensure that Contractor's staff were part of the team.

> *'We had a survey done with the staff as part of the new uniform. The uniforms don't stand out as a contractor' and 'Questionnaires are sent to contractor's staff to see how they like working on this contract.'*

The Contractor sees finding methods of financing new services as a responsibility of partnership. Presumably, in order for the Contractor to be able to do this and remain solvent, the funding for this must be found without eroding the profit margin.

> *'An example of working together is the bed maintenance and washing. We located a free area to use, the Trust couldn't pay for the service, so [the Contractor] funded'*

I asked why this partnering approach had come onto the agenda. I was told

> *'We needed to move forward, and the only way to do that was moving away from them and us', '[it] got rid of the conflict', 'it is not 'them and us' and 'we are fighting', so the effort goes into improvement' and 'it's all in the mindset - the usual approach is fixed on the bottom line, with the contract not flexible.'*

but partnering can be a difficult concept, as explained by an FM Manager who needs to work closely with the Contractor, but who also finds they are questioned about their relationship with the Contractor

> *'When there are PEAT inspections, [they] ask me 'why is it like this', but [they] also say that I mustn't be too involved'*

But the FM Manager felt that their approach was right, as

> *'You get out of a contract what you put into it.' 'People think you can wash your hands of a contacted out service. We put lots of work into this one.'*

Stein have moved away from contracting out their soft services, saying

'We spent about three years getting Hotel Services back in house. We used a multi disciplinary group.' And *'Now it is back in house. It was a huge job - TUPE[39] while doing Agenda for Change'*

However, they continue to use contractors in other areas, they favour local contractors and

'..have a number of capital contracts on measured term contracts and architects on term commission.'

This gives them stability through longer working relationships. The FM Manager told me

'They are part of the team. They work together regularly.'

Theme 7 Stability, Experience and Change

Several of the FM Managers had iconic stories to tell of how their fortunes had changed. Whilst not always for the better, these events had impacted on the culture of the Trust and brought about dramatic change. Oliver spoke of their

'huge backlog maintenance problems with the old sites' and *'There were three old Victorian hospitals within acute, and the new hospital was built here. It was the site of an old style psychiatric hospital - it included a farm. The site was split into three, one piece the hospital, one piece residential and one piece a country park.'*

but then explained that having a new hospital can also bring problems to a Trust

'This was [an early] PFI in health, the contract was signed in 1997. We started as a 0 star Trust. There were problems everywhere, we were still bedding in the new hospital', 'The Chief Exec came up with the implementation plan and manipulated the hospital to focus on achieving the targets' and *'Occupancy was supposed to be 86% of 430 beds, but right at the beginning one of the day wards was converted into 16 beds and the observations ward in A&E into 20 beds. We have hardly deviated from this - a treatment centre is being built and will add 40 beds. We have plenty of theatre and radiology capacity, but no beds to support. The Strategic Health Authority would only sanction 430 beds at the time, but knew the hospital would have to grow as it is in the xx xx and there is to be big residential growth in the area.'*

[39] Legislation that relates to terms and conditions of staff transferring to a new employer

Of their Chief Executive, I was told,

> *'Our CEO is going places, s/he was no 2 at [another Trust], now s/he is with us, this is a step in his/her career.'*

Stein had also had to move themselves from a failing position to one of more credibility

> *'8 years ago there was a turnaround.', 'The CEO [had] made enemies with the regional board and there was financial starvation', 'There was a change in culture, they replaced the old CEO', 'The new CEO brought in new people at the top. He didn't know them before.' 'The new CEO took no prisoners, s/he was ruthless.' 'S/he got rid of people, if you didn't fit in you went', 'It became quite a clique', 'S/he had a best buy Finance Director, s/he was really hot. S/he was very personable and very sharp. S/he built up a strong loyal team around him/her and s/he was right for the times.' 'We had a [one sex] chair, tough wo/man, s/he transformed the organisation, S/he knew everyone, s/he was patient orientated', 'They were the right people'* and *'S/he moved on when s/he had fulfilled their job, and that is vitally important, s/he came in to turn things round and s/he made enemies.'*

These changes had not been restricted to the Chief Executive and the Chair, they had hit to the heart of the team. One FM Manager told me

> *'I was the Director of Estates, including Ops and Maintenance'.*

Now he works on the many capital schemes and the Ops and Maintenance teams report to the Human Resource Director, as does Hotel Services. I was told how differently the teams used to work at that time

> *'10 years ago Estates and Facilities were separate, we now have a project group for all schemes on which Facilities is represented. The projects are driven by others [not estates], for example we have schemes that are for the Patient Environment Team.'*

But this is not the only change for members of the Stein team

> *'Up to 6 months ago we had [a Contractor], now our services are in house.'*

Smith tell of how they arrived at

> *'350 beds and just this one hospital. [We] have lost lots of hospitals over the last 10 - 12 years and have centralised on this site', 'in 1992 we were an integrated Trust, 4 years ago we became acute only and transferred*

property and staff out of the Trust' and 'The hospital was built between 1970 and 1990's. The first part of the hospital was built in 1970 and it was finished mid 90's. Then we added a few departments, but no major builds.'

Oliver felt very strongly about the stability that occurred when people stayed, explaining that between them the FM Management Team at the Trust shared 50 years experience of the NHS, albeit from differing backgrounds and through contractor and NHS employment. An FM Manager felt this stability was not only needed within the Facilities Team, but across the Trust:

'I think this is a crucial thing, this stability' ... 'Why do people have to leave an organisation to advance, why can't they be given secondments and big pieces of work. It can't be healthy that people have to leave and all that experience and background is lost'

A new addition to the FM Management Team at Oliver could see the benefits of being within this team of experienced people, and said.

'I came here from [a contractor] and it is so different, it is the best move I ever made'.

Harriott told me

'The culture is started with the Chief Executive and changes when s/he goes.'

The majority felt that experience within the team at all levels delivered the results. Their observations included those from an FM Manager talking about his contribution to the Trust Board

'I need understanding, experience and background to make a real contribution' (Oliver)

to an FM Manager involved in designing capital schemes

'We know what lasts' (Smith)

or an FM Manager advising the FM Management Team

'I could say when we had tried something before, we didn' t waste time and effort on the same things that way' (Oliver)

and an FM Manager avoiding problems in his/her day to day work

'I try to spot problems before they occur, I can do that because of experience' (Stein)

Smith explained how that stability enabled them to create a more cohesive patient environment because

'most of [my] team have been here a long time and have been involved with the colour schemes and therefore set the ambiance of the hospital'

'We are managing to have schemes that allow us to retain our expertise'

Many of the FM Managers that employed in-house staff talked of the low turnover of the workforce, Smith reported that

'People stay at the Trust, although there is turnover with nursing staff, but there are lots of people been here a long time. The hospital is in a nice area if you can afford to live here'

Whilst Smith largely saw the stability of the workforce as a positive, they were worried because

'The average age of the workforce is getting higher and higher. Not sure how to crack that one. We would like apprenticeships, but there are not the schemes'

Lawson also expressed concerns over excess stability in the workforce

'Many of the staff have been here for a long time. You think that is good, but it brings its own problems, it is hard to make a change it takes a long time as they are set in their ways.'

I was given this example by which to measure the stability of the workforce at Lawson

'[this Facilities Management Leader] hasn't been here for long - only 6.5 years.'

Stein also felt that excess stability within the workforce brought its own problems

'Lots of the staff have been here 20 years and there is history. It stops people working together'

However, they felt that it was dependant on which of the FM teams was being considering. I was told that

'[Team A] don't leave', ' [the members] are mostly fifty plus' while *'[Team B] staff are younger' and '[they] staff get up the ladder quickly, so there is more turnover'*

However Smith reported a very different problem, telling me that

'Recruitment and retention is a problem'

All of the Trusts within the Research Group are either a Foundation Trust already or applying to become one. This means that they have had to prepare to apply for Foundation Trust status, work through the various assessments associated with gaining approval of their application, and then restructuring themselves to become a Foundation Trust.

Harriott saw the direct link between their Trust's desire for Foundation Trust status and the focus the Trust put upon gaining three star status:

> *'We had a great desire to be a Foundation Trust and to do that we needed the stars', 'The CEO could see how s/he wanted to run the Trust and s/he wanted the freedom from the SHA' and 'The CEO wanted to be a Foundation Trust, s/he has a business approach and it appealed to that.'*

The FM Managers at Smith did not agree with one another over the impact of becoming a Foundation Trust. One FM Manager felt that the difference was noticeable, saying

> *'The difference with being an Foundation Trust is the dynamics of the Directors - Non Executives for Foundation Trusts have finance and marketing focus, not representative for the local community as previously - this is setting aside the charitable arm of the Trust.'*

whilst a colleague said

> *'There is not a significant difference now we are a Foundation Trust. Alleged benefits have not materialised, the PCT are not paying according to tariff. The DoH is giving different advice to Monitor and freedom from the DoH is not evident here.'*

A further FM Manager felt that the difference was yet to be felt

> *'We have to start using the freedoms e.g. moving into new businesses, but what opportunities are there really? We're starting to look at super clinics - could we provide the facilities for Primary Care and then get consultants working there.'*

However, the s/he felt that caution was necessary

> *'The NHS has cash limited the opportunities of where to take Primary Care or Independent Sector business, but here you have to make sure not to score an own goal and end up loosing.'*

The benefits of becoming a Foundation Trust were described as

'Since we have become an FT there is an increased sense of pride' (Smith)

'The Trust has more freedom now it is a Foundation Trust' (Stein)

'Foundation Trust status gives us an ability to run as a business and we are good at running a business' (Harriott)

Stein also saw that being a Foundation Trust could bring threats with it.

'This is a Foundation Trust, we have to think for the future', 'There will be lots of competition now we are a Foundation Trust.'

Whilst Harriott said of competition

'I don't think FT status will break up the networks between Trusts as we saw the danger last time around[40]*. I am optimistic about this, in fact I make a point of exchanging ideas with [my neighbouring Trust].'*

Smith reported that

'Financial monitoring in an FT is dramatically more rigorous, although there is flexibility around the borrowing limit.'

And Oliver spoke of the need for would-be Foundation Trusts to have a robust financial plan for the future

'This trust is going for FT status if it can solve its financial problems'

Of financial stability Rhodes said

'We had a financial surplus last year (£1M surplus).'

This year £160K had been assigned for FM schemes, and the FM Manager said

'we're quite capital rich'

However, they were cautious when talking of next year

'Money will be tight this year because of the tariff change, we also have Cash Improving Process [target's] to save.'

Stein also reported a healthy financial position, saying

'Finance was good at Foundation Trust point and is still going well'

they also reported a cautious view of the future

'The organisation is quite keen on making savings at the moment' and'They plan ahead, but money will get tighter.'

[40] The Manager is alluding to the Thatcher Government when GP Fundholding was brought in, and GP's could purchase services from the hospital of their choice. As GP's moved their business around hospitals had to face up to competition.

Lawson said of their position

'We have an £18M deficit now and we are not doing anything about it.'

Oliver also reported a financial deficit

'The Trust has a turnover of £100M per annum' and 'There is a deficit of £7.5M this year.'

and told how the FM Management Team had been involved in some very difficult changes to help deal with the financial position

'We were asked to come up with a plan to reduce cost. It reduced quality. We talked to the Trust about two things - them doing some of the things themselves e.g. staff emptying their own waste bins - and reducing standards. We ended up with a list of 12 things and a saving of £400K. When we were considering the cuts in service I was close to saying no we are not doing this, but we know what the pressures are. Being on the Board I know the pressures. My bosses know the pressures too and they say we are in partnership. We didn't quite get to the level of not offering an appropriate services, so we agreed a figure with the Trust's Chief Executive.'

These changes left a sour taste in the mouth of the FM Management Team. I was told that

'The management team were bitter. The threat of competitive tender was waved at us. I got the impression that the Trust thought they would be in the right if they tendered. The auditors would say it was right. But they wanted us to be here - they know we do a good job and give value for money. Perhaps the auditors would say they did the right thing, and so would the central managers. The [Facilities Management] managers felt like victims of success. We provide a good service, so it could be cut. They were demotivated. But we talked.'

Harriott reported that they had

'... big savings to find - everything has to be signed off by the Executive.'

While Smith felt

'We are quite a lean Trust, so we can keep our costs down. But, this can cause a problem.'

They also reported an element of instability creeping into the larger health community, saying

'Payment by results has been interesting. Tariffs have changed now' and 'The PCT has not agreed last years budget and now the whole PCT is changing.'

But how did the FM Management Team assure their Trust that they were providing good value for money services? Some FM Managers spoke of their ERIC returns

'We are very efficient, our ERIC return is embarrassing sometimes as we are in the red' and 'The ERIC return is good. The contract price is excellent' (Lawson)

'Our ERIC returns show lower quartile costs, but good standards. Also, we are affected by the fact that our domestics do patient drinks' (Smith)

Stein FM Managers had less time for benchmarking, saying

'The small site makes benchmarking information a challenge.'

Oliver also complete ERIC returns, but in addition have

'... just gone though benchmarking because the Trust is under pressure. We said that in 1997 we had been through the competitive tendering process and that we can extrapolate prices from there, but the Trust could not afford the costs. We went through a bit of an adversarial process they employed EC Harris to do the benchmarking. If it wasn't for the personalities involved we would have had a big contractual issue. The Trust finally accepted we were value for money, but they still could not afford to pay for the service.'

Both Smith and Lawson have also experienced an outside review, but in their case a review of the whole Trust. At Lawson the FM Managers were proud of the outcomes around their services.

'Ernst Young have been called in to do a total review of the Trust and in the 93 page report, FM has not been criticised at all'

The review at Smith was undertaken because

'The Trust was looking to expand, but now there is a radical review. A couple of strategic reviews are being re-looked at. A couple of wards don't comply with dignity and privacy target', 'The strategic review will take a while to be digested. There is talk of freeing up estate. There is to be less commissioning by the PCT' and 'The bed numbers are being reviewed'

One FM Manager reported that the review had caused their work to slow down, saying

'We have 2 schemes at the moment, but we are quiet and trying to get the backlog done. Then we have the PCT scheme.'

Less commissioning by the PCT could be a problem for Smith

'We have to be of a certain size to maintain viability - too big: unmanageable, too small: too costly.'

Outside links were also felt to be important

'We have close links with Trust A and Trust B, I think that is why we have stayed as a Trust'

The FM Managers spoke of how the financial pressures reflected on their areas of work, and some examples of the processes used (or avoided) to cut costs were discussed

'We use value engineering to get within price' and 'We went to look at P21 [Procure 21] and didn't think it appropriate for smaller schemes. It is relevant for larger schemes. We have not recommended it for use here. We don't know if P21 will continue, we need an updated contract - that is where NHS Estates were good. There is no one filling that gap at the moment. They are leaving us to our own devices. Monitor doesn't give the same guidance.' (Smith)

'We stopped first class mail and now we print off all departmental use and over £100 of first class can be billed, but we haven't done that yet' (Lawson)

'Some services are over provided against NHS standards e.g. two hot meals. This would give room for a CIP [Cost Improvement Programme]' (Smith)

FM Management Teams also faced challenges where costs had increased considerably. One example given was the large increase in energy costs.

'If there is a big issue like this extra money is given, but I have to play my part and make sure that energy conservation happens, that is the bit I can do.' (Stein)

Not all Trusts treated cost pressures in this way and Smith reported that their Trust has

'.. a policy of no non pay inflation because direct labour is small, no non pay inflation is a problem. We need to increase the investment in the estate. We need investment into small infrastructure. We could be imaginative with

moving revenue around' and 'We have not had increases in money, but we have had increases in throughput.'

FM Managers reported that they had to make savings from their budgets.

We have this difficult financial position, and now CIP's and I think we made a wrong decision last year when I made all areas take 1.7% out of their budgets regardless (Harriott)

I had to make a 5% saving on pay last year, the plan had to be signed by me (Stein)

Whist Smith felt that

'Estates have managed to maintain a good level, avoided being hacked back' although *'Over a ten year period chunks of revenue have been taken out of Facilities Management and estates is now a pressure because the new more sophisticated building needs money.'*

They said that they were sure that this would impact on their Patient Environment

'I am not sure we will maintain excellent this year, financial pressures mean we have contained expenditure e.g. on building infrastructure.'

The need for FM Managers to respond to change was largely seen to be a positive thing by the FM Managers.

'We need to keep ahead of the game,' (Lawson)

'We have to be constantly abreast of initiatives.' (Smith)

'Change is good, instead of just running a tight ship', 'I like to see the change - it's the icing on the job', 'I enjoy change' and *'We are fortunate that in the different levels from the top down, we have people who want to make a difference.'* (Harriot)

'Change is good, you are not stuck in a rut' and *"We are finding new ways of working.'* (Stein)

'We are always changing things and making a difference.' (Rhodes)

Although it was recognised others may not share this view

'The NHS is packed with 'we've always done it this way'. (Harriott)

Some of the FM Managers recognised that their Organisations expected them to be in the forefront of any changes, saying

'I'm expected to be innovative. We've introduced new procedures and new ways of working.' (Oliver)

'*There is a corporate expectation that Facilities will achieve.*' (Harriott)

Others of the FM Managers spoke of their particular skills in this area

'I am creative.' (Harriott)

'Problems, I can fix them!' (Smith)

With some acknowledging that they looked for changes that would improve their service delivery.

'... I never think things are good enough and I like to seek out areas to improve upon' and 'I look for continous improvement all the time.' (Lawson)

'I enjoy success. I like to know it is running well, not that we are just getting away with it.' (Harriott)

Some of the FM Managers wanted to be sure that there was relationship between change and benefit.

'You have to ask will you get benefit from changing, or are we just changing' (Lawson)

'We make changes only if they are necessary.' (Stein)

'There are so many quick fixes for the impossible to solve' and 'I get frustrated when the political short term approach comes in. No money, no election; loads of money an election.' (Harriott)

Whilst others recognised that some people found change harder to manage.

'[Estates Officers] work closely with the guys and they have to bond with them. They supervise... its difficult for them' and *'Estates Officers here find it hard to implement change themselves, but when I make changes they are supportive. But they blame me.'* (Stein)

'If we need a change of direction my management team come to me. We come up with an idea and they enact it' and 'I will always recommend the way forward.' (Harriott)

'It was hard to make changes at first, but not now. Its how you package it and the training.' (Lawson)

'Its not easy to make changes around here' and 'It's very hard to get people to accept change.'

Harriott felt that their organisation had created a culture where change could happen

'Everyone has been so set in their ways', 'They used to have a real fear of the staff, the service came 2nd to not upsetting staff. Then we took on a few staff groups and won and the unions crumbled', 'They've set up a culture that allows change' and *'We have a culture that is results orientated, so the clinical director is interested in achieving results'*

And this had resulted in

'We don't have the renegades that say they won't do it', 'Put forward a good idea and they say yes',' The Joint Consultative Coucil works really well. Staff members can get things through. They have got things in place that allow agreement and then when people get upset, they say it is already approved' and *'It is easy to get changes agreed here compared to other Trusts, we have an easy HR structure.'*

I asked Smith if there were opportunities for change within the Trust. I was told

'Yes, easily as long as people know why, everyone is flexible'

'What have you go to loose? Get involved the planning stage and get the right people involved. Why not try something new if it makes something better.'

When talking about implementing change, the FM Managers had different approaches.

