Leadership conversations: the impact on patient environments

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LEADERSHIP CONVERSATIONS: THE IMPACT ON PATIENT ENVIRONMENTS

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LEADERSHIP CONVERSATIONS: THE IMPACT ON PATIENT ENVIRONMENTS

ABSTRACT

Purpose
This study examines 15 NHS Acute Trusts in England who achieved high scores at all their hospitals in the first four national Patient Environment audits. No common external factors could be found to explain this. This research examined whether the Facilities Managers responsible for the Patient Environment displayed a consistent leadership style.

Design/methodology/approach
Six of the 15 Trusts gave permission for the research to take place and a series of unstructured interviews and observations were arranged with 22 Facilities Managers in these Trusts. Responses were transcribed and categorised through multiple iteration.

Findings
The research found common leadership and managerial behaviours, many of which could be identified from other literature. The research also identified energy and time being devoted to creating networks of conversations (*sensu* Ford, 1999). This creation of networks through managing conversation is a behaviour less evident in mainstream leadership literature or in the current Department of Health and NHS leadership models.

Practical implications
The findings of this study offer managers (particularly those in FM and managers across NHS) a unique insight into the potential impact of leaders giving an opportunity to re-model thinking on management and leadership and the related managerial development opportunities. It provides the leverage to move Facilities Management from the role of a commodity or support service, to a position as a true enabler of business (Author 2004).

Originality/value
Original research in a previosuly under-examined area is persented. The study illuminates how Facilities Management within Trusts achieving high PEAT scores is led.

Key words

Facilities Management; Patient Environment; leadership; language; organisational conversations; organisational networks

1. INTRODUCTION

Leadership research and commentary tends to focus at organisational level, usually commercial or military, and the chief executives or equivalent senior figures within them. When looking at health care, it rarely dwells in the world of Facilities Management. This study seeks to redress the balance by describing an investigation of managers at both operational and strategic level responsible for the patient environment within acute trusts who are responsible for providing acute hospital care in the English National Health Service (NHS).

The White Paper *'Modernising the NHS'* (Department of Health 2000) revealed that a national patient survey indicated public concern for the quality of hospital care as manifested in standards of hygiene, cleanliness, and hospital food, which had been neglected over the years with efficiency savings and competitive tendering regimes taking their toll. Talk of a 'third-world' NHS highlighted the difference in standards from other countries in the modern western world. Growing media references to hospital acquired infections have merely re-enforced the attention and the drive for modernisation continues with the introduction of 'modern matrons' when the then Prime Minister sought to put matron firmly back in charge of the ward. 'Special deep cleans' were also carried out introduced in an effort to further improve the patient environment and cut the rates of infection. Despite this refocused attention a search of the contents of the Journal *Leadership in Health Services* (23 July 2008) yielded no hits for Facilities Management (FM) - the commonly used term for non clinical support - 2 for cleaning and 1 more for food.

The changes introduced in 'Modernising the NHS' included a suite of new performance measures. For FM there were two immediate targets. One concerned unit costs (Department of Health, 2005) and arguably obscured retention of too much, low quality estate (May and Price 2008). The research described here focuses on the second target; the patient environment measures known as the Patient Environment Action Team (PEAT) initiative. In 2000 every NHS Acute Trust [1] was required to prepare detailed action plans to improve their patient environment, focusing on nineteen separate elements that were, following consultation, set by the Department of Health (DH). The elements were deemed to comprise the patient environment and included car parking, entrances and reception areas, visitors' and ward toilets, cleanliness of wards and public areas, 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 take responsibility for the implementation of these action plans. In order to ensure progress PEAT Teams were established to assess hospitals against the nineteen elements. The inspection teams usually consisted of a mixture of skills, for example, nurses, doctors, FM directors/managers (generally seen as responsible), non-executive directors and dieticians.. They also included patients, patient representatives and/or members of the public. Under the programme, every inpatient healthcare facility in England with ten beds or more was assessed annually. Prior to 2004 each hospital was awarded a colour to denote a good (green), acceptable (amber) or poor (red) performance. The approach was changed in 2004, with hospitals being rated as excellent, good, acceptable, poor or unacceptable with additional elements of assessment being introduced, including privacy and dignity; segregation of men and women in sleeping areas; and toilets/bathrooms. Trusts that achieved a score of 'good/excellent' in 2003 were allowed to self-assess, with external validators undertaking random visits to verify the scoring.

