Facilities management in the NHS: overlapping authority and demarcation disputes

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Abstract

Purpose

The research aimed to investigate the implementation of the new ward housekeeper role a hospital setting. The outcome was to propose a model to demonstrate how FM departments and clinical ward teams work effectively together to deliver catering and cleaning services.

Methodology

The context of the implementation of the role was deemed a necessary feature, particularly to understand the organisation structures. In this case the context being a hospital and the underlying mechanisms in place such as local recruitment and retention issues. Therefore an interpretive approach was taken and a series of semi-structured interviews were the primary method to collect data, supplemented by some non-participant observation and document analysis.

Findings

The findings from the two themes enabled the development of a model to illustrate the working relationships between FM departments and clinical ward teams.

Practical implications

The findings from the study are of significance for hospital facilities and estates departments and clinical stakeholders who have a responsibility for ward catering, cleaning and the environment.

Originality/value

The significance of this study emerges through the advancement of methodology within the context of facilities in healthcare and through the contribution to knowledge and practice as a result of the proposed mode. This was the first type of study to look in detail at ward housekeeping models, using an interpretive approach over a relatively long period of time.

Keywords

Facilities management, hospitals, ward housekeepers, power, authority, NHS

Research paper

Introduction

Understanding general management theory and academic writing on the related issues of power, conflict, overlapping authority, line staff and functional relationships appears to be a neglected area in facilities management (FM). Using a ward housekeeper (a multi-skilled domestic and catering role) in the UK National Health Service (NHS) as a focus, the series of case studies presented in this paper suggest how the relationship between the FM directorate and core business - in this case healthcare - is an important operational consideration.

The last twenty years have seen the relative importance of non clinical healthcare factors grow in prominence with the general public. The publication of the NHS Plan (Department of Health, 2000) raised the profile of FM in the NHS. The consultation process prior to the NHS Plan saw the public rank cleaning standards and catering as concerns. The NHS Plan had a chapter dedicated to healthcare facilities and estates which outlined the commitment to clean hospitals and improving hospital food. The two areas were subsequently co-ordinated by the Department of Health through the "Clean Hospitals" and "Better Hospital Food" initiatives. A poll by the British Medical Association (BMA) verified the findings from the NHS Plan consultation. Their survey asked 2000 patients to rank 10 NHS spending priorities. Clean hospitals came out on top when ranked by the public. The quality of food was ranked 9th out of 10 priorities (improved accidence and emergency and shorter out-patient waiting times were respectively ranked 2nd and 3rd).

As part of the Clean Hospitals initiative a number of policy documents and guidance followed from the Department of Health, *National Standards of Cleanliness* (NHS Estates, 2001), *Winning Ways: Working together to reduce Healthcare Associated Infection in England* (Department of Health, 2003a), *Standards of Cleanliness in the NHS* (Department of Health,2003b), *A matron's charter: An action plan for cleaner hospitals* (Department of Health, 2004a), *NHS Healthcare Cleaning Manual* (Department of Health, 2004b) and *Towards cleaner hospitals and lower rates of infection* (Department of Health, 2004c). The Better Hospital Food initiative saw less

documentation and guidance but did result in a new NHS menu, 24 hour catering service and the introduction of the ward housekeeper role.

The idea of a multi-skilled worker was not a new concept and had been implemented in other NHS hospitals since the mid-1990s (Akhlaghi & Mahony, 1997 & Mahony *et al*, 1997). The NHS Plan formalised the multiskilled worker role as a "ward housekeeper" and set targets against the implementation - 50% of hospitals to have the ward housekeeper in place by 2004. To help hospitals the Department of Health introduced guidance on the role and some underlying principles:

- Ward sisters will manage the ward environment, supported by the Ward Housekeeper.
- Ward housekeepers must be ward based, and must be seen as part of the ward sister's/charge nurse's team.
- Ward housekeeping teams must be multi-skilled and flexible in their work practices.
- Patients must be involved in setting up and evaluating the service.
- There must be commitment from Trust management.
- A system of continuous quality improvement must be in place.

(NHS Estates, 2001a)

An early review of the role in an acute ward setting (May and Smith, 2003) and in a mental health ward (May and Suckley, 2005) found themes connected to the recruitment of ward housekeepers, induction programme, training, integration and management to be important considerations in the successful implementation. Furthermore the flexibility of designing the role to meet specific care needs or organisational requirements was also a significant factor in enabling the ward housekeeper to be effective.

The aim of this research was to review the ward housekeeper role, specifically focusing on the implementation in hospitals and the variation of models adopted based on the guidance produced by the NHS Estates (NHS Estates, 2001a). The research was to assess the impact of the role, primarily focusing on patient care and soft FM (cleaning and catering). In addition the research also investigated the issues of migration of ownership and resulting tension between ward/nursing teams and FM departments.

In considering the relationship between FM directorates and ward departments, this paper presents a model which suggests how both can work together to deliver, via the ward housekeeper, effective housekeeping services. In doing so it extends the knowledge on how departments can effectively deliver patient focused services. In addition the proposed model in this paper can be used during negioations between FM and clinical directorates when implementing new projects.