'*At the end of the day I decide what I want to do and discuss it with my boss.'* (Stein)

'*I pass all changes past my collegues.'* (Stein)

'*You have to adapt to circumstances, you either dig in or become conciliatory.'* (Harriott)

Theme 8 Integration with Clinical Teams

Although FM is recognised

'...as a support service to clinical people.' (Stein)

the FM Managers saw themselves as

'part of the hospital team.' (Lawson)

and were keen that their teams were integrated within the clinical teams, particularly at ward level.

'Its not about the patch of lino, its about the patient experience. Encourage the porters to talk to patients and cleaners to listen to patients – for example I'm in a lot of pain but I don't want to bother them - and the cleaner

telling the nurse that little old lady hasn't eaten and has just hidden her food' and 'Another important thing is that the staff think they are part of the hospital. The management team try really hard at this. We give them a badge with a leaf that signifies the ward they work on' (Oliver)

'The ward manager has to own a lot of the PEAT criteria - e.g. protected meal times'. (Rhodes)

Stein think the skills and the experience of the FM Manager allows a better link to be created and maintained

'I am a nurse, so I know what nurses expect. You can debate with them'

and Harriott reflect this need for a robust partnership, saying

'The Clinical Directors are strong individuals in their own right, so I have to be strong', 'It is different in the Clinical Directorates, you have to take people with you' and *'The knocks come from above not from my teams. Look at the workforce and cost cutting, every vacancy is to be fixed term if not you have to have Exec approval. The previous week I was told I was under recruited in domestic, I wrote papers to avoid red tape, but [my boss] told me they had no appetite to change the procedure. So I went round the departments and talked to my people and I saw the real world. That's the game...'* (points up), *'...that's real.'* (points down corridor to his staff)

While Stein felt that

'Relationships are key'

Lawson reported that, as times have become increasingly difficult in the Trust,

'I worry about Facilities Management becoming isolated as we are doing our own thing these days.'

They are very careful to work closely with the wards to try to prevent this isolation and say

'We have dedicated staff at ward level. Although sometimes we have use relief or do some swops. We have a full time relief team', and *'We have zone co-ordinators for the contract ...[who] looks after 6 wards'* also *'a zone co-ordinator for maternity and for mental health', 'The zone co-ordinator is responsible for input into the fabric of the building through [the designated Estates Person].'*

They also allow wards to have input into what gets done each day

'Wards have a little leeway in what gets done. The manager can say do this and don't do this.'

Smith echo this desire to integrate with the wards saying

'They - the domestic - are part of the ward/department team', 'Domestic staff are designated to an area and are part of the care team on the ward', and *'The domestic is managed by the ward team, their line manager is through Facilities Management.'*

Oliver report

'We have particular people at ward level, we are always trying to create ownership for what they do', 'We want wards to say 'my cleaner', Our contractural obligations have to be done every day, but after that the ward manager can ask for things to be done' and *'This close working with the wards works really well'.*

Stein are considering

'Moving to a domestic [managed] at ward level. I am worrying about professional levels.'

Harriott report that whilst the staff report to FM

'Nursing staff dictate what happens at ward level'

Oliver are

'trying to develop the housekeeping role. Agenda for Change helps with that. It is incumbent for us to give better value. Better qualified staff need to be able to offer more'

Within this new arrangement, line management structures will remain with FM but

'an HCA[41] will transfer to FM to form the housekeeper role, the wards were very resistant at first, but we are starting to persuade them, we'll take over bed making and such tasks. When the Trust is scratching for money this is a good idea.'

The PEAT initiative was seen as a good way to encourage integration, and Stein explained how they involved nursing staff and others from outside FM

'Modern matrons and infection control are also involved, along with my Facilities Management Manager' and 'We have a Patient Environment

[41] Healthcare Assistant

Team made up from Facilities Management, Estates, Matrons, PALS, Patient Reps, Infection Control, Catering'

They further integrate their approach by including both

'.. domestic and nursing duties in our inspections.'

Rhodes spoke of the inclusion of a number of different disciplines on their PEAT teams

'The Ward Manager, Non Exec Member, Modern Matron, Infection Control, Estates and a patient from patient forum do our inspections. We also include the ward housekeeper'

Modern Matrons are seen within the NHS as a key resource in achieving joint working within the patient environment agenda. The FM Managers reflected different views on the Modern Matron. Rhodes explained to me that

'[Modern Matrons] seems to work well, they relate well and the nurses are managed'

'There are 3 modern matrons....specialise in diffferent areas - e.g. linen'

'They are highly regarded, they used to be nurse specialists.....'

'On an inspection the Matron will talk to the nurses and ask for improvement.'

'We've gone to Modern Matrons meetings with initiatives.'

Smith reported that

'Modern matrons are invited to the monthly PEAT inspection.'

However, they felt

'Modern Matrons are a difficulty, they are sometimes not involved. It's dependant on their interest and that's variable'.

Rhodes told me that

'We do an inspection 2 per month at larger hospital, 1 at smaller'

'We focus on 3 or 4 criteria that are not met - e.g. paper notices, bars of soap.'

They inspect domestic cleaning schedules and

'A cleaning schedule has been set up for nursing duties and this is checked at the PEAT visit.'

This idea of inspection is not new to the Rhodes team

'Before we had PEAT regimes, we used to do walk rounds – my colleague did this when s/he worked at another hospital'

In addition to inspections, Lawson told me

'A questionnaire goes out to all wards, and there is a stakeholder questionnaire'..'I go with [the Contractor's manager] and carry these out at ward level' and 'There is good teamwork with the rest of the Trust regarding PEAT. The nursing staff are attentive to what we are wanting and I always give them feedback.'

Stein reported that they now had a

'well motivated group, known as PET, who are not easy to manage'.

The FM Manager said

'I had to challenge poor attendance at PET'

but was now happy that all disciplines were now represented within that group. S/he told me how they get motivated people to become engaged with FM

'We don't ask for a rep from a certain directorate, we ask for people who are interested in the topic, with an organisation this big you usually find everyone is represented.'

They also link into other groups in order to strengthen the effect of integration and further benefit their Patient Environment.

'We are linked in with an Arts Group. We change our pictures every other year.'

Good relationships with other specialist clinical teams were also seen as key, for example

'Infection Control has a high profile with clean your hands'. (Harriott)

The FM Management Team at Rhodes try to enhance their value to the ward team

'We offer suggestions to nurses to help with their problems' and 'Cleaning of equipment used to be a housekeeper duty, now the HCA's are helping'

Oliver also try to maximise their value

'We asked the ward managers how we could improve our service. One area that we can add value with is the translator service. One of our cleaners became a translator and the Sister wrote from the ward to say how pleased s/he was. I offered this service to the other wards - only two wards raised the issue of confidentiality. I took that as praise, it used to be

raised a lot. We're not going out to sell [the information] for goodness sake.'

They have also spent time looking at how they work with clinical colleagues when things go wrong. They told me

'We talk about a no blame culture quite a lot. If is possible to blame us the Trust will do so, but it is usually six of one and half a dozen of another, so we investigate and say this is what we did and this is what we can do about it and this is what you did and what can you do about that and usually we come to an agreement' and 'When the Sister sees something wrong, s/he needs to talk to the cleaner, not be ringing the office down here.'

Smith felt that customers were not always interested in working with FM, they felt that

'All the customer wants are jobs done quick.'

Although the FM Managers were keen to ensure that there was integration with clinical staff, they were not prepared to ensure integration at any price, but felt that 'rules' or 'standards' were important.

'They are pretty good at sticking to the rules if they know the reason why, you've got to have rules.' (Smith)

'We don't let the wards do their own thing.' (Stein)

They were also prepared to challenge and be challenged when things did not work – which did happen from time to time

'Mostly our schemes work, but sometimes we have to do modifications to make them work.' (Smith)

Harriott spoke of the difficulties engaging nurses

'The Nursing Directorate are not as involved as they should be.'

and report, after high level discussions,

'It could be put in their objectives this year.'

Lawson challenged the culture of nursing teams, by raising the issue of

'not sharing the chocolates with the domestics. It may be seen as trivial, but it is important to the staff.'

Rhodes echoed this difficulty and explained how, with PEAT becoming part of the nursing agenda

'We still have to sort out the problem with commodes - cleaning between patient use, a nurse should be doing this with the wipes that are there.'

Stein and Oliver have used standardisation as a way of improving the patient environment. Health and safety issues motivated the organisation to move in this direction. They told me

'We had a HSE[42] visit in 1999, and 2 improvement notices about how we managed the display screen regs. They were critical of the furniture. We decided to gut the hospital over 3 years and replace all the furniture' (Stein)

'There are safety issues with standardisation - re medical equipment - intravenous pumps. There is a nurse in the purchasing department and s/he is the interface with the clinical people' (Stein)

' 'We are hot on Health and Safety. The company is keen to drive this. On site we use H&S as a protection of you as a staff member. People don't respond on how things will look in bids, they do think about getting needlesticks and slipping and falling.' (Oliver)

Rhodes told me that in order to specify the correct level of services for wards

'...the areas are divided into high, med and low risks as per the National Standards.'

and considerable effort goes into obtaining buy in at ward level, for example

'[A] ward cleaning manual has been introduced, it includes specification, contract details and times of domestic services, e.g. 3 domestics and 1 hostess' and 'Wards getting 100% results are put forward for an award at the end of the month.'

This will be followed by

'...a good practice guide and an audit of nurses practice ...'

They have also worked out a method of reporting on achievements which ensures that people throughout the organisation are aware of the standards being achieved

'We send the information to wards and departments, almost as a name and shame document', 'The Associate Director receives copies of the monitoring results' and 'We send the Directorate their Directorate report.'

[42] Health and Safety Executive

They say

'Although time was taken setting up the system it is now fairly routine.'

Smith told of a situation where FM were challenged for not delivering appropriate standards of service

'We had a complaint from a ward regarding décor. We had a healthy dialogue over moving it up the decorating agenda'

To safeguard against such problems with service delivery, they try to involve their customers in conversation about what is required

'We talk to the client regarding how it will work. The brief is then worked up to be compatible with the budget and we often get a pint into a quart pot. Things get added.'

Lawson also talked of the need to involve clinical staff, this time in service design, whilst maintaining a cost focus. The example spoken of here was a move from traditional cleaning methods to the use of microfibre.

'There has been a cost analysis and infection control have been involved.'

This ability to respond to feedback by clinical staff was also voiced at Rhodes. They told me that, following an issue raised by nurses over the amount of time spent by domestic and hostess staff at ward level,

'The domestic and hostesses have to sign in and out of the wards, this is welcomed by the contractor, excuses are being removed.'

Harriott try to ensure they have regular dialogue with Clinical Directorates, saying

'There are regular team briefs and FM meetings where we discuss topics in depth, [the management team] are exposed to other Directorates, but we do not send everyone to the meetings.'

Theme 9 Integration with the Corporate Agenda and the Top Team

Both Smith and Harriott spoke of the importance to the Corporate Agenda of the PEAT initiative, saying

'PEAT is important because of the star ratings.' (Harriott)

'The Executive are interested in PEAT because it affects the star ratings, they are more worried about outcome than process.' (Smith)

This importance meant that the FM Managers had the perception that, not only did PEAT belong to everyone within FM, it needed to be part of the Corporate Agenda and be overtly supported by the Top Team. I was told that

'If something is on the clinical agenda and not on the corporate agenda it will fall down' and 'The issue is to get integration with the big picture. Some never will, they always see only their area.' (Harriott)

'The Patient Environment is one of the corporate objectives'...' [it is] high on the agenda, ownership from Exec, we are all committed to this' (Stein)

'The organisation as a whole is interested in patient environment, you see that when you notice the re-flooring of the hospital streets' (Harriott)

'Everyone, including the CEO, is aware of PEAT.' (Rhodes)

'[The] CEO would know about the targets within PEAT because it impacts on other targets. S/he always talks food and cleanliness'. (Harriott)

This support by the Top Team was expressed in terms of actions taken by the Top Team, or by PEAT being allocated by the Chief Executive to other Directorates as well as FM as a shared objective. Harriott described how PEAT was an objective of the FM Management Team, but was also part of the Corporate Agenda and therefore featured as a shared objective with the Modern Matrons.

'PEAT belongs to both me and my deputy, it belongs to the organisation. Matrons will be given cleanliness and nutrition.' (Harriott)

This was a theme they expected to develop in the future; they felt that

'Cleanliness is higher on the agenda now, but food will come. Nutritionists will then become interested.' (Harriott)

Stein also reflected this desire to integrate with the Corporate Agenda

'Our objectives and priorities are a direct reflection from the Board.'

This meant that they

'...have to treat PEAT as important, it is the key target for us, and for our boss, it is in his objectives.'

Relationships with others were seen as key and importance was placed on the way The FM Managers approached people in terms of status.

'I treat people from CEO to cleaner as the same' and ' Status is not [an organisational] thing.' (Oliver)

Harriott told me of a conversation that had taken place between an FM Manager and an inexperienced HR Manager

> *'[S/he] asked me at a Christmas party, how do you talk to all the staff the same? I do it in a light hearted way, but I can do it on serious topics too. My mother's philosophy, right is right and wrong is wrong.'*

While Stein recognised that status could still be an issue in bringing in standard approaches and procedures

> *'Mobile phone policy… We have signed where people can and cannot use a mobile phone. Sometimes a consultant ignores it - we let them to some extent' and 'Consultants status is still enormous.'*

Smith FM Managers spoke highly of their boss, whose behaviours and work patterns allow strong links to be made with the top of the Organisation.

> *'[My Boss] spends a lot of time in HQ, he is astute politically and aware of what is going on outside', '[My Boss] has a lot of sway in the Trust. There is a new Chief Exec and a new Finance Director. There has been a lot of change. [My boss has] been here for 9 - 10 years' and '[My Boss] spends 50% of his time on corporate work and 50% on Facilities Management'*

This link between the FM Manager and the organisation is also underlined by Harriott

> *'Less and less of my role is about FM, more is professional management of Health Services'*

The need for integration that reached all was suggested by Oliver, who said success was created by

> *'…integrated teams, no silos, integration with [the] Trust, ownership by staff'*

Smith were keen to keep FM high on the Corporate Agenda as they felt that

> *'The better the estates importance the better the environment.'*

Lawson was worried that by joining an FM team some isolation became inevitable

> *'I think I have been more insular since Facilities has been formed. Before I used to be part of the Trust and know more what was going on, but I have all those relationships with people and they are still there.'*

However, Harriott felt that it was the calibre of the FM Manager that impacted on the success of any integration with the Corporate Agenda

'...It is important that whoever heads up FM has the respect of the Board and just below in the Clinical Directorates.' (Harriott)

Stein felt there was little point in having strategies within FM if they were not integrated with the Corporate Agenda

'We have a written estates strategy, we did it in the way required by NHS Estates. The NHS Estates way is not of real value' and 'It needs to be part of an overall business plan.'

They gave an example of why they felt this integration between the FM Agenda and the Corporate Agenda is so important, saying

'There is no great problem getting people on board, e.g. staff charges for carparking. There were battles with Consultants about it. But the decision had been made' and 'The Execs were all supportive. They are generally supportive.'

Another example of the improved service delivery that becomes possible with the integration of the FM and Corporate Agendas is standardisation (or a 'house style') that further improves the environmental standards and allows for greater efficiency.

'We have standardised office furniture, it gives a corporate approach. We don't move furniture when people move[43]'. (Stein)

'We want a consistent style, a house style... not fragmented.' (Smith)

Smith reported that whilst they canvassed views from many groups in a variety of ways

'...they know what to expect with the house style. We know what they need, so we don't create a problem for them.'

As mentioned by Harriott in an earlier quote where floor coverings were mentioned, the integration of the Agendas allows for investment to be applied to the right areas, thus enabling the upkeep of the environment.

'The age of the building is important, if people have something nice they look after it' and 'They have always kept up the infrastructure. We know that the right environment and nice décor impacts on people's health - Professor Ulrich's work.'

However, it was seen that differing standards within FM could undermine the hard work

'...annoying that estates professionals get the costs down by providing loads of magnolia boxes. We had a battle with maintenance people who only fitted standard fittings. We are getting away from those constraints now.' (Smith)

Harriott felt that

'You need to understand what is really happening when you talk to those above you and get the priorities of what is important and get clarity.'

Stein also thought that the conversations that went on in an organisation were important to setting the FM work agenda

'There are lots of groups working in parallel, you hear things from one group to another. I never mind hearing things over and over again at different meetings, it means it is important.'

Not only are they keen on ensuring that people from the larger organisation is at their meetings and hearing their conversations, they like to be part of others' agendas. These are then worked into the FM agenda, to help with achieving their part of the Corporate Agenda

'There is an Arts strategy group now, we were picked up for being clean but sterile. Art now goes into all new building environments.'

Reporting on the achievements of standards is key at keeping up the involvement at Rhodes. I was told that

'We send reports from our monitoring system to the Cleaning standards group, Non Executive Director, FM director, 3 Matrons, Infection control, the Deputy Director of Nursing, Hotel Services Manager and Contractor.'

The culture of the organisation was also seen as key by some of the FM Managers

'The Trust is very, very focused on patients.' (Stein)

'The Trust has always looked to get a good image, but not been excessive, no icon buildings but try to look good.' (Smith)

[43] Movement of people (and possibly their equipment) around a building is known as churn and brings large and sometimes unseen costs to the organisation

'We recognise that happy patients equals good business performance', ' We are a ruthless, business machine', '...[the business focus] can cause us to change direction and the patients are left if they don't bring business rewards' and 'The business ethos is mostly fine, but can cause a strain on staff because of why they work in the NHS.' (Harriott)

Harriott saw a match between the organisation's culture and the FM Manager as a key attribute for success.

'Every organisation has a culture and you have to fit with that culture. If I didn't I would have to leave.' (Harriott)

Close integration with the Clinical Agenda can also have its disadvantages as reported by Smith

'The corporate side [of my job] is expanding and this has an effect on standards.'

Stein were worried about the standing of the services traditionally provided by FM as it became more and more aligned with the model practiced at this Trust, moving away from the single identity of FM

'Integration of FM [into clinical services] is coming. Internal/external signposting is an example of this. Estates are now not signposted, as we are only clinically focussed.' (Stein)

Each Trust had a different way of expressing who made up their Top Team. It seems that the organisation of the Top Team has a direct impact on the FM Management Team. It dictates who they work with at this level, where responsibility for the Patient Environment lies and who can influence it. For example, the Planning and Development Manager at Stein handled capital planning, while Smith reported similar arrangements, saying

'Strategic planning set the brief', 'Strategic planning are heavily involved in getting the brief. They use ADB [Activity Data Base] s/heets and we look at how the user wants to use space. ADB s/heets are very general and are often oversized. We do quite detailed plans.'

Harriott told me of how they were affected by the changing role of the FM Director, who now

'... has responsibility for all areas bar nursing and holds the budget for them. That affects us.'

Their Trust's business approach helps assure integration within the Top Team

'The Executive place a responsibility for a target at the Director's level.'