The researchers established that 15 out of 183 non-specialist acute trusts in England had consistently achieved 'green' ratings at all their sites (a trust may have more than one hospital) in the first two rounds of PEAT and good or excellent in the third and fourth. For reasons of consistency, the sample was restricted to general acute trusts in England (health policy in Wales, Scotland and Northern Ireland is devolved). As non-specialist trusts, the research group could not claim to draw on particular sources of extra income. A desk based study (MacDonald, 2007;

MacDonald et al. 2008) examined the sample in terms of size; number of hospital sites; age; geographical spread, demographics and economics of the catchment areas, population size, density and age profile of the catchment population; economic activity also the affluence and health profiles of the population. The sample shared no common externalities. Contrary to the arguments of advocates of either outsourcing or in house management, the sample included examples of both. There was neither a single common organisational structure for the management of FM services nor a common managerial tool such as a particular quality model or measurement scorecard. The inference was that the consistently high standards of patient environment might be explained by the managerial behaviours or qualities of those responsible. This paper describes the search for such commonality.

2. LITERATURE

The NHS modernisation agenda has seen repeated arguments that 'old' management models, based on managing the status quo and technical expertise, can no longer meet the requirements of the changing NHS (e.g. Cook 2003). The change narrative stresses new and more flexible ways of working introduced by a new style leader who motivates and inspires, fosters positive attitudes and creates a sense of contribution and importance with and among employees. It demands 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 2004, Hogan *et al.* 1994, Alimo-Metcalfe and Alban-Metcalfe 2003). The Government established a Leadership Centre [2] to support the NHS in developing its managers into leaders. The Centre commissioned research into a leadership model derived from interviews with a number of highly successful Chief Executives from the service. 50 in-depth structured interviews were carried out, comprising 46 Chief Executives and four Directors, to collect rich data about what leaders actually said, did, thought and felt on specific occasions that led to successful outcomes. From 2002, Department of Health (DH) FM development centres were also run. Role play was observed across a variety of activities and graded against a set of criteria (Figure 1). These centres are now run by the private sector. Both the NHS Leadership Centre and the DH FM leadership models draw heavily on trait theories of leadership

The Chartered Institute of Management studied 1,900 public sector managers (Charlesworth et al 2003) and found that the top three personal attributes sought from today's public leaders are clarity of vision (66%); integrity (52%); and sound judgement (50%), with the top three skills listed as: communication (63%); engaging employees with the vision (62%); and creating an enabling culture (60%). Alimo-Metcalfe and Alban-Metcalfe (2003) researched what NHS employees expect from their leaders. These studies are summarized in Figure 1 where they are contrasted with Bennis and Nannus's (1985) model, it being one of the more established frameworks from research into corporate leadership in the public sector.

More generally the rhetoric of leadership frequently subscribes to the separation of the role of the manager and that of the leader (e.g. Potok, 1972; Bennis, 1992; Adair, 2003). Not only is the work of the manager and the leader seen as different, but that of the leader is 'better' than that of the manager, one new style, and one old hat. The same theme recurs in the policy documents discussed above. There are however challenges to this idea of manager versus leader. There are 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 that makes them feel anxious and uncertain. Indeed research has found that groups of people who faced a crisis (e.g. turnaround situations) rated the charisma of the leader as more important than those in a more settled environment (Gemmill and Oakley 1992, Meindl 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 (Ritchie 1997). There is an arguable case that splitting management and leadership is a social defence: one 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).

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	Leading change through people Empowering others Drive for results
Management of self	Creating an enabling culture	Is a good networker Has personal leadership qualities including a charismatic nature Empowers his/her team	Personal Style	Self belief Self awareness Self management Drive for improvement Personal integrity Intellectual flexibility Collaborative working
Wallenda Factor				Seizing the future

Table 1 Comparison of Four Leadership Models after Bennis and Nannus 1985, Charlesworth et al., 2003, Alimo-Metcalfe and Alban-Metcalfe 2003, NHS Estates Development Centre 2002, NHS Leadership Centre 2004

Our study therefore had two objectives:

- Were there common 'leadership' approaches among the sample of managers responsible for the consistently excellent patient environments?
- If so were these adequately captured by the 'transformational leader' models being advocated as part of the modernization agenda?

3 RESEARCH QUESTION AND METHODOLOGY

The most appropriate approach appeared to be broadly ethnographic: observing and speaking with the postulated FM leaders in their own contexts. This proved more problematic to arrange than anticipated. The research, being national, required the approval of the NHS National Ethics Committee: a body that was initially sceptical of research that was firstly non-clinical and secondly inductivist. They felt that the research should also investigate failing Trusts in order to establish the difference. It took considerable persuasion to convince them that the research was not concerned with proving the 'right' way to lead, but merely to discover whether there was any common discourse among the successful FMs. They were also concerned that the information was of a sensitive nature and required a signed consent form at each trust before the research started. In the event, six out of the 15 trusts in the sample gave that consent, the remainder either replied after the

research had been concluded or did not reply at all. No reasons were given as to why the remaining 9 trusts had not been able to grant consent within the timescale.

Once consent was received, the FM directors/managers were approached and the principal researcher received invitations to interview key members of the FM management teams, all of whom had been involved in the PEAT inspections. Given the perceived sensitivity, and in order to preserve confidentiality the trusts, were coded as Rhodes, Smith, Oliver, Stein, Harriott and Lawson and no demographic and/or descriptive information was included in the research report. The decision as to who should meet the researcher was left with the FMs and meetings were arranged to last for one hour, with FMs being asked to talk about the reasons why they had achieved high standards of patient environment over the previous four years. Some meetings were arranged on a one to one basis and some as two to one or a group. Lawson also provided an opportunity to talk to the contractor's management team, who chose to hold their discussion as a group. In all 22 FMs at director, senior manager and operational manager level contributed to the research through 16 conversations in the six Trusts.

We term these 'conversations' rather than 'interviews' to emphasise the researcher's intention of an open exploration for any common attributes/traits/behaviours rather than the testing of any hypothesis. We do though use conversation not in the colloquial sense but rather (Ford, 1999)

> *conversations as a complex, information rich mix of auditory, visual, olfactory and tactile events and includes not only what is spoken but the full conversational apparatus of symbols, artifacts, theatrics etc that are used in conjunction with or as substitutes for what is spoken. The speaking and listening that goes on between and among people and their many forms of expression in talking singing, dancing etc may be understood as conversation. Similarly, listening is more than hearing and includes all the ways in which people become aware and conscious of, or present to the world.*

The sessions were informal, with no research instrument. FM's were asked to tell the researcher about their organisation and how FM was structured. They were then invited to discuss their success in their own words. The Researchers also wanted to look at the physical environment delivered by the FM managers. It was felt that this less overt message given by symbols, signs and unspoken language would further inform the findings from the interviews by showing the subconscious aspects of the FMs' work world, allowing a match to be made between the rhetoric spoken by the FM's in the interview and the reality of the environments they delivered. Observations commenced upon entering the site and ended upon leaving and were made at any point in the visit, whether in a general area of the hospital, a clinical area, in the FM department or in the FM's office. No special steps were taken to visit specific patient areas unless the FMs volunteered an opportunity.

4. FINDINGS OF THE RESEARCH

4.1 Method of Analysis

Once the conversations were completed, the phrasing from them was grouped by coding each comment made by each FM. This procedure was reiterated several times and minor adaptations resulted in identification of 142 categories (Table 2). The categories were then grouped into themes, and each theme was named. For example, when talking about pride, the categories for Pride in Organisation and Pride in Achievement were grouped 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, during which 10 themes emerged that grouped the categories in a logical manner. The notes of the researcher's observations were checked against the 10 themes, looking for anomalies; they were found to marry with the categories and therefore fit the 10 themes. For reasons of length sample quotes and observations have not been included in this document, but are available from the authors (MacDonald, 2007).