At Rhodes the

'The Operations Board is basically the Exec Team and Directors', 'The Operations Directors may have more than one Directorate each' and *'The Operations Directors for each Directorate sit on the Ops Board.'*

They explained that this close working with doctors was due to their Chief Executive

'Our CEO has been here about three to four years', 'S/he was the Medical Director and then became Chief Exec' and *'S/he is a surgeon and can relate to the sharp end because of this.'*

Harriot FM Managers also spoke of close links between doctors and managers, saying

'Doctors have always been involved with management here - for a long time' and *'We have a consultant with an MA in business management.'*

and of their Directors and CEO they said

'We have good top level management', 'Our CEO is a charasmatic leader, s/he's inspiring' and *'Our CEO can play a meeting - it is a fine art, a real skill. S/he knows who to influence, where and why'*

One FM Manager at Harriott felt so strongly about the integration of the Top Team, s/he remarked

'Four of five of us would be uncomfortable with a new CEO, unless it was one of us' (Harriott)

Stein reported just as positively on their Top Team

'The Directors are dynamic and it rubs off' ,'You can do anything when you are supported' and *'The current CEO ... runs a good business. [S/he] is a different chap to the previous CEO, but good.'*

Smith have a new Chief Executive, of whom they say

'We can see [s/he] is patient focussed, but at the moment finance has to be top of the agenda.'

Of the Oliver Executive Team, the FM Managers told me

'Our Chairman is very good, s/he's from the oil industry', 'All our Non Executive Directors have got finance or community backgrounds. It's a good mix. They're a good group, they have a grip of the issues'

'Our Nursing Director is, well shall I say, a time served nurse, s/he came from the HA, the HR Director is into Trade Union movements and the Finance Director has ambulance trust, pct and now acute experience. We have a new Service Development Director s/he is well experience, so it is a good mix', 'Our Chairman is clearly a business wo/man, s/he has certainly bitten the bullet re the financial position. S/he is much more demanding regarding this, s/he's really going at the Directors and the NED's are following that lead' and 'This is a caring organisation at the end of the day and maybe that is a female attribute.'

Oliver also talked of the integration between the FM Management Team and the Executive (Top Team).

'I am integrated with the Exec Directors - I have a relationship with the HR Director, we worked very closely when the TUPE arrangements were taking place. They were very supportive. Now the A4C issues are bubbling away', 'We've got an excellent relationship with the Infection Control Director' and 'When there are complaints issues and problems etc at ward level, I try to support the nursing director by saying lets try to do that. Sometimes my boss thinks [I have] gone native.'

Lawson do not feel so integrated with the Top Team, saying

'I don't really have anything in common with the other Execs.'

They were also less positive than other FM Managers about the Executive Team and feel that

'The Board needs to take a grip on [the loss of stars], they are too nice as well', 'The Exec Team often goes off at a tangent and makes decisions on what they think would be a good idea rather than make a proper business decision... We prepare business cases for the things we want to do and then expect the Exec Team to consider those options... Why can't they write proper business cases which consider options in the same way that we do. They just make up a list of 'he said, s/he said.'

They spoke of the inexperience of the Directors

'None of the Directors have experience of working at Director level... The Finance Director is just behaving like a rabbit staring into the headlights.'

Giving the example of some recent project work that had been agreed at the Board and was to be led by FM.

'They are too busy to be able get their project plans written... Why are they not treating these projects as a priority, they need to get sorted out. Our project is on time, so why aren't theirs... I say to them I am not here to worry about whether they are progressing their projects, just to collect their information.'

The Chief Executive at Lawson

'...has been squeezed out now and replaced by an interim manager, [s/he] is a friend of the old guy and the same sort of person, The CEO was so nice, [s/he] worried more about what people wanted to do, than what they should do' '[S/he] said what did we want to do, not told us what [s/he] wanted and who was to take on the work' and *'We called it Planet [Aa]. That was his name – [Aa]. We knew we were living on cloud nine and Planet [Aa] would have to go.'*

Of the previous Chief Executive who reigned over the Trust while it had three stars, they said

'We had a good chief executive when we were a three star trust, but [s/he] has been gone for about 18 months now ' and *'The old CEO used to say I want you in the lower quartile [of ERIC], and we did it.'*

However, of their Director they said

'[S/he] is good at reading and at seeing what is coming in the future' and *'[S/he] encourages focus'* and *'There is a different management culture here'*

Stein felt that their Executive were focused on outcomes and results, for example I was told that

'I have an assessment and Patient Environment has been a key target for me for the last 5 to 6 years.'

They reported that when there are savings to make,

'Those who did not make the savings had to go in front of the CEO and Finance Director' and *'The idea of having to go in front of the CEO and Finance Director is horrid.'*

When asked what would happen if they had to go in front of these people, I was told

'Oh, I think they are alright, it's the idea of having to go.'

Rhodes told me of the systems they had in place to ensure the Executive are kept up to date with the achievements around the Patient Environment standards

'There are high level board indicators for the Trust Board', These high level standards go to the FM Exec Board each month, then to the Operations Board and then to the Trust Board' and 'The Operations Board gets a high level report.'

Lawson said that, to ensure that the Patient Environment became important to all the Top Team, they had members of the Top Team on the Patient Environment Team, along with users of the service

'The Nursing Director did the PEAT inspection, the CHC[44] sent us a patient and we had one from the Patient Involvement too.'

However, they also reported

'For the first time since the beginning of the .... contract there are no Executives available for the Partnership Meeting, they are too busy, what will [the contractor] read into that?'

At Oliver the FM services are provided by a contractor through a Private Finance Initiative arrangement, and the most senior FM Manager sits on the Trust Board as does the Hospital Company Director.

'I sit on the Board and the Hospital Company Director sits on the Board too' and 'My being on the Board was instigated by the CEO [on franchise]. I am there to represent our services and to buy in to the ethos, not to contribute to the debate - although I do from time to time.'

Lawson told me that one of their Directors left recently, and

'We have shared out the work of the Director that has gone, rather like kids sharing out marbles' and 'I didn't put my hand up for any of the work when we were sharing out the marbles. I waited to see what [s/he] would want me to do.'

[44] Community Health Council (now disbanded in favour of the Patient Advice and Liaison Service)

It seems that not only is it important for the FM Management Team to have access to the Top Team, but also to be involved in the agenda of other Directors. Smith illustrated this by saying

> *'[S/he] sits on the Clinical and Non Clinical Risk management group, this has a lot of weight and [s/he] can explain the rationale to people.'*

Stein described how relationships were more important than structure, saying

> *'I report to the CEO, but I don't mind who.'*

This emphasis on relationships was also reflected by Smith

> *'At each hospital processes are the same, but the difference is in: the personalities and how they get on; where the CEO's priorities lie; where the alligences lie.'*

They felt that the amount of time the Top Team needed to spend on FM matters was minimal, saying

> *'Facilities is a support function and provided you have the resources and the time you don't need to tie up Board and Executives time.'*

But they made the observations

> *'I would take issues to the Chief Nurse and Directors Group if they remained unresolved, but this would be a last resort', 'It is easy to get things discussed at the Exec Group and the Board' and 'We get lots of support when we need it.'*

Obtaining finance and investment was of interest to most FM Managers. It was felt that if your issues are on the corporate agenda, finance is more likely to follow. Age of the estate was of interest at Stein

> *'The hospital is 25 years old and the importance of estates is becoming more important.'* (Stein)

They feel that the requirement to invest in the Environment has become a higher priority as the hospital ages

> *'Finance do listen, and more so lately. For example there is no official plant replacement programme, but they have asked me to put together a plan and they will invest in that plan now', 'We have not decorated our wards for about 12 years ...Money is made available now for ward décor, but we have no decant ward so we have to work over the weekend. I think this*

means the quality is poor and the costs are higher' and 'We are upgrading bathrooms bathroom by bathroom on each ward.'

But Harriott reported difficulties in obtaining investment

'We just held our head above water with the PEAT last year, but we had no direct investment in things like chairs, floors etc. We got £300K to upgrade bathrooms, but no more.'

Rhodes understood that their Top Team likes to see

'Lots of investment in things that make a visual impact.'

And not in other areas

'The chairman says don't spend on things where there is no revenue return, that is hard for Facilities, like resurfacing a road.'

They take a pragmatic view to the funding necessary for PEAT, saying

'Most solutions don't cost much, e.g. wrong fabric on furniture, with small amount of money we can replace or recover.'

They explained that they had to make a case for the investment required

'We have to compare the requirement for resurfacing a road with buying medical equipment, so we have to make a good case' and 'We make a case and have a weighted score.'

They are content that this regime is fair, and if their case is good they will receive their allocation. They feel that

'The allocation procedure means that things like bins don't get lost in amongst the larger things.'

Smith echoed Rhodes' thought that cases for investment into the environment have to be strong, asking

'How does the Trust decide how it will invest capital? Usually clinical areas make stronger cases.'

However, they felt

'We usually get decent amount of money for infrastructure of the estates, but there is not always enough funding.'

At Stein

'Finance have come up with a risk methodology for investment which we have to use','We have a bidding process and a risk register, and of course there is PEAT' and 'We can get access to funds to solve problems.'

However, they reported that support from others within the Top Team helps bring investment

'Our Director of Nursing is heavily into the Patient Environment, [s/he] gets funding for all sorts of schemes.'

Rhodes explained that their investment is sought through a *'... capital prioritisation meeting.'* While Oliver spoke of the investment that had been made by their organisation into equipment for the maintaining standards of the Patient Environment

'The carpet in the main corridors looks so much more welcoming, we have just invested £11K in a sit-on cleaner and we have just managed to get the old shampoo out of it.'

But felt that in order for standards to be maintained

'From the outset the work has to be properly priced. The private sector has to make a profit and the Trust has to recognise the cost of the services.'

And spoke of the difficulty around finances

'I have to make my numbers and I have my budget, but we are not a claims conscious company. Things happen e.g. A4C and I have to make sure we don't miss out. The Trust have been very dilatory on paying out. They want chapter and verse on everything before they pay out.'

But

'We're in it for the long term and we are not adversarial. We want to win new business, so we want our clients to recommend us to others, so it is not in our interest to be adversarial and difficult.'

Theme 10 External Perspective

Although

'There is increased patient involvement with PEAT.' (Smith)

and additional requirements to include patient views in the PEAT inspection, the FM Managers were interested in their local communities. Their conversations took several different approaches, from being aware of what the community thought of the Trust, the need to ensure that the local community were on board, the differences brought to bear by their communities particular attributes, to the effect on recruitment.

'We are here for patient care, if it were my granny or my kids, I'd want it to be good', 'We have strong support from the local community, people have high expectations of us and 'The local people are very lucky, they don't

realise until they go elsewhere, I took my mother in law to [another Trust]' (Smith)

'There is a lot of local feeling for the hospital. We can use that to appeal to staff, what if it were your family.' (Lawson)

'The community is more demanding because of this [affluence].' (Stein)

Stein saw the community as one of their major stakeholders and said

'We can't win without getting the stakeholders on board.'

One FM Manager told of his experiences

'I have attended the Local Health Scrutiny Committee re carparking. They can call us any time. They can report us to government. They are tough meetings, you can't waffle' and *'I have had to attend the Patient Public Forum to talk about cleanliness, catering and other audits.'*

Whilst another FM Manager at Stein felt that the community had a lot to do with the success of the Patient Environment.

'I think it is a lot to do with the local community, when I worked at [another Trust] they were proud of their hospital, it was local and friendly It was spotless, mind you they had a strong FM Manager.'

The FM Managers felt that a positive feeling within their Community was important and attention needed to be focused on this.

'Patients have to have confidence in us and they get that from how the hospital looks' (Stein)

You need to put yourself in the patients' position' (Lawson)

They were aware that the local perception of the Trust could be damaged by the way people carry out their work in the hospital

'We have several major incidents running at the moment, but they are just bubbling along, no one is managing them... We have managed to keep our blunders out of the local newspapers so far. We have been very lucky.' (Lawson)

'We have some difficulties with the planners, we breached an agreement in the past by selling houses on the open market. The Council remembers that, but we have worked hard to re-establish the relationship and things are better now' (Stein)

'The Council wants to talk to one organisation, not to mental health, acute etc - they want to talk to the NHS.' (Stein)

'We have had our upsets, we took on someone who worked for a paper and they built up a story around a grasshopper. It does a lot of damage'. (Rhodes)

'They had done a lot of work around recruitment, but then Panorama did something similar to us' (Rhodes)

The FM Managers also felt that their Community was a useful pool upon which they could draw. Whether this was to use to

'externally validate their views' (Stein)

or to give inspiration in problem solving

'Interpretation of things is important, when I walk around other places I steal ideas - e.g. M&S toilets. There was no room for a cleaners cupboard, so we used a cubicle for the cleaners and put a sink in that - that was Sainsbury's that did that' (Smith)

Smith reported that they used community members within their PEAT inspection group

'An external assessor is always used and now we include a staff governor.'

They had already had

'.. two external validation visits. They both supported our in house PEAT score'

Other also reported this approach

'We have a patient forum' (Oliver)

'Patient Involvement People are interested in various aspects of PEAT, 5 different groups are interested in catering and 6 in cleaning,' and 'The quarterly PEAT report goes to the Patient Quality Group, a number of patients and trust board members attend this.' (Rhodes)

'The key is to have PAL's on board, and bring in patients for decision making', 'The patient forum has been involved on our group for the past 2 to 3 years.' (Stein)

The FM Managers had a variety of views of the impact of Patient Choice

'xx and yy are the nearest hospitals to us. They may be competition to us when Patient Choice comes along. But patients would like to come to their local hospital' and *'Effort has to be put into creating the best environment for patients'* (Smith)

'Patient choice will bring competition, and hospitals will become isolated due to the competition. Just like fundholding', 'Patient choice is just around the corner. Public don't have a knowledge of surgeons, we have to get right what the patient sees' and 'Not so bad as for other Trusts, for example xx Trust, they have 3 hospitals in a 20 mile area. People in Stein won't go somewhere else...you can't be complacent, the GP's will notice it and the patient will ask the GP.' (Stein)

'I am not sure how the Patient Environment will affect Patient Choice. In London maybe, I'm not sure here. Rural places will not find that choice makes a big difference. Especially when clinical services are cutting back. It will be more about GP funding links with Foundation Trusts' and 'This must be the hospital of choice and patients see the environment and it helps them make their choice'. (Harriott)

Smith told how they were trying to make their hospital an attractive place, and thus patients would choose to use them

'We are trying to get away from a clinical look - we are discussing uplighters and radiator covers' and 'We are trying to stay away from the clinical look'.

The FM Managers saw that the success of their organisation brought benefits. The FM Managers mentioned the impact the Trust reputation and their profile within the local community could have on recruitment.

'It is good to recruit, people want to work here, Consultants don't mind working here' (Harriott)

'We are successful, so we attract a better calibre [of staff]' and 'The local community work in the hospital and are related', 'The Trust is one of the major employers around here - you work here, for the police or the council, other than that it is tourism.' and *'[Staff] have a stake in the community.'* (Lawson)

'People in this area are better educated, more affluent. It may make it difficult to attract staff', 'Quality of local workforce is average' and *'Good skill base for craftsmen in local area.' (Stein)*

'The location of the work force is important, we are inner city here so we are ok.' (Rhodes)

'I wanted to work at my local hospital for a long time, so it was grand when this job was advertised and I got it.', 'It is quite a deprived area', 'This is a working class area.' (Oliver)

'We have an older, wealthier population.' (Smith)

As well as talking of the local community, the FM Managers observed the role played by the national bodies within the NHS and Department of Health. Harriott said that following the changes around NHS Estates and PEAT being managed by the National Patient Safety Agency (NPSA)

'The NPSA is looking.'

Smith felt that there were adverse motivators from the DoH and SHA's

'There is significant investment which goes to poor performing Trusts.'

Stein felt their involvement in the Regional Basic Care Network helped with sharing good practice.

'I am chair of the regional basic care network. They do best practice presentations etc. It is a good forum to get 30/40 people together. It is linked to HEFMA and they share good practice or raise questions. HEFMA is active around here, there is a sub group for hotel services.'

5.4 Reflections on the FM Managers and their Environments

This section looks at the FM Managers wider environment and their activities within this environment, in an effort to establish whether the ten themes identified within the conversations are evident in the reality of their environment. The ten themes are shown at Figure 5.1.

I was particularly looking for the less overt messages of symbols, signs and unspoken language. The language of FM is that of the environment, to which all NHS stakeholders are exposed, whether they be staff, patients or visitors. Patients' and visitors' perceptions of their environment are reflected in the purpose of the PEAT initiative and are the rationale for the emphasis of the Patient Environment. The importance of the environment is particular for staff members such as these whose motivations and understanding are facilitated through the physical manifestation of the organisations' culture and its priorities in investing effort and money. As we saw in the conversations, metaphors such as 'giving people space' are used within FM teams, reflecting the nature of their work and giving a common and shared language.

The unspoken message had really started before I met the FM Managers. It started when I carried out my desk research and made my initial contact with the Trust and the FM team[45]. My views will already have been conditioned by such interactions as the Trusts' websites, the standards and methods of communication from the Research Managers and the welcoming and interested response of the secretaries who helped set up the meetings.

The next set of unspoken messages was available to me when I arrived on site. Here I saw visible manifestations of the impact the FM Managers made on the Patient Environment. For example, one of the criteria in a PEAT assessment is around car parking. I visited sites during normal working hours and parked in public car parks with no prior arrangements being made. I had no difficulty parking, and found external signage and directions easy to follow. (It is quite expected in the NHS to arrive at a hospital for an appointment and struggle to find a car parking space; in fact FM people often arrange special car parking arrangements for their colleagues to ease difficulties for 'family members'). However, I noticed that car parking fees tended to be quite high – perhaps indicating that maintaining this level of quality comes at a price to the public and that the Trust was prepared to levy that charge. The Pride and Commitment theme was being reflected in the standards achieved on these sites, along with Integration with the Corporate Agenda and the Top Team. The FM Management Team had obviously acquired funding for car parking schemes and had the support of the Top Team to implement higher levels of charges. External Perspective was also in evidence in that services such as car parking are high profile and if poorly managed can soon bring adverse publicity to the Trust.

The Pride and Commitment theme was further reflected in the public areas of the hospitals I visited. I saw neat corridors, attractive entrances and appetising cafes. Internal signage was good and it was easy to find my way around once in the hospital. All these factors evidenced the reasoning for the high scores awarded by the PEAT assessments, but also demonstrated the high level of contribution by all members of the FM team, underlining the themes of Maximising the Contribution from FM Staff and Maximising the Contribution from the Contractor's Teams.

[45] See Chapter 4 for a discussion on how contact was made with the Research Group members

Upon meeting the FM Managers, I was struck by the similarity of their attitude towards my research. Nearly all the FM Managers were intrigued by my study and wanted to know more. They were also curious to know about the other Trusts in the Research Group and how they approached PEAT standards. In fact, on two or three occasions I had to decline an invitation to 'tell all' in order to ensure that an FM Manager was not tainted by the views of others, given to them before we talked. FM Managers were also keen to gain something from the time that they spent with me. Almost every one asked me to be sure to contact them with the outcome of the study, with one FM Manager asking me for a list of six things that s/he, as member of the FM Management Team, should focus on in order to ensure success. This attitude highlighted to me the conversational theme of Opportunity for Self Development.

The FM Managers told me that they had not known they were part of a group of Trusts with consistently high standard of Patient Environment until I had approached them to be part of my Research Group. They did not seem surprised by this, feeling it merely reflected their Trust's record of success, the hard work and commitment of their people and the support that they received from their Top Team. They were not surprised that there was no recognition around being part of this high performing group. Indeed, they did not want recognition; they thought they were simply 'doing their job.' The themes that I have subsequently identified within the analysis of the convesationsare evident here, particularly the themes of Pride and Commitment and Integration with the Corporate Agenda.