Neither categories nor themes are separate or isolated. They worked closely together in mutual support: each adding strength to the others as they contributed to the FM's overall approach. For example, pride and commitment is listed as theme 1, but pride and commitment was reflected in the personal style (theme 2), as the FMs talked about their work which led them to feel lucky or think positively (theme 3). This gave them the ability to find ways to solve problems (theme 7), and improve integration with other teams (themes 8 and 9).

Many of the findings resonated with the leadership themes that had been identified in the literature search. More attention is given in this paper to the energy and time being devoted to deliberately creating networks of conversations (in the sense identified above). Such a creation of networks through managed conversation is less well developed in the literature (exceptions being Ford and Ford 1996, Ford 1999, Price and Shaw, 1998) and under represented in the specific NHS Leadership models reviewed above. Conversation becomes the route to what might be called political awareness or networking ability.

With this in mind, we describe each theme.

4.2 Theme 1 Pride and Commitment

The FMs demonstrated pride in their organisation and their teams, rather than pride in themselves and their attainments. They were modest and self-deprecating. They were surprised by their place in the research group, and were keen to retain their anonymity. They were not to be found on the national circuit talking about their success and their attainments. Their surroundings spoke of an absence of self-aggrandisement, and a need to be accessible. Their 'pride' was an understanding pride. It allowed people within the organisation to be who they were: to see life through their own lens. The FMs acknowledged the contributions individuals made but tempered their pride with an allowance that they and others would make mistakes that were allowable and correctable. However, they were not shy of addressing problems and resolved issues rather than tolerating them. This evidenced their commitment to excellence. They had a desire to win and to be part of a winning team (Bennis and Nannus' 1985).

4.3 Theme 2 Personal Style

The positive self-image and strong ego called for in the literature (Bennis and Nannus. 1985) was evident in the Research Group as was emotional intelligence (Bennis and Nannus, 1985; Golman, 1996) when they spoke of how they managed themselves. Rather than being heroic leaders (Yukl, 1993) they displayed a more facilitating charisma [3] seeing themselves as simply 'doing their job'. They showed definite concern for factors such as fairness, commitment, reliability, integrity and leading by example, thus building up trust over time (Bennis and Nannus, 1985; Clark and Payne, 1997).

The FMs themselves defined leaders as those who took responsibility, could win hearts and minds, and create teams both within FM and across the Trust. They recognised their personal style, and the ability to change it 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 recognised that this could be difficult, and 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 bring on board. The FMs evidenced their willingness to change their approach to accommodate others' needs and ensure their success in winning hearts and minds.

	Theme	Category within theme	Category within theme	Category within theme	Category within theme	Category within theme
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	Loss of direction Mistakes External recognition Loss of pride	Model service delivery to standards required Personal commitment Rewards for 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 factors**	Lucky	Services contracted in or out Site/size/geography	Learning	Innovation	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	**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 Opportunities for change	Financial pressures Value for money/benchmarking Isolation	Change and creativity Benefits of change Managing change
8	**Integration with clinical Teams**	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 Focus on outcomes and results	The PEAT inspection team Organisational culture Disadvantages Organisation of top team Opinions on top team
10	**External perspective**	Major stakeholder Patient Environment	Positive feeling by community Involvement of patients	Commitment to local community	Recruitment National body	Pool to draw upon Patient Choice

Table 2 The themes (in bold) and categories used to code conversations

All the leaders described deliberate Management by Walking About (Peters and Waterman, 1995), creating situations whereby they were accessible, visible and seen to be leading by example. They wanted to be seen as fair, honest and open and liked to know what was going on, and to be seen to be enquiring. This underpinned their conversations discussed in theme 5. They described creating space and opportunity for their teams by delegating work, whilst maintaining a supportive and advisory role. They were prepared, to relinquish formal control if they could produce better results by giving control to others. However, they were clear that the responsibility to deliver the patient environment remained with them, and achieved this through either integrated working or direct line control. There was a genuine commitment to teamwork and a network approach (Bennis and Powell, 2000; Goodwin et al., 2004; Downes, 2005; Lipnack and Stamps 1990).

4.4 Theme 3 Luck and other contributory factors

The FMs tended to attribute PEAT success to factors that were outside their control. They spoke of the estate they managed, its situation, geography or condition. In fact the desk based research carried out prior to this study (MacDonald et al. 2008) contradicted such assertions. It showed that the postulated external influences and Trust characteristics were not common to the sample.

They also described themselves as fortunate to have the freedom to innovate however it is the researchers' contention that such freedom was actually an earned capacity granted by the organisation due to the establishment of the individuals' successful track records. In finding solutions they established an interactive, self-rewarding process; a virtuous circle of trust and success. We see hints of the theories of mood and emotional control (Stodgill, 1948) and again emotional intelligence (Golman, 1996; Digman, 1990; Goldberg, 1993; Hogan and Hogan, 1992; McCrae and De Costa, 1987; Passini and Norman 1966).

4.5 Theme 4 Opportunity for personal development

The FMs expressed commitment to the personal development for all FM staff, whether management or shop floor, NHS employees or contract staff. They were keen to use managers as mentors and coaches and to tap into and build networks and were enthusiastic about their own continued learning. Some had undertaken some recent academic study. They focused their learning efforts on improving their methodologies and their development derived from opportunities to widen their portfolio, rather than being groomed as part of a succession plan. They had moved on from training and were talking the language of learning (Price and Akhlagi, 1999) seeing coaching, mentoring and networking as more beneficial than training courses.

The FMs 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 recognition. They managed the tensions between needing staff on duty and releasing them to undertake learning. Agenda for Change [4] 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 FMs 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 treated as another tool for personal development. One team had developed a unique team assessment process in order to ensure maximum contribution to self-development and the business agenda across their teams. 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 see evidence of the learning organisation (Tran, 1998).

4.6 Themes 5 and 6 Maximising the Contribution from the FM Team and the Contractor's Team

The FMs acknowledged that staff made up a large part of the FM resource and as such were key in delivering the services at the standards required. They 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 (Partnering Agreement at Lawson) or by recognition by the Trust (contractor in attendance at Trust Board at Oliver), or by simply working well together.

The FMs recognised that they needed others to be engaged and involved in their agenda in order to achieve the business aims. 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 FMs valued visibility and accessibility, thus creating opportunities to be approached. The physical manifestation of approachability was evidenced when they took a researcher 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 FM spoke of looking the part by wearing a suit, no matter how hot; the physical manifestation of smartness that was one of the organisation's values. They spoke of the ceremonies they used to celebrate success and loyalty (April, 1999).

The FMs 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 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. The FMs 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). They 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 encourage questions. They also wanted teams to work towards sorting out their own problems before turning to managers echoing Wing's (2005) requirement for a leader of a high performing team to not become a distant person who stated a vision and walked away.

Simultaneously however 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. In marked contrast with the view expressed in some literature about the difference between leaders and manager and whether one role should replace the other (Bennis, 1992; Adair, 2003; Potok, 1972; Alimo-Metcalfe and Alban-Metcalfe, 2004) the FMs made efficient management a base from which to develop leadership. The observation supports Hewison and Griffiths' (2004) call for leadership in the NHS to be one element in a manager's contribution if leadership was not to become a management fad. An example is the interest shown by the FMs in performance systems, and their powerful use of the information falling out of those systems (see theme 8 and 9), evidenced the need for leaders to manage and managers to lead (Fritchie, 1997).