The idea of leadership was not new to the FM Managers, and they found no difficulty in talking about their attitudes and beliefs. Initially, they were slightly hesitant over what I expected and I feel that they would have been more comfortable with a structured interview and an end outcome. This structured approach fitted with the rather practical stance that the FM Managers took; evidenced though office décor (for example aerial photographs and site plans) and other non-verbal signs (clothing, computers etc). However, the FM Managers seemed to have single occupancy offices, therefore I think that a certain level of status and hierarchy was being evidenced, although it was low key. To me, this reflected their ability to Integrate with Clinical Teams and with Top Teams (by retaining some feeling of 'place' or status within the organisation), while showing an ability to Maximise the Contribution from FM Staff by being accessible and down to earth. It also gave me an indication of their Personal Style, essentially giving a feeling of 'being in touch' with the practical world of FM.

Once the FM Managers were in their stride, they were keen to put over their point. They demonstrated a strength of feeling over their behaviours and approaches and were keen to impress upon me the importance of these. They wanted me to realise the relationship between what they were saying and their success. This was particularly true when they talked of their approach to FM management and the theme of Personal Style. This strength of feeling again demonstrated the theme of Pride and Commitment.

The FM Managers' strength of feeling, energy and enthusiasm was almost tangible. It made the conversations feel rather exciting and challenging. When they talked of commitment to PEAT and belief in what they were doing, I believed them. It was easy to see why others would be motivated to join them in their quest for the perfect Patient Environment. They felt full of bounce and not worn down by the constant demands and changes of the NHS. Even when they talked of difficulties and accepted things as they were, they talked of how they might be able to change the situation for the better – there was no frustration or 'giving in' in their acceptance, merely a 'statement of where we are now'. It was not surprising to see a positive attitude to change coming through in the analysis of their spoken conversation, as they certainly evidenced levels of enthusiasm and preparedness for hard work. I felt that they would not rest until they had found the best way to solve a problem. These underlined the strength of the Pride and Commitment theme between the FM Managers and also showed how they could Maximise their Staff and Contractor's Contribution through motivation and positive thinking, and Integrate with Clinical and Top Teams through energy and enthusiasm.

Their energy and enthusiasm provided me with an interesting challenge as a Researcher, as did their practical approach to their work. Some of the FM Managers did not want to spend the time in their office or the meeting room, but wanted to show me examples of what they were talking about, so some of the conversations took place walking around the hospital for some or all of the time. This meant that tape recording or note taking was difficult and observation of the FM Managers was more of a challenge as well. These on foot conversations were speckled with greetings and conversations with other people. Some FM Managers were kind enough to take me to meet the next FM Manager and this meant additional on-foot conversations took place. One group discussion had been arranged to take place in the Staff Restaurant over lunch, which coincided with a busy lunch period. These incidents called on my

experience of working within FM and the skills I had learnt of plotting a journey in my memory as a means of reminding myself of the content of an on-foot meeting. However, it spoke volumes about their Pride and Commitment and Leadership Style, evidenced by the FM Managers efforts to see and be seen, their desire to be accessible and their will to bring about real and tangible benefits to the Patient Environment. Again, this behaviour underlined their ability to Maximise their Staff and Contractor's Contribution and Integrate with Clinical and Top Teams.

As I was 'handed over' from one FM Manager to another, I was able to observe two of the FM Managers having a brief conversation. There was evidence here of close working, with small pieces of business being discussed as the opportunity for conversation presented itself. One FM Manager checked with the other whether he had forgotten that a piece of mandatory training was being run that day, as he was just off to attend himself. It transpired that there were two sessions and they were attending different ones. The comment 'I wouldn't want you dropped in it' demonstrated care for a colleague. I particularly noticed the quiet, almost conversational approach that they took with one another – very informal, brief conversations about work, interlaced with personal chat. This quietness felt very calm and controlled, it gave me a feeling of confidence and focus. The theme of Personal Style was strong here.

The FM Managers were very enthusiastic about working within FM and saw themselves as FM professionals. However, this did not mean that they all had the same approach. As the conversations flowed, each of the FM Managers was free to take their own stance on leadership and its impact on the Patient Environment. Some FM Managers were very interested in the systems and tasks that needed to be addressed, whilst others were more focused on the people and the people issues. I believe that this underlines the idea that the FM Managers put forward, namely that there were a number of different Personal Styles, all of which were appropriate in context and with due regard to the personalities they are dealing with.

These reflections on the FM Managers and their Environments can only strengthen the case for the ten Themes highlighted by the analysis of the conversations. The observations show that the rhetoric rehearsed during the conversations could be found in the environment and in the actions and behaviours that were interwoven between

and around the conversations with the FM Managers, and thus serve to embed my findings in reality.

5.5 Conclusions

This chapter has offered a detailed analysis of the research undertaken, leaving the reader with a full picture of the FM Managers' conversations and my reflections on the FM Managers and their environments. The analysis highlighted ten themes that were evident across all twenty-two conversations and in my reflections of their environments. These were:

- Theme 1 - Pride and Commitment
- Theme 2 - Personal Style
- Theme 3 - Luck and Other Contributory Factors
- Theme 4 - Opportunity for Personal Development
- Theme 5 - Maximising The Contribution from FM Staff
- Theme 6 - Maximising The Contribution from the Contractor's Team
- Theme 7 - Stability, Experience and Change
- Theme 8 - Integration with Clinical Teams
- Theme 9 - Integration with the Corporate Agenda and the Top Team
- Theme 10 - External Perspective

In the following chapter, I reflect on this analysis, and offer my initial reflections. This chapter will also consider the limitations of the study and include information on the additional literature searches that I undertook in order to add further understanding to the conclusions I am forming.

The final chapter will move on to draw final conclusions by reflecting back though the previous chapters and building on my initial interpretative thoughts. I will also offer areas of interest for further research.

Chapter 6 Reflections, Limitations and Further Literature Search

6.1 Introduction

Figure 6 signposts the reader to the position that Chapter 6 Reflections, Limitations and Further Literature Search takes in the research route.

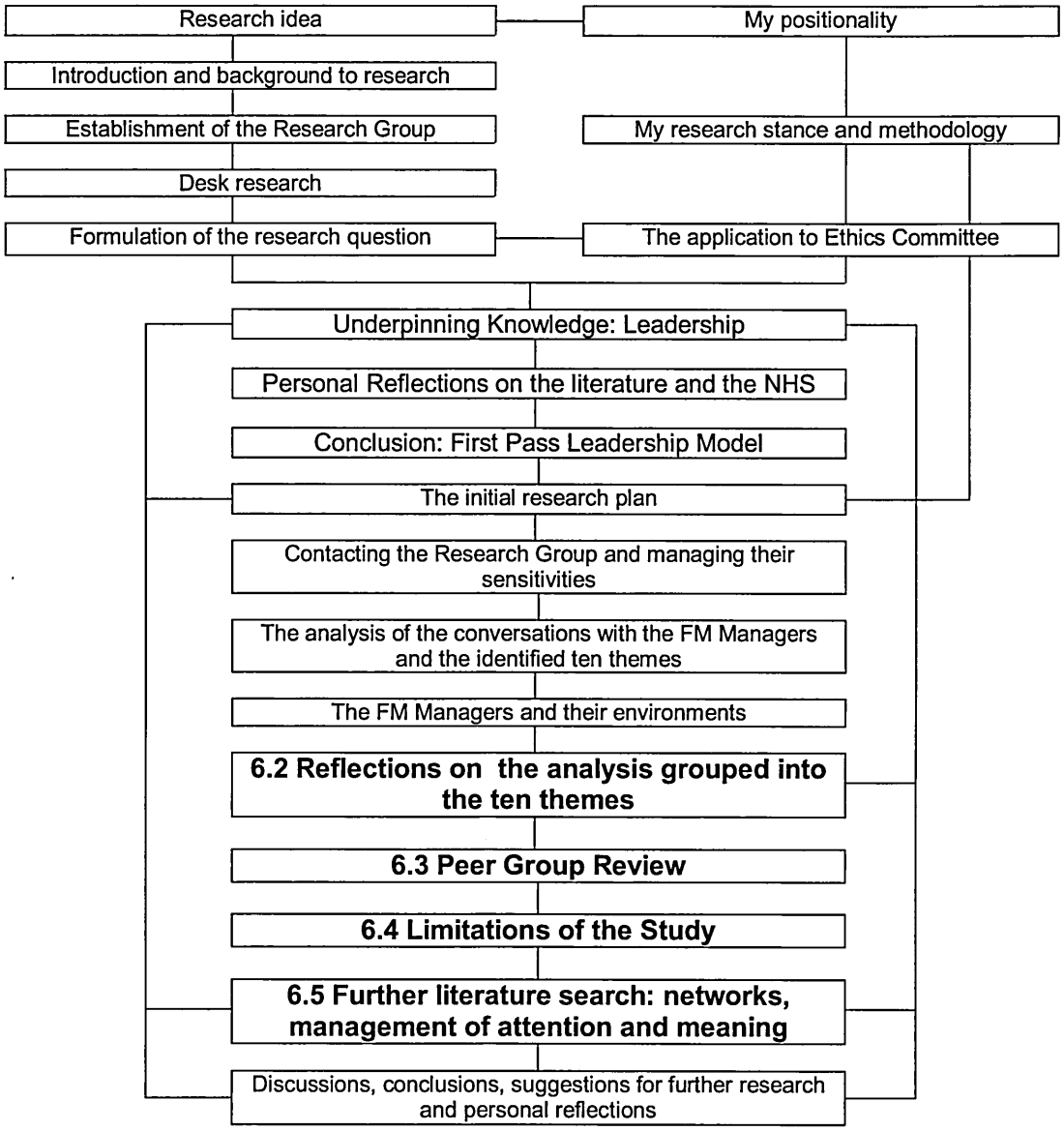


Figure 6 The Thesis set out in the Research Pathway

Chapter 5 Conversations with the FM Managers contains the details of the field research undertaken in this study, analysed into the categories and codes that reflect

the FM Managers conversations. The analysis allowed ten themes to be identified, these are shown at Figure 6.1. There is a wealth of information contained within the analysis and within my reflections of the FM Managers environments, and the following work lays out my first thoughts.

I include a synopsis of a review conversation with my Peer Group, during which the ten themes were discussed, and my peers raised issues worthy of further debate. I also looked at the limitations that constrained my study and their implications.

Given the unexpected nature of some of my findings, a further literature search is included in which I discuss the additional theory required to complete the picture before the final conclusions could be reached.

6.2 Reflections on the Analysis

The analysis of the conversations as laid out above indicates to me that the FM Managers were concerned with ten themes (see figure 6.1). There is also evidence in Section 5.4 Reflections on the FM Managers and their Environments that underpinned the rhetoric of their conversations; the behaviours of the FM Managers and the outcomes demonstrated at their hospitals reflected the ten themes. With this in mind I make the following reflections on the ten themes.

No	Theme
1	Pride and commitment
2	Personal style
3	Luck and other contributory factors
4	Opportunity for personal development
5	Maximising the contribution from the FM Teams
6	Maximising the contribution from the Contractor's Team
7	Stability, experience and change
8	Integration with clinical teams
9	Integration with the corporate agenda and the Top Team
10	External perspective

Figure 6.1 The ten themes

The themes are presented as ten entities each having distinct characteristics, it should be kept in mind that these themes are not separate or isolated but work closely together in mutual support, each adding strength to the others as they contribute to the FM Managers' overall approach. For example, pride and commitment is listed as theme one, but pride and commitment was reflected in the Personal Style of the FM Managers, theme 2, as they talked about their work. This in turn led the FM Manager to feel lucky (or think positively), theme 3; this gave the FM Manager the ability to find

ways to solve problems, theme 7, and thus improve integration with other teams, themes 8 and 9.

Theme 1 Pride and Commitment

The FM Managers demonstrated pride in their organisation and in their teams, rather than pride in themselves and their attainments; they were rather humble individuals who were modest and self-deprecating. Interestingly they were not the individuals on the national circuit talking about their success and their attainments; they were surprised by their place in the group of Trusts who delivered consistently high standards of Patient Environment, and were keen to retain their anonymity. Their surroundings spoke of an absence of self-aggrandisement, and a need to be accessible, with offices being small, often situated in out of the way places and mostly within the operational centre of the FM organisation.

The pride that the FM Managers showed in their organisations and their teams was an understanding pride; it allowed the people within the organisation to be who they were, to see life through their own lens. The FM Managers acknowledged how much an individual had to contribute (whether that be formal skills or life experience) and respected them for this contribution. They also recognised the difficulties they faced in helping each of their teams to maximise their contribution to the good of the organisation. Their pride was tempered with an allowance that they and others would make mistakes and, if these mistakes were freely admitted, this was allowable and correctable. However, they were not shy of addressing problems and saw the need to resolve issues rather than tolerate and live with them. This was evidence that FM Managers were committed to excellence, and to offering the best possible services. They were prepared to put in extra effort (more than they expected others to) and they were prepared to face unpleasant decisions and tasks. They felt obliged to deal with difficult decisions in order to move services forward. They also faced up to situations that they could not improve, recognised their sphere of influence and worked to find the best solution within the constraints. This ability to deal with difficult situations would enhance the FM Managers' opportunities to maximise the contribution from FM staff and contractors as it would symbolise the FM Managers' ability to lead and demonstrate their support to the standards and behaviours they required from their teams.

I saw publicity from, and visited, each of the Trusts in the Research Group where I observed organisations in which the language of excellence was spoken and pride in one's organisation was the norm or expectation. This organisational stance may assist the FM Managers to maintain their own feelings of pride as the analysis showed that it was important to them that they worked in organisations of which they could be proud; once within such an organisation they would proactively seek reasons for pride. They may choose to leave an organisation rather than be part of a failing organisation, or one where they felt they did not fit. I see a link between pride and commitment, in that pride enhanced the commitment of the FM Manager; a sense of failure was linked to a dwindling of commitment to the organisation and thoughts of leaving. This evidence shows that the FM Managers had a desire to win and to be part of a winning team; this desire to win and a focus on winning was identified by Bennis and Nannus (1985) when they spoke of the 'Wallenda factor' in leaders.

The FM Managers used their pride in their organisations and teams to maintain their own commitment to their organisation and their desire for high standards. They approached their work with energy and enthusiasm and expressed a real desire to improve things, being rather self critical in nature. PEAT standards were spoken of as an ideal way to get FM topics (for example the Patient Environment) onto the Corporate Agenda, and the FM Managers were committed to making these conversations happen, then to grasping the opportunities when presented and making the necessary changes to service.

Theme 2 Personal Style

The FM Managers defined leaders as those who took responsibility, could win hearts and minds, and create teams both within FM and across the Trust. They spoke of their personal style, and the ability to change their style to fit individuals and circumstances. They spoke of the need to be able to manage conversations by communicating well and selling ideas and vision to a variety of people at different levels in the organisation. They also recognised that some of these conversations and situations could be difficult, but that they had to be managed, preferably without damaging relationships. This evidenced their understanding of motivational factors and the differing ontology and levels of understanding of the range of people they needed to include in their teams. The FM Managers evidenced their willingness to change their own approach to accommodate others' needs and thus ensure their success in winning hearts and minds.

To ensure that FM teams remained motivated and committed the FM Managers adopted Management By Walking About techniques (Peters and Waterman 2004). They created situations whereby they could be accessible, visible and seen to be leading by example. They wanted to be seen as fair, honest and open. They liked to know what was going on, and to be seen to be enquiring. This underpinned their conversations discussed in Theme 5 Maximising Contribution from the FM Teams, which related to staff motivation and feelings of being valued.

The FM Managers observed the need to be business focussed and to ensure their teams performed well, but they recognised that work levels were high and therefore the route to high performance was through everyone in the team contributing at a high level. They felt this meant they needed to establish clarity about their role and that of others. They needed to create space and opportunity for their teams by delegating work, whilst maintaining a supportive and advisory role. They were prepared to relinquish formal control in order to achieve their goals, but only if this would result in an improvement in standards. This evidenced the ability to delegate to others, whilst retaining overall control. It also shows that the FM Managers saw no need to protect the size of their teams or their budgets if they could produce better results by giving these to others to manage. However, they were clear that the responsibility to deliver the Patient Environment remained with them, and were happy to achieve this through integrated working as well as direct line control. This does not reflect the traditional hierarchical structures of the NHS, but moves away to more of a teamwork (Bennis and Powell 2000) or network approach[46].

Theme 3 Luck and other contributory factors

The FM Managers thought of themselves as lucky, as having the ability to find solutions to dilemmas and difficult problems and as having the freedom to innovate. They employed the power of positive thinking. It is likely that the freedom that the FM Managers say they enjoy would be awarded by the organisation, due to the successful track record that they have established. The ability to find solutions to problems could be seen as an interactive self-rewarding process, a virtuous circle; the freedom awarded after a successful solution creates greater freedom for the individual to act on their own initiative, which in turn aids the solution to problems, gains more success,

[46] This is discussed in greater depth in Chapter 7

more freedom and so on. One benefit of this upward spiral would be an increase in the individual's positive thinking and thus a greater belief in the luck of their position. The FM Managers used their positive thinking to find ways around difficult situations thus ensuring that the agenda did not stumble because of obstacles that could not be surmounted. We see hints of the theories of mood and emotional control (Stodgill 1948) and emotional intelligence (Golman 1996, Digman 1990, Goldberg 1993, Hogan and Hogan 1992, McCrae and De Costa 1987, Passini and Norman 1966).

The FM Managers seemed to think there were reasons for their success that were outside their control. They spoke of the estate they managed, its situation, geography or condition. For example, they claimed that the size of the organisation could put them in a good starting place. The desk based research[47] carried out as part of this study dismisses this idea as it shows that the external influences and Trust characteristics are not creating a pattern of advantages that would assist the FM Managers within the Research Group in delivering high standards of Patient Environment. Again we are seeing the use of positive thinking to control mood and emotion, and thus an increased belief by the FM Manager that they find themselves in a position that allows them to achieve.

Theme 4 Opportunity for personal development

The FM Managers saw the need for personal development for all staff within FM, whether management or shop floor, NHS or contract staff.

When talking of their own personal development their main areas of interest seemed to be in growing the depth and breadth of their experience. They were keen to use managers as mentors and coaches and to tap into and build networks, thus keeping up to date. The FM Managers reported that they felt encouraged to learn and develop their skills, and some were enthusiastic to do this. One or two reported that they had undertaken some recent academic study. However, the FM Managers appeared to focus their learning efforts on improving their methodologies, while their personal development seemed to derive from opportunities to widen their portfolio, rather than through being groomed by others as part of a succession plan. The FM Managers had moved on from training and were talking the language of learning (Price and Akhlagi

[47] See Chapter 2

1999); training courses were not felt to be the medium that would offer most benefit, whereas coaching, mentoring and networking could prove to be more beneficial.

The FM Managers saw learning for staff as key to helping them deliver to the standards required, with emphasis being placed on mandatory, NVQ and other such skill training. They recognised that there were tensions between needing staff on duty and releasing them to undertake learning. The new national job grading system, Agenda for Change, was seen as a useful vehicle to encourage staff to train and progress in their jobs and indeed to gain promotion, perhaps into clinical teams. The FM Managers recognised the risk of losing staff as they became more qualified, but were prepared to take this risk in order to allow their people to develop. Appraisal systems were seen as another tool through which personal development could be discussed. One FM Team had developed a unique team assessment process in order to ensure maximum contribution to self-development and the business agenda across their teams.

Despite this emphasis on personal development, career development within FM was not such a strong theme within the conversations. While the FM Managers saw learning as a help in delivering to the standards required and as a basis for their staff to become better qualified or educated, the more important reason for having a strong focus on learning was to help the staff members feel valued, and thus become more motivated to contribute their best. When this commitment to learning is viewed in tandem with the FM Managers commitment to improvement and to increasing staff morale (Themes 5 and 6 Maximising Contribution), we begin to see evidence of the Learning Organisation (Tran 1998).

Themes 5 and 6 Maximising the Contribution from the FM Team and the Contractor's Team

The FM Managers acknowledged that staff made up a large part of the FM resource and as such they were seen as key in delivering the services at the standards required. FM Managers were keen to see all FM staff valued in the same way, whoever employed them. They did not want to see a difference between directly employed and contractor's staff. Where contractors were used they were likely to be well known, selected for quality as well as price and encouraged to become an integral part of the FM team. This was either approached formally (for example, the partnering arrangement at Lawson) or by recognition by the Trust (for example, contractor in attendance at Trust Board at Oliver), or by simply working well together. In order to

share the integrated thinking of the FM Managers, I have integrated my reflections for these two themes (Theme 5 Maximising the contribution from the FM Teams and Theme 6 Maximising the contribution from the Contractor's Team) and my comments below apply equally to in-house and contracted-out services.

The FM Managers' conversations recognised that they needed others to be engaged and involved in their agenda in order to achieve the business aims. They showed that they were prepared and able to enter relationships in order to make this happen, and that they approached those relationships from a point of respect for others and the skills that they brought with them. This was evidenced in a variety of ways, not least in their transactions with their staff. They also had pride in their staff and ensured that they were adequately represented with others. The FM Managers thought of themselves as articulate and able to communicate and persuade staff of a vision. They also recognised the need to be open to challenge and debate and they wanted to hear the point of view of their staff and of those to whom they provided services.

The FM Managers believed that their staff were largely committed to the organisation and wanted to deliver a good service, although some teams were more challenging than others. They wanted to understand their staff as people and treat them well as they believed that this would help their staff feel motivated and valued, and thus deliver their best. When speaking of how they wanted their staff to be treated, FM Managers wanted staff to be:

- Given feedback, praise and recognition, both formally and informally;
- Included in decision making;
- Given responsibility and ownership for delivering their services by allocating them to work within clinical teams;
- Assisted to relate to the corporate agenda and other corporate initiatives;
- Assisted in introducing new interest into their jobs;
- Given opportunities for training and development.

As previously mentioned, where contracted out services were used the FM Managers saw Contractor's staff as their own, and wanted them to have all the same advantages and opportunities.

The FM Managers also spent time and effort on encouraging changes in management and supervisory behaviour to create integration with their own leadership style, as they felt this could be an area which could let their endeavours down. To help negate this

problem they made every effort to recruit people with customer focussed and team working attitudes and personalities as well as technical skills. This echoes the thoughts of a Cabinet Office workshop where the recruitment of staff who were people-orientated was seen to be best practice when building a customer focus culture (The Whitehall and Industry Group 2001). They had moved away from the traditional idea that people should be recruited for their fit with the package of work that has been designed and described as jobs (Price and Akhlagi 1999). The FM Managers were keen to encourage their staff to work together in teams, particularly with clinical staff at ward level and they would meet regularly with staff to discuss the agenda, including PEAT, and allow questions to be raised. They also wanted teams to work towards sorting out their own problems before turning to managers.

Although the FM Managers were intent on gaining the best from their teams through valuing them and including them in decision making, they recognised the need to deliver the business objectives. In order to ensure this happened systems were in place to monitor performance against standards and enable teams to understand how they (and other teams) were performing. Resolving poor performance was seen as an essential element of the performance system. The literature search contained in Chapter 3 Underpinning Knowledge highlighted a debate around the difference between leader and manager and whether one role replaced the other (Bennis 1992, Adair 2003, Potok 1972, Alimo-Metcalfe and Alban-Metcalfe 2004). Within that chapter, I acknowledged I saw a place for leadership in the NHS whilst it could only be one element in a manager's contribution to the NHS reforms if it were not to become a management fad (Hewison and Griffiths 2004). This interest in performance systems demonstrates the FM Managers continuing interest in a role that is seen as a manager's role rather than a leader's role (Bennis 1992) by those that support the leader versus manager role. I believe the interest shown by the FM Managers in performance systems, and their powerful use of the information falling out of those systems (see Theme 8 Integration with Clinical Teams and Theme 9 Integration with the Corporate Agenda), evidenced the need for leaders to manage and managers to lead (Fritchie 1997).

Theme 7 Stability, experience and change

Most of the FM Managers recounted organisation-wide changes that had occurred within their Trusts and impacted on them and/or their teams, changing the culture of the organisation. These conversations, stories in the memory of the organisation that

are part of the cultural web (Johnson and Scholes 1995), were offered as an explanation of how the Trusts came to be where they were today. Thus the FM Managers demonstrated how they used organisational legends to depict the need for the changes that had happened and help me, as the listener, understand the behaviours that were needed to support the new culture. In the hands of these FM Managers, history became the new rhetoric, rather than an underpinning of the old culture.

The FM Managers spoke of the need for stability and the need to retain experience, especially within the top teams. Experience was seen to underpin results, although length of service, largely seen as positive, concerned the FM Managers in areas where big changes were needed within a very stable work force. Newer members valued the experience within the FM Management Team and felt they could learn from it.

Not surprisingly, given the timing of the research, Foundation Trust status was discussed as the next change agenda, along with Patient Choice to a lesser extent. The move to Foundation status was largely seen as a positive opportunity that would allow the Trust to grow, but there were differing views around the benefits and some FM Managers were cautious in their expectations. Foundation Trusts brought financial issues to the fore, and the FM Managers were concerned about the impact that any future financial pressures might have on their ability to deliver to standard, given the experiences of the past. The discussion within Theme 10 External Perspective in the paragraph below provides further evidence of the FM Managers' cautious approach to the national agenda and their desire to protect their organisation from any non-beneficial impact.

The FM Managers viewed the management of change as a key part of their role, with many of them saying this part of their role brought satisfaction. They explored the relationship between change and benefit and the differing needs of the individuals who found themselves caught up in the change initiatives. One FM Manager spoke of how the culture of their organisation had been adapted by the Top Team to allow change to happen freely, giving further evidence of the emotion and mood control discussed in Theme 1 Pride and Commitment. As discussed earlier, I do not support the view that leadership skills should replace management skills; however, I do support Potok's (1972) argument that leaders are motivated to change the system and in order to do so free themselves from the norms of the group. The FM Managers' conversations

evidenced their ability to abandon the norms of FM and their motivation to change the system. This was demonstrated by the FM Manager from Harriott who said to me

'The NHS is packed with 'we've always done it this way'.'

Other FM Managers who spoke positively of the opportunities for change within their Trust further evidence this behaviour.

Theme 8 Integration with Clinical Teams

Recognising that FM was a service that supported clinical delivery, the FM Managers saw themselves and their people as part of the hospital team. They were keen to ensure that their teams were integrated within the clinical teams, particularly at ward level. This desired integration was furthered by the FM Manager working closely with others outwith the FM organisation, for example, Modern Matrons. There is no formal line management relationship between a FM Manager within FM and a Modern Matron, but the FM Managers saw an opportunity to engage the Modern Matrons in their vision and were prepared to invest time and effort into building the relationship. The FM Managers not only evidenced a desire to work within and to create processes and/or structures where none existed, but also an ability to create these processes and/or structures that inspired ownership in their staff, thus earning staff a place within the ward or clinical team. They evidenced personal credibility that generated respect and allowed a robust relationship with open dialogue among clinical team members. The FM Managers talked of needing to have skills that enabled good relationships to be built and maintained with all types of people at all levels in the organisation, whilst moving services forward and addressing difficult issues. These relationships needed to be strong enough to ensure that FM was not isolated or side lined by the other (possibly perceived as higher) priorities on the clinical and corporate agendas. These discussions further demonstrated that the FM Managers were emotionally intelligent individuals who were developing relationships and networks and exhibiting corporate behaviours that build increased trust, rapport, and co-operation (Clark et al 1960), improving integration with Clinical Teams. Underpinning these behaviours were the methodologies that the FM Managers employed to build integration, these included allowing wards to have control over what happens on a day to day basis, asking for input from clinical staff over improving the value of the services and promoting ownership. They were happy to address issues jointly and non-defensively with clinical and other staff. The traditional clinical and non clinical boundaries were crossed by the FM Managers when looking at how nursing and FM responsibilities could best interact together, for example, involving nursing staff and specialist clinical staff in the PEAT

initiative, and by giving assistance to achieve tasks that were traditionally seen as nursing responsibilities. They also understood it would further the FM agenda if Top Team commitment was evidenced to others, for example, the inclusion of Top Team members in inspection teams and other such visible activities. On the topic of visibility, FM Managers ensured their own visible involvement and commitment to others' agendas, gaining reciprocal support and buy in for their own agendas.

The FM Managers recognised that visibility and commitment needed underpinning with formal systems and feedback mechanisms that worked both laterally across the organisation and vertically from top to bottom of the organisation. They spoke of the mechanisms for reporting that they used to achieve this (at several Trusts I was given copies of paperwork to bring away, that I have since used in my workplace). I have spoken in Themes 5 and 6 Maximising Contribution of the perception that it is a manager, and not a leader, that focuses on systems and structures and has an eye on the bottom line (Bennis 1992). The analysis of the conversations with the FM Managers shows that they are concerned with systems and structure and their eye is firmly fixed on performance (NHS language for the bottom line). Shohet and Lavy (2004) report FM performance measurement to be one of the most essential issues in the effective implementation of a facilities strategy and that issues important to organisational success can be determined from the information drawn from these measures. The information on performance that the system provides gives the FM Managers the ability to manage attention (Bennis and Nannus 1985) and to get others to listen to their intentions and focus on their agenda and visions. For example, a joint solution to the problem that a ward's equipment is not meeting cleanliness standards can be facilitated by showing the ward manager information from the ward cleaning performance measurement system. If the FM Manager was seen to put importance on the results from these performance outcomes, for example, if they were reported to the Trust Board as part of the PEAT update, then the cleanliness standards will catch the attention of others (Loughran 1992). This is then further enhanced by importance being attached to the information by members of the Top Team represented at the Trust Board, or by the results being set as organisational objectives by the Chief Executive.

In addition, the FM Managers were prepared to put considerable effort into seeking integration, without expecting similar efforts from clinical colleagues. They did this by maintaining momentum when others were less engaged, achieving the integration, with appropriate conditions attached rather than at any price, that would maintain standards,

by finding other agendas that aligned with PEAT, and by identifying vehicles they could use to bring about improvements.

Theme 9 Integration with the Corporate Agenda and the Top Team

Many of the behaviours and actions of the FM Managers in ensuring integration with the Corporate Agenda and the Top Team are the same as those that ensured integration with the Clinical Teams. There is clear evidence that the FM Managers understood that there was a need to approach the two (often entwined, but sometimes separate) agendas differently. This difference was often in the language employed when presenting the FM agenda rather than in the content of the agenda; for example, the FM Managers had embraced the importance of the relationship between the star ratings and the PEAT inspections, and were prepared to ensure that this was reflected in a way that would be understood and acted upon by the Top Team. By translating the importance of PEAT into the corporate language of outputs and results (bottom line) they had ensured its place on the Corporate Agenda. Again, we see evidence of the FM Managers managing attention (Bennis and Nannus 1985). The benefits of PEAT being on the Corporate Agenda were described by the FM Managers; several reported that their Chief Executive knew all about PEAT and overtly supported the initiative, giving it credibility and standing within the Organisation. They spoke of receiving investment and support with difficult situations. The FM Managers were quietly confident of the direction of their services and that of the Trust and how they and their services fitted within the Corporate Agenda. This gave a feeling of focus and stability to FM just when it could be experiencing a buffeting by the speedily changing NHS agenda brought about by the national financial difficulties and the changes in Government Policy of which the FM Managers had spoken.

Integration with the Top Team is not achieved by the FM Manager lodging a paper with the Trust Board, decision taken, direction set; nor is it managed through management structures, but in a more far reaching and sophisticated way. The FM Managers achieved this by gaining the respect of their Top Team for the contribution of the FM team through recognition by the Top Team in realising the organisation's aims[48]. The analysis shows that this involves the building and maintaining of relationships. This relationship building with the Top Team members appeared to take two forms. The first

[48] For example, at the time of the research, a certain level of PEAT score was mandatory to the award of three stars, and thus the gaining of Foundation Trust status. If an FM Manager could ensure the PEAT score he/she would be seen to help deliver the organisational aim.

was an understanding by the FM Manager of how to organise their work to ensure that good links and relationships were built and sustained with the Top Team. This was achieved by transmitting the benefits of the FM agenda and by consistently reporting on achievement. The FM Manager would then sustain the relationship by offering service developments that would increase standards. The second form was evidenced in the understanding the FM Managers displayed as to who could influence the FM and the Corporate agendas. Once this understanding of the power base had been formed the FM Manager ensured that strong links were made and maintained. This relationship building was not undertaken in a cynical or self-interested way, but for the good of the services and the organisation.

In order to strengthen the integration between the FM and Corporate Agendas and with the Top Team, the FM Managers ensured that FM objectives were shared by other members of the Top Team, possibly by allocation through the Chief Executive, but not necessarily so, and offering a reciprocal arrangement over others' objectives. They found other agendas that aligned with theirs and used these agendas to bring about improvements in a way that benefited both their own and others agendas. They also ensured that they were linked with other groups with similar agendas. The FM Managers were also aware that their agendas competed with other agendas, perhaps clinical. To ensure financial investment and support from the Top Team, they needed to ensure business cases and funding bids were integrated with the Corporate Agenda and were strong, robust and able to compete with clinical requirements.

Giving respect and understanding to all, including the Top Team, was important to the FM Managers. The FM Managers were also concerned with the culture within their area and were interested in ensuring that there was a match between the FM culture and the favoured Trust culture. This is evidence of their understanding of the need for cultural fit and for the FM team to work within the organisational context. The literature regarding FM Managers working within organisational context does not abound, although a reference can be found to the necessity for FM to engage with the human dynamics of the organisation they support and enable (Price 2004), and there is perceived to be an inescapable relationship between leadership success and the organisation's culture (Alimo-Metcalfe and Alban-Metcalfe 2003).

Theme 10 External Perspective

When considering matters external to their Trust, most of the FM Managers were mainly interested in their local Communities. Some used the Regional and National networks such as HEFMA, but largely they were not interested in leading the national agenda, becoming involved in a practical way only when it impacted on their Trust and its services.

When speaking of their community, the FM Managers expressed the need for the community to have pride and confidence in their local hospital and how the FM Managers could ensure this by not taking/allowing actions that could damage that pride and confidence. They wanted to ensure that the community was on board with the Trust's activities and direction and spoke of attending community meetings such as the Scrutiny Committee. The FM Managers wanted to contribute to the external environment, for example by recruiting staff from the community, even if it meant they had to find new ways of engaging with different community styles. They also wanted to draw from it by tapping into the community for ideas and validation, for example, public involvement in PEAT. This evidenced the FM Managers' understanding of the how to win stakeholder support for their organisation and its activities. By using their community for ideas and validation they were insuring against organisational isolation whilst securing a local interpretation that would fit their communities needs and expectations. This strategy would also allow the FM Managers to claim that they are playing their part in the delivery of the Performance Improvement Framework for Public and Patient Involvement in the NHS (Department of Health 2003) and underline the FM contribution to the Corporate agenda.

The external perspective of the FM Managers was more an interest in the local community, rather than an interest in the national arena of the NHS. Indeed, FM Managers may have been interested in staying away from the national scene, in the same way as they were keen to ensure that they could not be identified in this research and took a cautious approach to new national rhetoric as evidenced in Theme 7 Stability, Experience and Change. This may be to protect their achievements from the glare of publicity, or to avoid the dilution of effort experienced when a manager invests time in the national agenda. Their lack of interest in participating in the national arena echoes the evidence in Theme 1 Pride and Commitment when I spoke of the FM Managers being rather humble individuals who were modest and self-deprecating. However, their lack of interest in the national arena does not mean that they are not

interested in contributing to and delivering the targets set by the Government and Department of Health.

When listening to the FM Managers talk of the local community's relationship with the hospital, I did wonder if the pride they felt in their organisation could allow them to over-estimate the pride felt by the Community and therefore miss the impact of such initiatives as Patient Choice. It will be interesting to see what unfolds as time evidences the impact of such changes in Government policy.

I consider that the Reflections are leading to the proposition that the FM Managers are evidencing the skills and attributes of leadership as laid out in Chapter 3 Underpinning Knowledge. Before reaching such a conclusion all aspects of the debate must be given consideration. I now step back from my Reflections on the analysis to look at the other influences on my thinking, and to enable a discussion of the broader picture (see Section 6.6 Discussions).

6.3 Peer Group Review

In October of 2006, I attended the NHS Estates Development Centre[49] as an observer. Some eight Senior Managers and Directors formed the team of observers and we worked together, as we have done in the past, to observe and give feedback to eight would-be Directors of FM. I took the opportunity to raise initial findings of my research with them and we discussed the themes that had surfaced. Whilst the group were broadly accepting of the findings and felt the themes to be pertinent to a leader within the NHS, they questioned if the FM Managers were working in organisations where their style was accepted and allowed, or indeed encouraged or even demanded. The Peer Group identified several cultural characteristics of the organisations that they believed would facilitate the FM Managers' success, but they did not recognise them as fitting their own paradigm of the NHS. These ideal organisational characteristics included: the expectation that a manager would be innovative and implement change, with the support of the organisation as the manager faced up to the inevitable challenges; pride in being an achieving organisation and a desire to be seen within the group of top performing Trusts; an acceptance that calculated risks and occasional failure characterise an organisation making change and that this can be managed; an

[49] See Chapter 3 for information on the NHS Development Centre

acceptance of individuals working outside hierarchies and a preparedness to relax control to allow this to happen. There are strong connotations of the Wallenda factor (Bennis and Nannus 1985) in the Peer Group's observations relating to their ideal organisational characteristics.

This led me back to look again at the conversations to see if these ideals had been reflected. I found some evidence of the ideals in that FM Managers talked about being required to make changes and be innovative, there being pride in being an achieving organisation, being given support and working within an organisation that would take managed risks (see Figure 6.2).