4.7 Theme 7 Stability, Experience and Change

Most of the FMs 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 stories and legends were offered as an explanation of how the Trusts came to be where they were today. Thus the FMs demonstrated how they used personal stories to gain trust and organisational legends as part of the cultural web (Johnson and Scholes 1995). In this way they depicted the need for change and helped the listener understand the behaviours that were needed to support the new culture. In the hands of these FMs, stories and legends became the new rhetoric rather than an underpinning of the old culture.

They viewed the management of change as an essential part of their role, 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 spoke of how the culture of their organisation had been adapted by the top team to allow change to happen freely. This echoes 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 FMs' evidenced their ability to abandon the norms of FM and their motivation to change the system, e.g. the FM from Harriott said 'The NHS is packed with people who say we've always done it this way'. Others gave examples of the opportunities for change within their Trust. Despite their involvement with, and enjoyment of, change they also spoke of the need for stability and the need to retain experience, especially within the top teams.

4.8 Theme 8 Integration with Clinical Teams

The FMs not only evidenced a desire to work within and to create processes and/or structures where none existed, but also an ability to use these to inspire ownership in their staff, thus earning staff a place within the ward or clinical team. Recognising that FM was a service that supported clinical delivery, the FMs saw themselves and their people as an essential 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 FMs working closely with others, for example, Modern Matrons. There is no formal line management relationship between a FM and a Matron, but the FMs saw an opportunity to engage the Matrons in their vision and were prepared to invest time and effort into building the relationship. They evidenced personal credibility that generated respect and allowed a robust relationship with open dialogue among clinical team members. The FMs saw the need 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 priorities on the clinical and corporate agendas. These discussions further demonstrated that the FMs were developing relationships and networks and exhibiting corporate behaviours that built increased trust, rapport, and co-operation (Clark et al., 1960), improving integration with Clinical Teams. Underpinning these behaviours were the methodologies that the FMs 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. The traditional clinical and non clinical boundaries were crossed by the FMs when looking at how clinical and FM responsibilities could best interact together, for example, 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, FMs ensured their own visible involvement and commitment to others' agendas, gaining reciprocal support and buy in for their own agendas.

Formal systems and feedback mechanisms, that worked both laterally across the organisation and vertically from top to bottom of the organization, underpinned such visibility and commitment. The FM's spoke of the mechanisms for reporting that they used to achieve this again demonstrating behaviour that literature tends to assign to a manager rather than a leader (Bennis, 1992). The conversations showed the FMs were concerned with systems and structure and their eye was 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. Information on performance was also used to manage attention (Bennis and Nannus, 1985).

4.9 Theme 9 Integration with the Corporate Agenda and the Top Team

Many of the behaviours and actions 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 FMs understood that there was a need to approach the clinical and corporate agendas (often entwined, but sometimes separate) differently. This difference was often in the language employed when presenting the FM agenda rather than in the content of the agenda. By way of example, the FMs 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 bottom line they had ensured its place on the corporate agenda. Again, we see evidence of the FMs managing attention (Bennis and Nannus, 1985) and speaking the language of the business (Price, 2002). Several FMs reported that their Chief Executive overtly supported the initiative, giving it credibility and standing within the organisation. They spoke of receiving investment and support with difficult situations. The FMs were confident in the direction of their services and alignment with the Trust's corporate agenda.

Integration with the top team stemmed from the FMs gaining the respect of their Top Team for the contribution of FM to the organisation's aims. They had worked at building and maintaining of relationships. This relationship building with top team members appeared to take two forms - firstly through an understanding by the FM 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 to each individual of the FM agenda and consistently reporting on achievement. The FM would then sustain the relationship by offering service developments that would increase standards. Secondly, by understanding who could influence the FM and the corporate agendas. Once the power base had been understood, the FM 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.

The FMs strengthened the integration between the FM and corporate agendas by ensuring that FM objectives were shared by other members of the top team, possibly by allocation through the Chief Executive, but not necessarily so, and by offering a reciprocal arrangement over others' objectives. They found other corporate agendas that were similar and aligned with theirs and used these agendas to bring about improvements in a way that benefited both these and the FM agendas. The FMs were also aware that their agendas competed with other agendas and they ensured financial investment and support by ensuring strong robust, business cases and funding bids that were integrated with the corporate agenda.