The expectation that a manager would be innovative and implement change *'I'm expected to be innovative. We've introduced new procedures and new ways of working.'* (Oliver) *'There is a corporate expectation that Facilities will achieve.'* (Harriott) *'They've set up a culture that allows change'* (Harriott) *'We have a culture that is results orientated, so the clinical director is interested in achieving results'* (Harriott)	Pride in being an achieving organisation and seen within the group of top performing Trusts *'We are seen as a successful Trust. Staff know they work for a successful Trust, 3 star, no job cuts and not financially hard up. They listen to the news and deep down this is important to them'* *'PEAT is important because of the star ratings'* and *'We had a great desire to be a Foundation Trust and to do that we needed the stars'* (Harriott) *'There is a lot of pride around here'* (Smith) *'We became a three star trust and have maintained that ever since'* (Oliver) *'The Executive are interested in PEAT because it affects the star ratings' (Rhodes)* *'It is generally recognised that [this] is a good hospital, people know we are an FT three star hospital and do well'* (Smith)
Support of the organisation as the manager faced up to the inevitable challenges *'I am integrated with the Exec Directors - I have a relationship with the HR Director, we worked very closely when the TUPE arrangements were taking place. They were very supportive. Now the A4C issues are bubbling away', 'My boss is super, he gives me freedom to do things my way, he supports me and lets me run with an idea', 'I get on well with my boss, he doesn't interfere. He drives the strategic direction. He is really passionate about certain things. He supports us really well and is highly regarded by the organisaton'* and *'My boss meets with me on a monthly basis and is always supportive, he is amazed if people don't behave honourably'* (Oliver) *'We get lots of support when we need it'* (Smith)	An acceptance that calculated risks and occasional failure characterise an organisation making change and that this can be managed *'You have to take risks. Weigh up the likelihood against the risk', 'I can't imagine that any FM team doesn't take risk. Resource is insufficient so you are either ignorant or taking sensible informed risk'* and *'The Trust has a no blame culture, that has changed now to fair blame, but no point putting a label on a department if things don't go to plan. Maybe they have restrictions or have to balance resources' (Smith)* *'I believe in taking risks and I used to think that I knew best and kept the risks to myself. Now I weight the risks and put forward a proposal so that the risk taking is shared', 'Managed risk is OK',* although *'FT financial liabilities make us risk adverse. We look more carefully at things. There is no bail out from the £20M deficit, the staff won't get paid'* (Harriott)

Figure 6.2 Evidence of the ideal organisational context as highlighted by my Peer Group

The idea that certain organisational contexts were supporting certain behaviours underlines the idea laid out in Section 3 Underpinning Knowledge, that leaders have the potential energy to behave in a variety of ways. The choice over the way the leader works is determined, among other things, by the characteristics of the environment in

which they find themselves and the individual's theory-in-use (Altman and Hodgetts 1979 Argyris 1990). It also emphasises the thoughts discussed in Theme 9 Integration with the Corporate Agenda and the Top Team where I discuss the need for leaders to work within of the context in which they find themselves (Edwards and Gill 1993) through achieving a cultural fit and seeking integration with other teams.

There appears to be a growing body of evidence that a manager may have the characteristics and abilities of a leader, but if these are not supported by the organisational context they may find themselves at odds with the organisation. There is also a question over whether the Peer Group conversation itself is a self-referential conversation about the impossibility of doing something differently. It could be a social defence, making the case to continue to do things in the same way, whereas the FM Managers may have the leadership qualities that allowed them to go out and create their own legitimacy and converse their own futures into existence. These thoughts are discussed further in Chapter 7 Conclusions and Further Research, Section 7.3 Further Research.

6.4 Limitations

In any research project there are limitations that inevitably impact on the research or the researcher, and in this section I lay out the main limitations of my study. Some of the limitations caused me to approach my study in a different manner, with some having a positive impact on the research. Other limitations arose because certain approaches were impractical or too difficult to achieve. Whilst discussing limitations may feel negative, this study and my quest for the DBA has been a very positive experience for me, and I cover these positive thoughts in Chapter 7 Conclusions and Further Research.

6.4.1 The Reality of the Organisational Context

Within Chapter 2 Desk Based Study, I looked at the Trust characteristics and the external influences that could provide the FM Management Teams within the Research Group with an advantage when delivering consistently high standards of Patient Environment. The desk research showed little similarity between the Trusts; therefore no advantage existed for these FM Management Teams. In the absence of any advantage, the FM Managers and their Environment became the focal point of my study.

However, whilst there is evidence that the FM Managers affected the performance and thus the productivity of their teams, one of the limitations of this study is that it does not look at the reality of the organisational context. The study is only able to portray the view of the context, including the relationship of the FM Managers with the Top Teams and with the Clinical Teams, as recounted by the FM Managers. Thus the examination of the context and the relationships remains incomplete. FM Managers talk of a Top Team that is interested and committed to high standards of Patient Environment; a limitation of this study is that we do not understand the Top Teams' motivations, beyond that the FM Manager works hard to ensure their continuing interest.

Whilst the ability to demonstrate the organisational context would have provided a fuller and perhaps more complete picture, the complexity of such an extended study meant that was not possible. Furthermore, the sensitivity of the topic would have made access to the Trust and the Top Team difficult, with no guarantee of open and honest dialogue.

6.4.2 Looking at successful Trusts only

The research finds no indication of externalities that would give an advantage to the successful FM Managers, and finds commonalties between the behaviours and actions of these people. It does not show that these are unique to this group, but enables that question of uniqueness to be asked should it be appropriate to do so.

Several times during the early stages of the research I was challenged (by peers and by the Ethics Committee) as to why I did not look at failing, average and successful Trusts, rather than only researching those who consistently delivered high standards. This could be seen as a limitation of this study, although I do not believe this to be so and take this opportunity to set out my reasons below.

Whilst I appreciate that the more traditional approach of making comparisons between failing, average and successful Trusts would have offered its own benefits, the NHS must move away from its traditional stance of searching for a simple prescriptive solution to its problems, that is 'if you stopped doing x and started doing y everything would work'. The NHS is one of the largest complex adaptive systems in Europe; complex adaptive systems arise from the inter-relationship between their members for example, firms in an economy or people and teams in an organisation. The order

emerges out of the web if interactions are understood (Price and Akhlaghi 1999). Because of the complexity and size of the system called the NHS, solutions that are simplistic and naïve will not work in the long term. As I said in Chapter 3, I am fearful for an NHS that looks for the magic solution, the pill for an instant cure. The NHS needs to look towards success and minimise its focus on failure. I do not decry the need for appropriate investigation following adverse incidents; however, time and energy would be better spent looking at the reasons for success and how these ideas can be incorporated into less successful Trusts, rather than spending that time and energy on identifying the reasons for failure. With this in mind, this study focused on best practice.

As I explained in Chapter 4 Research Methodology, the study has been carried out across England and offers research on a variety of Trusts, so cannot be claimed to be atypical. I offer this study as an opening conversation for any FM manager who wishes to understand the discourse of FM Managers who consistently deliver high standards of Patient Environment.

6.4.3 PEAT Scores

A potential limitation of this study may be the use of the PEAT initiative as a criterion for high standards of Patient Environment. Although these are pre-determined criteria and scores, agreed between the Department and Health and the NHS, would these criteria be seen as important by the patients and the public who visit Patient Environments, or is the NHS delivering its own version of the Patient Environment?

In order to make this study feasible, it was not practical to research the public's view on the criteria associated to the PEAT initiative. The sheer logistics of carrying out such research made the idea impractical for a single researcher, and secondly the standards used to identify the high performing Trusts had to be acceptable to all FM managers within the NHS. This meant any move away from national standards would have to be agreed with this group and again, logistically, this would not have been practical for this study.

My experience brings me confidence that the measures used by PEAT are realistic enough to bring a robust set of criteria to the study. Family and friends who stay in hospital talk of the good clinical care and the lack of cleanliness and maintenance of the ward. Patient complaints in the Trusts where I have worked often reflect the same

view. I was also encouraged by the visible excellence of the hospitals that I visited during my study. I was able to see why high PEAT scores had been awarded.

So, whilst I acknowledge the potential limitations of using the PEAT initiative, I feel that their use was a sensible and pragmatic approach to finding an objective methodology to use when identifying which Trusts should make up the Research Group.

6.4.4 Ethics Committee

The Ethics Committee proved to be a limitation on my study because of the amount of time and effort that was required to gain the favourable ethics opinion, and the positivistic stance taken. The cautious and traditional stance taken by the NHS to the management of research within Trusts caused a delay in my research that was limiting to the study as I had a four-year scholarship and needed to complete on time. It impacted on my focus on the study, as I was not able to proceed to plan and needed to adapt accordingly; I found myself drafting sections of my thesis much later than planned. The delay also introduced nuances into the study as changes were made in the NHS during the period of waiting that had to be accommodated, for example, changes to PEAT criteria and scoring, abolition of NHS Estates and the introduction of Foundation Trust status. In addition I was unable to accept a late invitation from one Trust, as I had to move swiftly to complete the conversations with the FM Managers and move into analysis once the favourable opinion arrived. Thus the opportunity to include another FM Management Team's views was lost.

6.4.5 Themes and Categories

Early in the study I highlighted that my influence as a researcher would be strong as I began to analyse and interpret the conversations. I set limitations upon the study as I started to interpret the phrases from the conversations and assign them to categories. My epistemology and ontology has influenced the analysis of the conversations and resulted in my adopting a particular pathway; for example, the identification of categories and their grouping into themes. Others, looking through their own lens, may have placed a different interpretation on the phrases and thus allowed a different picture of the conversations to be painted.

Whilst I recognise that these limitations will have impacted on my study, I do not believe that the impact has devalued the study, which remains a rigorous and wide ranging piece of research.

6.5 Further Literature Search

My analysis of the conversations with the FM Managers has shown they have an ability to work with others outside FM in a non-hierarchical way. They expend large amounts of time and effort on these relationships in order to ensure that the FM agenda becomes integral to clinical teamwork and to Top Team strategies and investments. In my study I have termed this 'networking' as it exists in a looser, more cross-functional framework than teamwork. Recognising that discussions on networks did not feature in my original literature search, and that networks are beginning to be adopted in clinical areas, I sought to identify whether these clinical networks are similar to the working practices I discussed with the FM Managers. I also searched for evidence of network working within FM.

I heard and saw the FM Managers interpretations around communication, selling the vision; this involved the need to talk in languages that others could understand and relate to. Whilst I have covered something of this topic in Chapter 3 Underpinning Knowledge, I return to the literature looking more specifically for further understanding around the management of language.

6.5.1 Networks

The collaboration brought about by networks can be tactical or strategic and work across organisational boundaries or within an organisation (McCarthy et al 2003). Networks are seen as flexible and multi-layered with the predominant relationship being peer-to-peer (Lipnack and Stamps 1990), with their success being due to collaboration. This collaboration is able to flourish when the benefits of network membership exceed the costs; a trust in reciprocity becomes a fundamental norm in the network (Koch et al. 2006). In setting up the network the promoter becomes a social architect, whose particular task is the maintaining of communication in order to actively and intensively foster an innovation process. Over time four promoter roles have been identified, promoter by power, promoter by know-how, process promoter and relationship promoter. The latter two roles are seen to overlap, and are sometimes combined, as they both deal with traits such as social and communication competencies. The roles of promoter-by-power and promoter-by-know-how appear to be minor in the co-operation context (Koch et al. 2006). Of these, the process and relationship promoter roles are key competencies of a leader.

The literature highlights three types of network: enclave (exclusive professional groups), hierarchical (highly managed) and individualistic (procurement and brokering) (Goodwin et al 2004). Healthcare benefits from using these different types of networks in a hybrid way, offsetting the risks of each type of network with the advantages of the other types (Goodwin 2005).

A recently improved understanding of healthcare as a complex adaptive system, and a growing interest in clinical pathway commissioning[50], have resulted in the idea that relationships between the parts of the NHS have great importance (Plesk and Wilson 2001). The boundaries between the parts are often perceived as inviolate; although the NHS is in theory one large organisation, these boundaries abound (Dreachslin et al. 1994). To negate some of the impact of such boundaries in patient care, both voluntary and mandated clinical networks that work across organisational boundaries and focus on clinical pathways for patients (for example, cancer, diabetes and neurology) are gaining popularity in the NHS. The clinical network has now become highly relevant to the current policy direction of the NHS (NHS Service Delivery and Organisation 2007). The need for networks within the NHS is supported by the National Clinical Director for Primary Care who likens a network to a metaphor for transformational, non-linear leaders who have the abilities to manage a multi-faceted service. This network approach is seen to help manage the objections by clinicians to the detailed specifications (Plesk and Wilson 2001) that result from traditional and bureaucratic NHS management styles (Cavill 2006). Studies to enable policy design and implementation are being undertaken by the National Institute for Health Research[51]. They seek a deeper understanding of the origins, processes and impact of network-delivered care, for example, Project SDO/103/2005: Studying health care organisations - delivering healthcare through managed clinical networks.

At a workshop held by the Department of Health in November 2005, pathology staff were asked to say what they saw as the keys to overcoming barriers when setting up networks; champions, strong leadership and communication were identified, reflecting the work around the relationship and process promoter roles. When asked what they would do differently next time they set up a network, members of the workshop wanted formal arrangements and re-negotiated contracts with providers. I believe this to

[50] This allows patients to be treating effectively without experiencing interruption at the boundaries of NHS organisations
[51] Information on the projects can be found at www.sdo.lshtm.ac.uk/sdo

illustrate that it is difficult for networking to live alongside, and in harmony with, the hierarchical and bureaucratic culture of the NHS.

However, Connor (2001) states that network structures will co-exist with, rather than replace, the current hierarchical structures of the NHS in the medium term. These networks will, of necessity, rely for their success on a relationship focus. However, Schmidt (1992) found that an organisation that is embracing a network culture has to work in a different way when managing its corporate vision as its power to mandate is weakened. In an effort to understand the new clinical networks, research is being commissioned, for example, by the National Institute for Health Research (Project NR89: The Management and Effectiveness of Professional and Clinical Networks[52]). This strand of research will study the origins of networks, the processes and leadership used to sustain the network, and the impact of networks.

Little information is yet available on the role of networks in the public sector, (Thompson 2005) or on the adoption of networking in the management structures of the NHS. McGuire (2002) finds that a vocabulary and an imagery to tell meaningful stories of management success in network settings has not yet been established; this would appear to be true of the NHS, where the recognition of the potential strength of networks is seen to be novel (Conner 2001).

It has long been accepted that there should be integration between the estate strategy and the corporate agenda (Alexander 1996) supported by an integrated resource management model that ensures constant two-way conversations between strategic management and operational management (Shiem-Shin 1999). The integrated resource model is essentially traditional in nature as it reflects vertical communication that passes up and down the hierarchical lines. Heng, McGeorge and Loosemore (2005) develop the thinking around the need for relationships to exist across organisations as well as following the formal structures, when they look at an FM Manager within a hospital environment as a strategic broker. The strategic broker is required to communicate, not only between strategic and operational levels, but across the different parts of the of an organisation This lateral and vertical communication ensures that effective solutions are integrated across different functions, by creating and assembling resources, including information, ideas, people and expertise, that may

[52] See www.sdo.shtm.ac.uk/files/reerachcall/102-brief.pdf for information on this study

be controlled by themselves or outside parties (Snow et al1992). Every time a successful solution is found interdependence, and thus the bonds, of the network members are strengthened (Awuah 2001). An FM Manager is more of a linking piece between disconnected parts of the organisation, and when acting as a broker, unexpected opportunities are presented and undetected problems are solved that might otherwise never have come to light. An intrepreneurial attitude that focuses on brokering social networks and exploiting opportunities enables the FM function to exceed the conventional expectations of the customer. The intrepreneur, whilst symbolising individualism and independence, is dependant on their network of personal relationships when making decisions and solving problems. It is from these networks that learning and influence emerge as part of an ongoing negotiated process (Taylor and Thorpe 2004).

If the FM Manager takes the initiative to start building strong relations the effect could be very great, but it is a slow process; therefore concentrated effort needs to be expended in building key relationships. If the FM Manager does not take up the initiative FM will always be seen as a cost to be constrained or a low-level service available on demand. The initial conversations are about the key features and concerns of the core business, but as the relationship builds, and the positive value of FM is realised, then a mutual crafting of the FM and corporate agendas occurs. In these collaborative endeavours soft factors such as trust are central (Barrett 2000).

6.5.2 Management of Meaning and Attention

In Chapter 1 Introduction and Background I discussed how FM managers traditionally worked within a relatively stable and unchanging world, where technical expertise was sufficient to build a career. This world has now changed and FM managers are being required to become leaders that create teams in order to deliver high standards of Patient Environment. As I demonstrated in Chapter 3 Underpinning Knowledge, communication is seen as a key attribute for a leader (Goldsmith and Clutterbuck 1985). It is recognised that the ability to communicate in a manner appropriate to the audience is an integral part of the communication skill for the FM Manager (Edington 1997) and will foster good connections with the overall goals of the organisation (Wing 2005). In Chapter 5 Conversations with the FM Managers, I explored the idea that the FM Managers who consistently deliver high standards of Patient Environment build networks outside of FM with both clinical and top teams. Networking calls for increased communication skills (Boje 1991) and conversations must happen across

departmental and professional boundaries to achieve excellence in healthcare. In many instances these conversations are messy, because managers are not willing to be disturbed from focusing internally on the part of the organisation for which they are responsible (Kerfoot 2003). I observed earlier in Chapter 3 Underpinning Knowledge, that leaders are managers of meaning and that this means that they have to be capable of shaping their followers' understanding of reality and re-shape and re-mould their own perceptions of reality. The literature studied showed that: communications skills were paramount; communication could be both spoken and unspoken (Ornstein 1986); and legends and story telling could be employed. My research shows that the FM Managers in the Research Group were also keen to seek feedback and hear others points of view; again we saw in Chapter 3 that the literature speaks of the skills of listening and of understanding others.

There are three elements to this examination of the management of meaning: communication, conversation and dialogue. Communication and conversation are seen as tools for announcing and explaining change and are part of the change process. However, others see change as something that happens from and during communication, conversation and dialogue; producing change is not a process that uses communication as a tool, but rather it is a process that is created and maintained by communication (April 1999, Ford and Ford 1995). Dialogue is the methodology by which a group can participate in creating and maintaining a pool of common meaning through non-hierarchical conversations without an agreed end point, a structured agenda or any pre-determined outcome. When dialogue methodology, although difficult and uncomfortable, is applied to specific intractable issues, remarkable progress can be made. Dialogue methodology is seen as a method of bringing meaning into people's working lives, and is thus a tool for a leader when engaged in managing meaning (Varney 1996).

Organisational symbols are also used as a method of communication, particularly during periods of great change, for example, the removal of the Berlin Wall was used to demonstrate the new freedom and the joining of Germany as one nation. Leaders should also be attentive to the use of ceremonies in the reinforcement of shared values (April 1999). In the same way, the leader can use story telling to communicate or change the culture of an organisation by redefining individual and corporate values. Stories can entertain, delight, frighten or inspire and are powerful leadership tools. Human beings learn from experience, their own and those of others and, as our

cognitive maps are shaped by the language we use, the images and metaphors that are used in story-telling provide employees with an understanding of life within their organisation (Forster et al. 1999).

Of course, communication is a two way process known as conversation. It has no impact or influence unless others listen to it, understand it and take action on the basis of what they have heard and understood. The issue for many leaders is to get others to listen to an important message. Frequently this is an issue because of the need to present information in a way that others can hear and understand (Price 2002), but frequently this is because the leader is seen as distant and removed. Consequently, there is a lack of trust in the leader, as the employee believes that the leader is unable to relate to and understand the issues that face the workforce. Story telling is seen as an important methodology to overcome this division, as the leader shares something of themselves or the organisation that the employee can recognise, thus building a bridge. Dialogue methodologies can be used by a group to analyse a story that is tied to a real issue, thus facilitating learning. (Harris and Barnes 2006)

6.6 Conclusions

In this chapter I have laid out my reflections on each of the ten themes deriving from the analysis undertaken in Chapter 5 Conversations with the FM Managers. I will draw some conclusions from these in Chapter 7 Conclusions and Further Research.

I included a synopsis of the review undertaken with my Peer Group, during which the ten themes were discussed. My Peer Group was very supportive of the ten themes, recognising that they would indeed contribute to success. Prompted by the themes, they identified several cultural characteristics that might exist in the Trusts that they believed would facilitate the FM Managers' success, but did not recognise them as fitting their own paradigm of the NHS. These ideal organisational characteristics included: the expectation that a manager would be innovative and implement change, with the support of the organisation as the manager faced up to the inevitable challenges; pride in being an achieving organisation and a desire to be seen within the group of top performing Trusts; an acceptance that calculated risks and occasional failure characterise an organisation making change and that this can be managed; an acceptance of individuals working outside hierarchies and a preparedness to relax control to allow this to happen. There are strong connotations of the Wallenda factor

(Bennis and Nannus 1985) in the Peer Group's observations relating to their ideal organisational characteristics and I will return to this discussion in Chapter 7 Conclusions and Further Research, Section 7.3 Further Research.

I referred to the limitations of my study: the reality of the organisational context; looking at successful Trusts only; the significance of PEAT scores; the Ethics Committee and my derivation of themes and categories. I discussed the manner in which these potentially circumscribed my work.

I identified and discussed the additional underpinning knowledge around networking and the management of meaning that was required to complete the picture before the final conclusions on the analysis and my reflections could be reached. In this discussion, I established the lateral, collaborative, trusting and reciprocal nature of the network and discussed the early literature that looked at the use of clinical networks in the NHS. I identified the role of the FM Manager as strategic broker, the associated abilities relating to a requirement to work laterally across the organisation and the structural hole theory that enabled the broker to seize the opportunity for advantage through forming individualistic networks where no network existed. I underlined the importance of the ability to manage meaning and attention, particularly in a network situation. I drew the readers' attention to the power of organisational symbols and ceremonies, story telling and dialogue theory.

In the next and final chapter, Chapter 7 Conclusions and Further Research, I will pull together the information from the study, and form my final conclusions. I will highlight areas of interest for further research and include reflections that look back across the period of my study, discussing learning points and the impact on my career and myself.

Chapter 7 Conclusions and Suggestions for Further Research

7.1 Introduction

Figure 7 signposts the reader to the position that Chapter 7 Conclusions and Suggestions for Further Research takes in the research route.

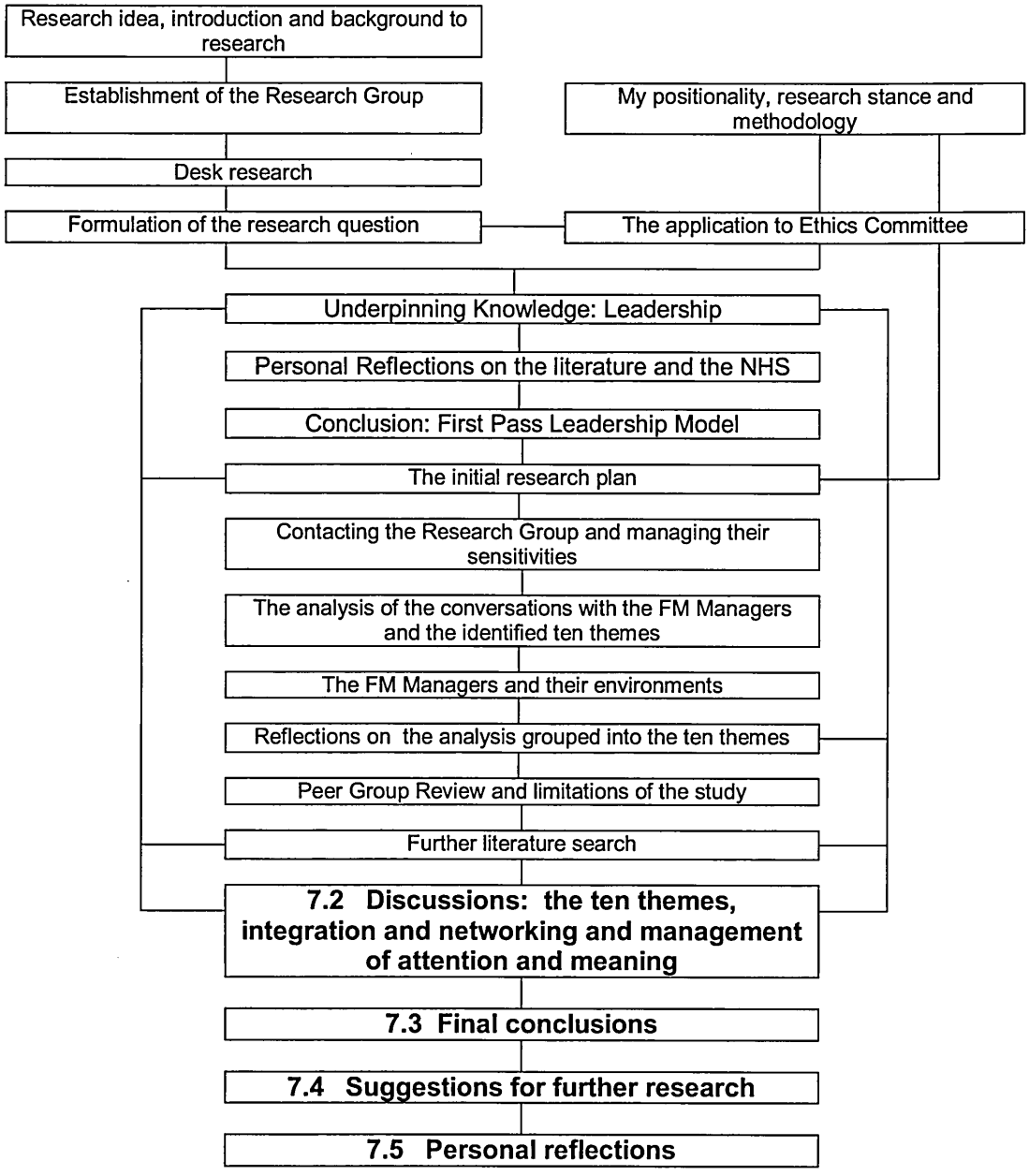


Figure 7 The Thesis set out in the Research Pathway

In Chapter 6 Reflections, Limitations and Further Research I laid out my reflections on each of the ten themes deriving from the analysis undertaken in Chapter 5 Conversations with the FM Managers in readiness for drawing out my conclusions in this chapter. I told of the discussions with my Peer Group and their support for the ten themes. They further identified several cultural characteristics that might exist in the Trusts that they believed would facilitate the FM Managers' success, but did not recognise them as fitting their own paradigm of the NHS. There were strong connotations of the Wallenda Factor (Bennis and Nannus 1985) in their discussions. I was unable to properly justify these thoughts from my conversations with the FM Managers, so return to discuss this topic in further depth in Section 7.4 Suggestions for Further Research.

I looked at the way in which the limitations circumscribed my study, moved on to the further literature search around boundary management, networking and the management of meaning and attention that would enhance my knowledge of existing leadership theories and thus enable me to bring further meaning to some of the findings from the analysis. In this final chapter I will be bringing together all the evidence as laid out in the document and making my final conclusions. I will also highlight suggestions for further research and I will reflect back across my the period of my study, looking at the learning that I have experienced and the impact on me and my career.

7.2 Discussions

In Section 6.2 Reflections on the Analysis I began formulating a belief that the FM Managers were using the language and evidencing the behaviours of leadership discussed in Chapter 3 Underpinning Knowledge. In order to understand this more fully I set the Reflections against the a priori underpinning knowledge that I had established earlier in the study (see Section 6.6.1 The Ten Themes).

I noted that there were other areas in the analysis that were worthy of attention as they were not fully represented within the leadership model drawn up in Chapter 3 Underpinning Knowledge; I have explored these in more depth in Section 6.6.1 The Ten Themes.

I also identified that the themes of integration (Theme 8 Integration with clinical teams and Theme 9 Integration with the corporate agenda and the Top Team) had a much

stronger influence on the FM Managers' conversation than I might have expected from the literature that I had reviewed. I also noted that the management of meaning seemed to receive significant attention from the FM Managers. In an effort to create a new understanding I have taken the second literature search and reviewed the themes of integration (see Section 6.6.2 Integration and Networking) and management of meaning (see Section 6.6.3 Management of Meaning) against this.

My reflections show that the FM Managers did not display evidence of leadership exclusively, but also evidenced activities usually thought to be management activities, such as an interest in systems, performance management and budgets (Bennis 1992, Adair 2003). For example, to encourage competition, boost morale, interest and standards within their teams, and to retain interest and manage attention with clinical teams and the Top Team, the FM Managers used performance management systems that recorded results, evidenced achievement and highlighted problems. The FM Managers felt that delegation, with the space and freedom to achieve, was seen to encourage the best from people; this echoed Wings' (2005) requirement for a leader of a high performing team. Her fear that leaders were distant people who stated a vision and walked away was put to rest by the FM Managers who spoke of gaining trust and support, by investing time and effort over a period of time. Here I give one example of management activity and one example of leadership activity to illustrate my point, but there are many examples of both types of activity. I believe the FM Managers were evidencing an integrated role of manager/leader.

7.2.1 The Ten Themes

Figure 6.2 shows the ten themes identified from the analysis of the FM Managers' conversations set against the leadership model identified in Figure 3.6 (after Bennis and Nanus 1985, Metcalfe 2003, Chartered Institute of Management 2003, NHS Estates Development Centre 2003 and the NHS Leadership Centre 2004). As can be seen from this figure most aspects of the leadership model are identified within the Themes of Leadership, the noticeable absence being risk-taking. I discuss this omission further in Section 6.6.3 Managing Meaning and in Chapter 7 Conclusions and Further Research, Section 7.3 Further Research. Given the near match of the themes and the leadership model, I conclude that there is a close relationship between the underpinning knowledge, the FM Managers' conversations and my Reflections on the FM Managers and their Environments. This evidences that the FM Managers are

exhibiting the attributes and characteristics of leaders as set out in the various leadership theories.

The positive self image and strong ego called for in the literature (Bennis and Nannus 1985) is evidenced by the Research Group. However, the FM Leaders evidenced the ability to manage self or emotional intelligence (Bennis and Nannus 1985, Golman 1996), speaking of how they managed themselves, for example, when frustrated by their lack of progress or caught up in the politics around cost controls. The concept of the heroic leader (Yukl 1993), is not seen here, but rather a more facilitating charisma[53] is used, with the FM Managers tending to see themselves as simply 'doing their job'. My Reflections indicate that the FM Managers showed definite concern for factors such as fairness, commitment, reliability, integrity and leading by example, that result in trust being built up over time (Bennis and Nannus 1985, Clark and Payne 1997).

In Chapter 1 Introduction and Background, I was concerned that FM managers in the NHS might focus on the delivery of government targets, to the detriment of service improvement that would allow delivery to become more effective, efficient and/or economic. If this were the case the delivery of short-term objectives and targets would be assured, but the reform that the Government seeks would not be delivered. I questioned whether FM managers might be operationally biased, spending the majority of their time on maintaining the status quo and collecting last year's data. This could result in them becoming uncomfortable with planning and strategy, and having few of the change management skills required to bring about the real business improvement being called for by the Government and members of the public.

I believe that the analysis of the research undertaken with the FM Managers in the Research Group dispels this concern; they were keen to become involved in change, and had a strong desire for new and improved service delivery. Far from having a mechanistic, backward stance towards the targets, I found that the FM Managers used targets as a mechanism for improvement upon which to model their services and build integration with clinical teams. Indeed, I believe that the FM Managers demonstrated the skills of the intrepreneur (Taylor and Thorpe 2004, Heng et al. 2005) and exploited opportunities as they presented. They showed their willingness to be independent, enjoying, and using, the freedom that success brought them. Their individualistic nature

was shown by their acceptance that they were different from other NHS FM Managers; as one FM Manager said

'The NHS is packed with 'we've always done it this way'.

7.2.2 Integration and Networking

The FM Managers worked consistently at integration, being prepared to put much time and effort into this activity, recognising that they would be the ones who contributed the most. This reflects Barrett's (2000) view that relationship building takes time and is a slow process. This also allowed them to ensure that FM issues remained on the agenda, and indeed became part of other people's agendas.

In reflecting on the language and the behaviours of the FM Managers underlying integration, I saw evidence of boundary management (Ancona 1990, Rosenthal 1997) and the building of social networks (Downes 2005). The study shows that the FM Managers are not concerned with creating structures within the organisation, but with the creation of social networks. These networks had little or no formal recognition by the organisation, had little accountability as a group and only a few of the members had responsibility for delivering the objective. I heard about the PEAT inspection teams which contained people from many disciplines, for example Non Executive Directors (no line management authority), Nursing Staff (the accountability for this group is spread across the Clinical Directorates), Infection Control Nurses (who have no line management authority but give professional advice) with the FM Manager holding the Patient Environment target as their objective. The only shared accountability is that eventually all reporting ends with the Chair of the Trust. This echoes the thoughts of Lipnack and Stamps (1990), who as I described earlier, saw networks as multi-layered and predominately made up of peers who enter into collaboration with one another.

There were two levels to the FM Managers' activities, not only were the FM Managers concerned with how they built and maintained their relationships with others, but they strove for these relationships to be mirrored throughout their organisation, for example, they spoke of domestic staff coming under the supervision of ward managers. Some were prepared to give up day-to-day control of their workforce, accepting all the challenges this would bring, and some built non-formal structures such as zones or

[53] Charisma being the capacity to inspire followers with devotion and enthusiasm (Concise Oxford Dictionary)

created joint FM/Nursing cleaning schedules. In their various ways they brought about a physical manifestation (or symbol) of their belief in an integration that facilitated lateral solutions to problems. This behaviour also hints of the reciprocity (Koch et al. 2006) that is required if networks are to flourish. FM Managers were seen to be interested in and supportive of others' agendas, which elicited collaboration from clinical teams; this was further evidence that trust was built through reciprocity.

The FM Managers evidenced use of the Structural Hole theory (Rosenthal 1997) by forming individualistic networks where no existing network existed (Goodwin 2004), for example building networks with Modern Matrons. They evidenced the use of a hybrid of networks thus offsetting risks (Goodwin et al 2005). For example, they used conclave networks between the FM Manager and members of the Top Team, but hierarchical networks in arenas such as the PEAT inspection team where status and formal acknowledgement of technical or clinical skills were important to impress the observers and thus ensure they progressed with the FM agenda.

This focus by the FM Managers on integration could be seen simply as having a vision and ensuring that followers are recruited to help deliver this vision; however, I believe that this is not easily achieved in the complex arena of the NHS with its multiple stakeholders and agendas. In the a priori underpinning knowledge there is mention of leaders: being good networkers (Alimo-Metcalfe and Alban-Metcalfe 2003); having relationship management skills (NHS Estates Development Centre 2003); and, accurately perceiving the emotions of others so that they can build strong relationships (Golman and Eisenberg 2000). These attributes are again highlighted in the additional literature review as being the attributes of the relationship and process promoter, termed strategic broker by Heng, McGeorge and Loosemore (2005) when looking at FM Managers working in Australian hospitals. I believe that this ability to be an effective strategic broker is where the FM Leaders are using to best advantage their leadership characteristics and attributes identified in the ten themes.

I do not talk here of networks which are used to drive people towards an organisational vision that has been shared from the top. The FM Managers conversations hinted of organisations that have loosened hierarchical control in order to allow networks to flourish, accepting that the organisations' power to mandate was weakened (Schmidt 1992). Evidence is beginning to point to the fact that an FM Manager will need to be operating within an organisational context that facilitates the use their networking and

leadership skills, as I see hints that this may be the case for the FM Managers within the Research Group. These thoughts are to be further discussed in Section 7.3 Further Research.

I see the networks that the FM Managers spoke of creating as being spun with a web of quiet, consistent conversations, reinforced with the tantalising glitter of symbols, decorations, stories and legends, and taking place between leaders and between leaders and followers. The FM Managers spoke of time and effort being spent capturing the hearts and minds of others both laterally and vertically across the organisation. They did this by spinning their visionary webs in advantageous places (with clinical teams) at advantageous times (reward events for FM staff, or in meetings to discuss others agendas) to catch the juiciest of flies (members of the Top Team who had the most power and influence). When they were sure of having created this advantage they moved into practical implementation and mutual adaptation occurred, so improving the services offered and increasing the interdependence, and thus the bonds, of the network members (Awuah 2001).

7.2.3 Management of Meaning and Attention

Much of the underpinning knowledge underlined the need for a leader to have exceptional communication skills (Bennis and Nannus 1985, Spinks and Wells 1993, Goldsmith and Clutterbuck 1985, etc.). But communication was seen to be much more than a simple ability to verbalise a vision, with language taking different forms (Musson and Cohen 1999), use of non verbal language (Handy 1995) and its use in the cultural web (Johnson and Scholes 1995), and perhaps more importantly the ability to present information in a way that gets others to listen and understand the messages, thus capturing their attention (Bennis and Nannus 1985, Edington 1997).

Evidence of the FM Managers ability to manage meaning and attention was found throughout the conversations and the analysis particularly highlighted this in Themes 5 and 6 Maximisation and Themes 8 and 9 Integration. The skill of managing language helped FM Managers to ensure that their vision caught the attention of their staff groups and the clinical teams, the corporate agenda and the Top Team, thus ensuring a place for the FM agenda within both the operational and strategic conversations. Specific mention was made by one of the FM Leaders about her/his ability to talk the language of nurses as s/he was one her/himself, thus becoming part of the 'club' and therefore accepted and respected. Another example of presenting information

according to the audience is when the FM Managers used their teams performance against the PEAT targets as a language to ensure the FM agenda arrived at the Trust Board for discussion. They spoke of high levels reports, thus presenting the information in a format that could be understood by Board members and from there it was computed into business plans and organisational objectives. Oliver re-wrote the 'middle-class' values of their organisation to show staff how the organisational values relate to them. They then rewarded their staff members for demonstrating their understanding and commitment to these values.

I have shown in Section 6.6.2 Integration and Networking that the FM Managers were working as a broker both laterally and vertically within their organisations. The literature search around networks showed that key skills of the broker were communication (Boje 1991), and I was interested in the view that April (1999) and Ford and Ford (1995) put forward that communication itself brought about the change, rather than change being decided upon and then communicated. I believe we saw evidence of this communication bringing resolution and change within the FM Teams as well as being part of the cross-organisational brokerage role. This is evidenced by the FM Manager who spoke of dialogue methodology (Varney 1996, Harris and Barnes 2006) being used though a team meeting where FM staff were called together to make suggestions and discuss problems that they were experiencing.

Physical manifestations underlining a spoken message and a personal belief are important tools for the leader when managing meaning and attention (Handy 1995), as is a willingness to be disturbed from focusing internally on their part of the organisation (Kerfoot 2003). The FM Managers valued visibility and accessibility, thus creating an ability to be approached. The physical manifestation of this approachability was evidenced when they took me out to walk the site. They spoke of giving and earning respect, and spoke with politeness and respect when greeting their junior staff as we walked; one spoke of looking the part by wearing a suit, no matter how hot, the physical manifestation of smartness which was one of the organisation's values[54]. The FM Managers spoke of the work being delivered by practical people and their offices underlined the idea of practical work, but hinted at their position within the larger organisation, thus underlining integration with the wider organisation. Many of the FM

[54] Or as a decoration of office, or as a contextual fit?