Giving respect and understanding to all, including the top team, was important to the FMs. They 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 culture favoured by the top team. They understood the need for cultural fit and for the FM team to work within the organisational context. The literature regarding FMs working within organisational context does not abound, although a reference can be found to the necessity to engage with the human dynamics of the organisation (Price, 2004), and there is perceived to be an relationship between leadership success and the organisation's culture (Alimo-Metcalfe and Alban-Metcalfe, 2003).

4.10 Theme 10 External Perspective

The FMs expressed the need for the community to have pride and confidence in their local hospital, and how they could ensure this by not taking/allowing actions that could damage. They wanted to ensure that the community was on board with the Trust's activities and direction, for example, they participated in community meetings such as the scrutiny committee. The FMs 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 tap into the community for ideas and validation. This evidenced the FMs' 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 allowed the FMs to claim their part in the delivery of the Performance Improvement Framework for Public and Patient Involvement in the NHS (Department of Health, 2003) and further underline the FM contribution to the corporate agenda.

The external perspective of the FMs was more an interest in the local community, rather than an interest in the national arena of the NHS. Some used national networks such as such as the Health Estates and Facilities Management Association, but largely they were not interested in leading the national agenda, becoming involved in a practical way only when it impacted on their Trust. Indeed, FMs 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. This may be to protect their achievements from the glare of publicity, or to avoid the dilution of effort experienced when investing time in the national agenda. Their lack of interest in participating in the national arena echoes the evidence in Theme 1 where FMs were spoke of as rather humble individuals who were modest and self-deprecating. 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.

5 CONCLUSIONS

Having previously found no external factor that could explain the existence of 15 Trusts with consistently exemplary results in three rounds of PEAT assessments (MacDonald et al., 2008) the observations reported above do show consistent 'leadership' behaviours exhibited by those responsible for the patient environment in six of the 15 Trusts. Their behaviours were consistent with the attributes and characteristics of quiet rather than 'heroic' leaders.

The emphasis placed by the FMs on integration and networking (theme 8 and theme 9) was stronger than was evident from the literature review or the current policy guidance. The FMs consistently devoted deliberate and significant time and effort to these activities, recognising that they would be the ones who contributed the most. Relationship building takes time and is a slow process (Barrett, 2000) but the effort ensured FM issues remained on, and became part of, other people's agendas. The study shows that the FMs were concerned, not with creating structures, but with boundary management (Ancona, 1990; Rosenthal, 1997) and the creation of social networks (Downes, 2005) throughout the organisation. These networks had little or no formal recognition and had little accountability as a group. They were multi-layered and predominately made up of collaborating peers (Lipnack and Stamps, 1990). Only a few of the members had responsibility for delivering the objective.

There were two levels to the FMs' activities, not only were they concerned with how they built and maintained their relationships with others, but they strove for these relationships to be mirrored throughout their organisation. Some were prepared to give up day-to-day control of their workforce, accepting all the challenges this would bring, while some created non-formal structures such as geographical zones or joint FM/Nursing cleaning/maintenance schedules. Thus they expressed what they believed, and facilitated lateral solutions to problems. FMs were seen to be interested in and supportive of others' agendas, which elicited collaboration from clinical and top teams.

The FMs evidenced use of the structural hole theory (Rosenthal, 1997) by forming individualistic networks where no existing network existed (Goodwin, 2005). They evidenced the use of a hybrid of networks thus offsetting risks (Goodwin et al., 2004). By using conclave networks between FM and the top team, but hierarchical networks for the PEAT inspection team where status and formal

acknowledgement of technical or clinical skills were important to impress the observers and thus manage attention. These behaviours required high levels of relationship building skills and political awareness.

The FMs focus on integration could be seen simply as having a vision and ensuring that followers are recruited to help deliver this vision; however, this is not easily achieved in the complex arena of the NHS with its multiple stakeholders and agendas. The literature mentions 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 are attributes used by strategic brokers (Heng et al., 2005) when working across the clinical and corporate agendas. This ability to be an effective strategic broker is where the FMs were using their leadership characteristics and attributes identified in the ten themes to best advantage.