Managers spoke of the ceremonies (April 1999) they used to celebrate success and loyalty.

I identified earlier that the FM Managers had iconic stories or legends to tell, thus depicting the use of story telling methodologies which provide an 'important container for life lessons' (Harris and Barnes 2006, Forster et al. 1999). They told the legends of how their organisations had become successful (or were failing) and the stories that made up the histories of FM and their Trusts. In this way they illustrated the results of people's behaviours, both good and bad, and communicated complex concepts in a short time and in unforgettable formats. These stories, particularly if they showed a human weakness or failure on their part, could also help the FM Manager enhance accessibility and integration by providing platform upon which trust could be built (Harris and Barnes 2006).

Taking risk and risk management did not feature as a strong theme when the literature search was carried out, this was of particular note when looking at the NHS Estates Development Centre and NHS Leadership Centre leadership attributes. The FM Managers' language during the conversations did not explicitly evidence risk taking and my Peer Group felt that risk taking was not an acceptable concept for the NHS. However, risk is inherent in any innovation or change and FM Managers are taking and managing risk when bringing innovation into service delivery and implementing their change programmes. I suggest that the FM Managers used different terminology (language) to discuss risk, for example, talking of service improvement instead of risk, thus making the benefit of the change outweigh any risks. This points to the ability of the FM Managers to understand the need for, and the use of, adaptive language that is appropriate to a particular conversation or audience, thus managing meaning and attention (Bennis and Nannus 1985).

7.3 Final Conclusions

In Chapter 2 Desk Based Research, Section 2.3 Conclusions I drew the conclusion that that the external influences and Trust characteristics were not creating advantages for the FM Managers within the Research Group that would assist them in delivering high standards of Patient Environment. At this point I re-framed my research question to ask 'is it leadership by the FM Team that enables the consistently high standards of

Patient Environment to be delivered?' Below I lay out the conclusions of my research into this question.

I concluded that that the FM Managers used the language and behaviours of leaders (see figure 7.1) albeit they did not adopt the heroic leadership style (Yukl 1993, Bolman and Deal 1991), but a more gentle, facilitating style. They displayed the traits of managing self (see figure 7.1) and emotional intelligence (Golman 1996); they invested time and effort in building trust (Bennis an Nannus 1985 and Clark and Payne 1997) between followers and other leaders, and used intrepreneurial skills (Heng, McGeorge and Loosemore 2005).

Whilst striving to deliver consistently high standards of Patient Environment, I believe that the FM Managers had developed an extended leadership role, namely, integration with Clinical and Top Teams. FM Managers achieved this integration through boundary management (Acona 1990), the building of networks (Lipnack and Stamps 1990, McCarthy et al 2003, Downes 2005) that varied in types, and the management of meaning and attention (see figure 7.1). They became the strategic broker (Heng, McGeorge and Loosemore 2005, Snow et al. 1993) between the FM Team, the Clinical Teams and the Top Team, using their responsibility for the Patient Environment to do this. In addition there was some evidence of brokerage between the Clinical Teams and the Top Team as the FM Manager engaged in the wider agenda taking them into areas outside the conventional FM portfolio.

Whilst networking skills were key for the success of the FM Managers within the Research Group, I found a lack of literature on networking within the NHS, particularly for those managers working within the FM arena; it appears that there is limited understanding of the model in practice. This underlines observations by Edwards and Gill (1993) regarding the flaw when leadership theory is developed in isolation of the context of the leader.

THE LEADER			
The Themes of Leadership	**Management of Attention**	**Management of Meaning**	**Management of trust, self and risk**
Pride and Commitment			Has genuine concern Sees mistakes as blips Results orientated/wants to win
Leadership Style	Exceptional communicator Accessible		Looks to take responsibility Integrity Self disciplined/style in context Charismatic Appropriate personal style
Luck and other contributing factors			Emotionally intelligent
Opportunity for personal development	Knowledge management		Learns by mistakes Intellectually flexible
Maximising the Contribution from FM Staff and the Contractor's Team	Focuses on people Empowering Holding to account Influencing/inspiring Creates enabling culture	Clarity of overarching vision Engages employees in vision Guides	
Stability, experience and change	Finds solutions to difficult/ complex situations/ problems	Seizes the future Finds new approaches and solutions	Challenges the status quo Sound judgement Takes appropriate risks, is a risk taker
Integration with Clinical Teams	Good networker/ relationship manager Collaborative	Understands prevailing culture/ context	
Integration with the Corporate Agenda and the Top Team	Good networker/ relationship manager Politically astute	Understands prevailing culture/ context	
External Perspective		Understands prevailing culture/ context Broad scanning	

Figure 7.1 The leadership model
Assigned to Figure 3.6 The themes of leadership after Bennis 1995, Chartered Institute of Management 2003, NHS Estates Development Centre 2003 and the NHS Leadership Centre 2004

However, the FM leader cannot fully utilise his/her leadership skills if their management structures, processes and plans are not in place to be drawn upon (Leadership Centre 2006). There will always be a requirement for the on-going practices of good management that ensure effective service delivery, underpin trust and credibility and use resources efficiently and wisely. Thus the FM leader in the NHS will need to embrace the role of the manager/leader (Fritchie 1997). The NHS is a complex adaptive system (Plesk and Wilson 2001) and the FM leader cannot hope to achieve his/her goals in isolation; the work of achieving the FM agenda has to be shared, with the FM leader becoming used to managing leaders and leading managers (Fritchie 1997) through their hierarchical structures and lateral networks. I believe that, in as much as the FM leader needs followers to deliver the agenda, s/he also needs the commitment and support of the organisation, by a display of empathetic leadership attributes emanating from the Top Team, to allow their leadership skills to be accepted and to flourish. I return to this thought in Section 7.4 Further Research.

After careful analysis of the external influences, the FM Managers conversations and their wider environment together with a search of the relevant literature, I conclude that, whilst the FM Managers in the Research Group retained the skills and the abilities of a manager, they also employed the language and behaviours of leaders. In this way they were able to maximise the contribution of the FM Team and the contractors' teams. In addition they took up the role of the strategic broker and, by networking laterally across the organisation, they were able to integrate the Clinical, FM and Top Team agendas and helped broker cohesion between the Clinical Team and Top Team. This engagement in the wider agenda took the FM Manager into areas outside the conventional FM portfolio. Thus I conclude that it was leadership by the FM Managers that enabled the consistently high standards of Patient Environment to be delivered.

7.4 Suggestions for Further Research

I believe that this research has shown that a Leader with all the recognised skills, characteristics and attributes, can make a real impact on the Patient Environment if s/he has the skills to take up the role of the strategic broker. There are, however, a number of questions that would benefit from further research. I offer these to the reader.

- I spoke to three women out of a group of twenty-two participants. The Trusts within the Research Group were selected by means of an objective process, therefore no gender bias was possible at this stage. There is a question as to why so few women were evident within the Research Group. The NHS as a whole employs a high percentage of women and FM soft services are traditionally staffed by females. Is there a potential gender bias in appointing females to management positions, particularly those in FM? Do females exhibit leadership skills in a way that would achieve high standards of Patient Environment? Do females in leadership positions take up the strategic broker role?
- The standards of the Patient Environment and the FM Managers' conversations in areas of extreme deprivation could be further explored. This further research would allow an understanding of whether the themes identified in this research are replicated in these areas with shared external influences, or whether a very different agenda is being addressed by the management teams in these Trusts. This research would be of interest to the NHS as they endeavour to engage with hard-to-reach groups and bring equity of access.
- The use of the network within the NHS should be given further consideration. I believe that the growing expectation that NHS managers will network in an innovative and lateral manner, outside of hierarchical structures will present a significant challenge. A tension inevitably arises between the traditional hierarchical control structures and the novel lateral collaborative structures. It maybe that a leader will need a particular set of skills around maintaining long term networks in addition to the skills of creating and working within networks.
- Can the extended leadership role flourish in the long-term in an environment of politically-motivated change and government control? The characteristics of the intrepreneur and the strategic broker that I discovered could mean that leaders find themselves constrained by the wider environment of the NHS. Is the development of the Foundation Trust able to offer the environment to foster these skills?

The key outstanding query raised by this research is that of the organisational context. I considered the context when discussing the limitations of the study[55] and my Peer Group raised the question of the facilitating context[56]. They thought that the FM leader would need to work within an organisation that accepted the languages and behaviours

[55] See Chapter 6, Section 6.4.1
[56] See Chapter 6, Section 6.3

of leadership that this research has uncovered. This correlates with my own personal experiences of working within the NHS (see Section 7.5.2 New Career). Indeed such an organisation may attract many managers who share these identified leadership languages and behaviours, keen to run their organisation as a non hierarchical, network culture that fosters leadership. In order to be successful does the Leader need to be within an organisation that welcomes the intrepreneurial activities of the strategic broker and support their actions, for example, the innovation and risk introduced by a leader who brings the Wallenda factor? Or do leaders create their own context and this idea of fit between leader and organisational context is a social defence put forward by those who consider themselves leaders, but have failed to reach the role of the strategic broker?

7.5 Personal Reflections

I have chosen to use this section to reflect back across the time I have spent on this study, realising the positive impact that this experience has had on me, both as a person and on my career. I made my bid for the scholarship from a very positivist angle. I was interested in performance management and information, persuaded that if an FM manager had a real and practical performance management system that gave quality information s/he would be able to adapt the working of his/her team to ensure the deliver of high standards. I remain convinced of the need for good quality information on performance, and indeed this was reflected in the conversations with the FM Managers. I now recognise the grey within the black and white world of leadership that any performance management system would need to attempt to address, if indeed it could.

Given that I expressly set out to research the FM world in which I worked and the group of people I called my colleagues, FM Managers, I have frequently asked myself whether I met up to the model of Leadership that I was forming. I now believe that there is no yes/no answer to that question for me; it would depend on the context, my fit with the organisation's culture and the job that needed to be delivered.

I have worked in the private sector and in the NHS, and now find myself outside the NHS once again, but this time working within the NHS. I entered the NHS in the belief that leadership of an appropriate type was needed in order to harness the motivations and skills towards an enhanced patient service. I have endeavoured to bring this about in the time I have spent in the NHS and I still believe this to be true. However, the concerns that I have over leadership in the NHS have been stated several times

throughout this document and remain with me as I reflect back over its gestation and (not unpainful) birth.

7.5.1 Ironist Epistemology

For many years I have wondered about my epistemology and how my rather questioning and seemingly unconfident approach could sit comfortably with the ideal of leadership as I saw it. So many appraisals, so much feedback, so many learning events and still I ask if I have it 'right' and indeed what is 'right', what is the final answer.

During the course of my study I have come to understand that my epistemology does not allow for the final answer, that I have fundamental and continuing doubts about any final vocabulary, as I know that it can always be redefined and re-presented in different ways. I recognise that I value this re-definition and re-presentation as a way to hold open the gates of negotiation and persuasion, the way to develop and learn and help others develop and learn. This lack of commitment to upholding one ideal, whilst possibly seen by others as a lack of conviction or confidence, keeps debate and learning alive and values the differences between individuals and their contributions. In my work I can now see that my ironist stance provides a common ground where diverse parties can collect around the table to debate their differences; my practical nature (born from years of working at senior levels within FM teams) enables me to broker agreement of the action plan that will help others move along the path of working together.

7.5.2 New Career

As I describe in Chapter 1 Introduction and Background, during the course of this study I have left behind my role as the Director of FM and have moved into the world of project management, working from outside the NHS for the NHS. I have made this move for two reasons, my belief that there is a need for a fit between the leader and the organisational context and my greater understanding of my epistemological stance. I recognised the poor fit between the hierarchical controlled, task focussed and performance managed Trust within which I had worked and my preferred leadership style of questioning, debating and facilitating. I understood that I could not feel, nor be seen as, highly successful working outside my preferred style and within a culture in which I could not fit. This realisation was brought about by my work for this thesis, bringing real personal benefit and I hope benefit to the NHS.

I now work as a Project Director and have moved towards working with clinical teams. I am in demand for my abilities to facilitate thinking and lead clinical teams towards change, and my epistemology stands me in good stead as I listen to all the different approaches, helping to identify the common ground and ensure that the differences are valued. I no longer feel that I need to adopt the heroic style of leader, not do I have sleepless nights over committing to hastily agreed, losing courses of action (Drummond 1991).

7.5.3 New Skills

During this study I developed the new skill of being able to take messy, qualitative data and organise and streamline it to identify themes and trends using a recognised methodology. I have recently become involved in directing a project that looks at the difficulties care homes face in accessing healthcare. I was able to take the results from semi-structured interviews and turn them into a cohesive and compelling report that elicited support for a rather controversial project from an Executive Team and their Board. This skill will stand me in very good stead when working with the NHS as much of the work is around people and their thoughts and ideas (either patients or NHS staff) and the data presented is often anecdotal and impossible to quantify. Many committed NHS staff are motivated by a desire to help patients and because of the nature of their work their attention is caught by emotive argument; it can be hard to attract their attention to quantitative information required to meet targets. Now that I am able to include the more qualitative data in my reports, I find I can capture their interest in the quantitative data as well; I am facilitating others to manage their emotions and brokering the clinical and Top Team agenda.

At the time the delay in receiving the favourable opinion from the Ethics Committee was frustrating, but in hindsight I recognise some valuable learning that came from this experience. It served to enhance my understanding of the NHS culture, for example, the status of clinical research over non-clinical research, and the barriers that are put in the way of learning if not approached by traditional methods. It also made me think hard about the fragility of the government's change agenda for health and where the power sits that can deliver or stop that change agenda. It reinforced my opinion that any changes made to the NHS will not be brought about by simple and easy solutions but through deep-seated and painful change that strips away tradition, power and the trappings of power. I also wonder how the less positivist clinical research fares, and whether a bias in favour of research around quantitative approaches may mean that quantitative studies gain more favourable opinions from the Committee. Would this mean that equal access to research was denied to some prognosis, for example, would

some forms of research into mental health struggle while drug trials would have an easier route? Does this thought have any relation to the medical profession's reluctance to accept alternative medicines? However, whilst an interesting aside, these questions have no place in this study.

I leave this study richer from having spent time and effort in understanding my motivations and myself and from spending time in detailed study of the NHS. I walk away with a whole new set of understanding and skills. I hope that as the reader closes this thesis, having gained an insight into the FM Managers who deliver high standards, s/he feels motivated to think some more about their area own of interest and how they can progress and develop their ideas[57], whatever they may be.

7.6 Summary of the Findings

The conclusion that I reach from my study is that the FM Managers in the Research Group have in common a hybrid leadership/management model, that is not the accepted model of leadership as conveyed by most of the debate. The FM Managers have a particular ability to take up the role of strategic broker by which they create and maintain non-hierarchical networks across Facilities Management, Clinical and Top Teams. We see here a model that brings success, not only in performance but in staff motivation and cohesion between clinical and Top Team agendas.

We must remember where the conversation started with the Government's view of the traditional NHS' rigid and hierarchical culture operating in a bureaucratic system as incapable of fulfilling the diverse needs of society, and challenging the NHS to change through the NHS Plan (2000). However, despite some limited successes, the impact of policy initiatives introduced under the guise of a modernisation agenda has been disappointing. In reality, when confronted with the paradoxes and ambiguities of the new public management, healthcare organisations have adopted coping strategies, thereby reducing the gap between policy rhetoric and service reality and maintaining the illusion of an NHS that is both modern and dependable (Kernick 2005).

7.6.1 The Conclusions for Professional Practice

This research has laid out ten themes of leadership, one of which talks about a Leader's Personal Style. This style is their own, and changes according to their

[57] I remind the reader of my positionality (Chapter 1, Section 1.4) I see facts as being of a transient nature, as ideas that merely last longer than other ideas, and so I encourage the reader to be ever seeking the new idea

audience, and the needs and requirements of their vision and goals and those of the organisation to which they are committed. I have also spoken of my own positionality as an ironist, which allows for constant development and change to both theory and practice. With these thoughts in mind, I feel it would be inappropriate of me to end this study by exhorting a leader to learn a particular set of skills or adopt a particular set of behaviours. I will, however, take the opportunity to reflect on how the research has informed and developed my own practice. I hope that this will show how the research may help the reader to become more capable of developing the skills discussed in this study.

One of the discussions often heard in the areas of the NHS where I work is around the volume of work and the constantly changing agendas and priorities. Over the last few years I feel that I have become increasing deadline- and task-focused in order to deliver these demands. This study has helped me to understand where I could be better investing my time and how I can bring a feeling of consistency to my world and that of those around me in this time of change. It has also underpinned one of my personal beliefs that we are all responsible for ensuring the development of those we work with. We need to ensure that leadership, networking and strategic brokerage are not skills reserved for a chosen few at the top of powerful hierarchies, but become endemic within all our teams.

I now have an improved understanding of the real impact that moving from an idea of communication to that of managing attention and meaning can make, particularly in a change situation. I now see the value of time spent managing meaning. Previously I rationed my time between executing the tasks relating to change management and directing the people in line with my idea. I now see that managing meaning is my real tool in bringing about change and that my rations must be apportioned accordingly, to nourish my networks and relationships and establish common goals. In this way my collaborators can develop and grow strong enough to deliver to a shared vision, leaving me free to foster new networks and extend the thinking around how the Corporate and Clinical agendas are to be delivered, the role of the strategic broker.

I see that consistency (one of the factors which helps build trust between leader and follower) is deliverable during these times of uncertainty and change. The value set of those that work in the NHS is so consistent – the desire to serve people in such a way that they can regain health, or perhaps depart from this world having experienced a good death. I can see that the ethical use of that theme can bring a feeling of value and worth for everyone in the various teams, no matter whether their contribution is

that of a nurse, a cleaner or a manager. Any service change or standard/target set can underline, rather than undermine, that value.

In understanding the impact of managing attention and meaning, I have come to see the networks that can be built and the integration that can take place between the different services. I now offer my help and support to areas outside of my sphere, and uncomfortable as this is on occasion, I find this is welcomed and that I can make a real contribution whilst receiving help and support in delivering my objectives. Once a network has become strong and supportive, there is room for one's role to develop to that of the strategic broker or intrapreneur, and this sees the Facilities Manager stepping forward to take a more corporate view of the world.

Recently I presented the findings of my study to a group of FM managers, after which they asked if I had found that the Trusts within my Research Group had an FM director on the Board. When I replied that they had not, I was asked how leadership could work in the way that I described in those Trusts without an FM director. It is imperative that we remember that this study did not reflect a hierarchical model of leadership, but one that was multi-layered across the FM Management Team and out into the clinical team and multi-layered up the traditional FM hierarchical structure. Thus the network is forged at management levels within FM, out-with FM and between ward housekeepers and cleaners and ward staff. This has focused my thinking on how we develop these skills in our teams as well as for ourselves.

The findings of this study offer FM managers across the NHS a unique insight into the potential impact of excellent leaders. This gives an opportunity upon which we could re-model our thinking of management and leadership and the related managerial development opportunities. This would provide the leverage to move Facilities Management from the role of a commodity or a support service, to a position as a true enabler of business (Price 2004).

Chapter 8 Bibliography

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