We do not talk here of networks which are used to 'drive' people towards an organisational vision that has been shared from the top. The FMs spoke 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). The networks that the FMs created were spun with a web of quiet, consistent conversations, reinforced with the tantalising glitter of symbols (e.g. models of integration which gave nurses control), decorations (e.g. long service and training awards), stories (e.g. information shared with more junior staff about their own experiences and difficulties) and legends (e.g. stories of senior staff who had performed badly and the fate that had befallen them), and taking place between leaders (e.g. FMs and modern matrons) and between leaders and followers (FMs and their staff). The FMs 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 (e.g. with clinical teams) at advantageous times (e.g. reward events for FM staff, or in meetings to discuss others agendas) to catch the juiciest of flies (e.g. members of the Top Team who had the most power and influence). When they were sure of having created an 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).

Evidence of the FMs ability to manage meaning and attention occurred throughout the conversations and the analysis particularly highlighted this in themes 5, 6, 8 and 9. This skill meant that FMs managed conversations in order to ensure that their vision caught the attention of their staff groups, 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. The FMs were working as brokers both laterally and vertically within their organisations. The literature search around networks showed that a key skill of the broker was communication (Boje, 1991), and we were interested in the view (April, 1999; Ford and Ford, 1995) that communication itself brought about the change, rather than change being decided upon and then communicated. 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 who spoke of dialogue methodology (Varney, 1996; Harris and Barnes, 2006) being used at a team meeting where FM staff were encouraged to make suggestions and discuss and resolve problems.

6 LIMITATIONS

Whilst there is evidence that the FMs affected the performance and thus the productivity of their teams, this study could not examine the wider organisational context, e.g. the relationship of the FMs with the top teams and with the clinical teams. It remains possible that attributes of particular Trust cultures permitted the behaviours noted to flourish.

The research finds commonalties between the behaviours and actions of successful FMs, but does not show these as unique to this group. Comparisons between these and less successful FMs may prove beneficial.

The use of the PEAT initiative as a criterion for high standards of patient environment may have limited the research to already accepted views. It is possible that they reflect the organisation's view rather than the expectations of particular groups of patients. The sheer logistics of researching the public's view on the PEAT made using any other criteria in this study impractical.

There was a gender imbalance in the study with only three female participants, all at the same Trust. It is not clear how or whether this biased the findings, or whether it reflects the broader NHS population from which this study was drawn.

The use of one researcher for the research may have allowed a bias in the work, although it is believed that the professional FM expertise of the researcher would compensate for this.   Two senior academics worked closely with the researcher throughout the study and were involved in the analysis and writing up.

7 IMPLICATIONS AND FURTHER RESEARCH

The study did find common leadership behaviours in the Trusts to which we were granted access. It also shows the apparent role of adaptive conversations (Price and Shaw, 1998; Price and Akhlaghi, 1999) being used to create networks through which 6 successful teams were, in their own ways, delivering excellent environments. It leaves open the question as to whether there was some other commonality in the Trusts examined, as for example the role of the CEO or Chairman. It also leaves open the question of possible barriers to such behaviour in other trusts or in common FM practice.

8. ACKNOWLEDGMENTS

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1 For readers unfamiliar with the organisation of the UK's public health service 'Trusts' are independent organisations introduced with a quasi market in the 1990s. Acute trusts essential manage general hospitals. For more detail see
http://www.nhs.uk/aboutnhs/howthenhsworks/pages/nhsstructure.aspx

Trusts have not however had to become fully commercial. The relative lack of managerial and policy concern for the Patient Environment might surprise a North American reader.

2 The Leadership Centre worked with leaders at all levels within the NHS, from front line leaders to those in the most senior positions.

3 Charisma being the capacity to inspire followers with devotion and enthusiasm (Concise Oxford Dictionary)

4 The NHS national job grading system