Literature review

The central research question for this study was to investigate the ward housekeeper role and evaluate its implementation longitudinally. As an applied research study, the theoretical framework is substituted by one which outlines the conditions for implementation of the ward housekeeper role. The ward housekeeper guidance issued by the Department of Health (NHS Estates, 2001a) provides this framework. However the underpinning themes of power and organisational structures provide some useful context to the study and are discussed below. The concept of power within the work environment is difficult to define and measure. It can be viewed in multiple ways. Power has been defined "as the capacity of individuals to overcome resistance on the part of others, to exert their will and to produce results consistent with their interests and objectives" (Huczynski and Buchanan, 2007, pg. 701). Power can also be exerted by groups, sections, departments and organisations over others (Dahl, 1957).

As an abstract concept, there are multiply ways in which power can be viewed. Power can be viewed as property, with three further sub-sets: power as a property of individuals; power as a property of relationships; power as an embedded property of structures (Huczynski and Buchanan, 2007). For this study, the concept of power in the organisation is perhaps most relevant when viewed as groups or departments exerting power over others. The complexity of NHS hospital support services, and particularly the ward housekeeper role which is often simultaneously managed by different departments, suggests that power struggles between departments will be evident.

Conflict is a large area of study within the field of organisational behaviour. Conflict can occur within various contexts (e.g. political, economic, social and psychological) and at different levels (e.g. personal, domestic, organisational, communal, national and international) (Huczynski and Buchanan, 2007). It could be argued that the pluralist reference frame for conflict (Fox, 1966; Fox, 1973) is the best fit for the NHS organisational structures. In terms of conflict, pluralist organisations are a collection of groups, each with their own interests. Some of the time the interests of the groups will coincide, at other times they will clash and cause conflict. The study of the ward housekeeper role involves conflict through pluralist organisational behaviour in that FM departments, ward teams, senior staff and even patients will have differing interests that will inevitably lead to disagreements and clashes.

When looking at the ward housekeeper role, the idea of overlapping authority is closely associated to conflict. For example, the ward housekeeping models show that the housekeepers routinely report to multiple departments (NHS Estates, 2001a). Demarcation disputes will cause difficulties. Ambiguity over responsibility or authority is an example (Huczynski and Buchanan, 2007). Earlier housekeeping studies (May and Smith, 2003) have shown that staff were relatively clear about lines of responsibility. In spite of this, there is the potential for groups to fight for the control of a resource (e.g. the ward housekeeper role) and individual departments and managers may attempt to gain ownership from one another. The notion of authority and line staff relationships is also relevant for this study. The concept of authority is important and is widely used in management literature. Authority is the right to give orders and the power to extract responses in order to achieve the organisational goals (Pugh, 1971; Greenberg and Baron, 2003). Authority is also a complex issue and widely discussed in relation to power, gaining compliance and political theory (Carter, 1979; Weightman, 1999).

In the context of this study, in order to help understand authority and power, it is useful to review the literature on the structure of facilities management departments and support services. Attempts to define the scope and organisational structure for facilities management departments are difficult (Then, 1999; Nutt, 2000). Facilities management is often described as a hybrid discipline that combines people, property and processes to support the built environment functions of an organisation. The level of responsibility and degree of autonomy provided to the facilities department, in addition to the level of support they receive from the organisation, will determine the impact and added value they can have on the core business (Alexander, 1996). Furthermore, the facilities dimensions and physical environment should be reflected in the organisation's strategic business plans (Then, 1999).

Due to the hybrid approach, the diverse nature of facilities management, and the wide scope of organisational settings that the function supplies, it is relatively difficult to construct a definite model for FM services. This is reflected in the lack of research conducted in this area. There are available models for holistic workplace, corporate PFI and total infrastructure provision that include facilities departments (Varcoe, 2000). Yet no models include a detailed look at how facilities departments should be structured or organised.

Despite the lack of work on the organisational structures for FM departments, Cotts et. al. (2010) proposes a number of areas to consider including the size of department; single versus multiple locations; outsourcing arrangements; centralised versus decentralised control; and property ownership versus leasing. They also recommend facilities departments can be put into models based on the size of operations ranging from a single office manager to a fully international model. Their public works model is perhaps most suited to that of a NHS hospital. These are unique bodies which include everything required to maintain a large organisation. They support the public by ensuring infrastructure and facilities are planned, funded, constructed, operated and maintained in a cost effective manner. The work by Cotts et. al. (2010) and Barrett and Baldry (2003) provide a useful discussion on facilities management models in different organisational settings, and offer a case study to demonstrate each type. Barrett and Baldry (2003) in their analysis of the public sector model provide the following:

> *"…. public sector case studies emphasise situations where policy decisions and processes are influenced by powerful factors which are often of a non-financial nature but relate to standards of public service provision, public probity and accountability, and the need to meet the expectations of a diverse and influential collection of stakeholder interests. Organisational change is an endemic feature of contemporary public sector organisations as they seek to respond to a broad range of dynamic environmental forces."*

(Barrett and Baldry, 2003, pg. 7)

The example provided for a public sector model is that of an NHS care trust that had responsibility for PFI and strategic project management, property and estate development and hotel and estate operations. They conclude the case study by discussing how the department had transformed their facilities strategies to be more closely aligned with the organisational objectives and core business. The concept of "visibility" of the facilities services with the core business was also alluded to. This is important to enable facilities departments to show they contribute in other ways that are not just financially driven. Previous work on ward housekeepers (May and Smith, 2003; May and Suckley, 2005) and work looking at the contribution of facilities services in the NHS and the impact on patient outcomes (May and Pinder, 2008) support this.

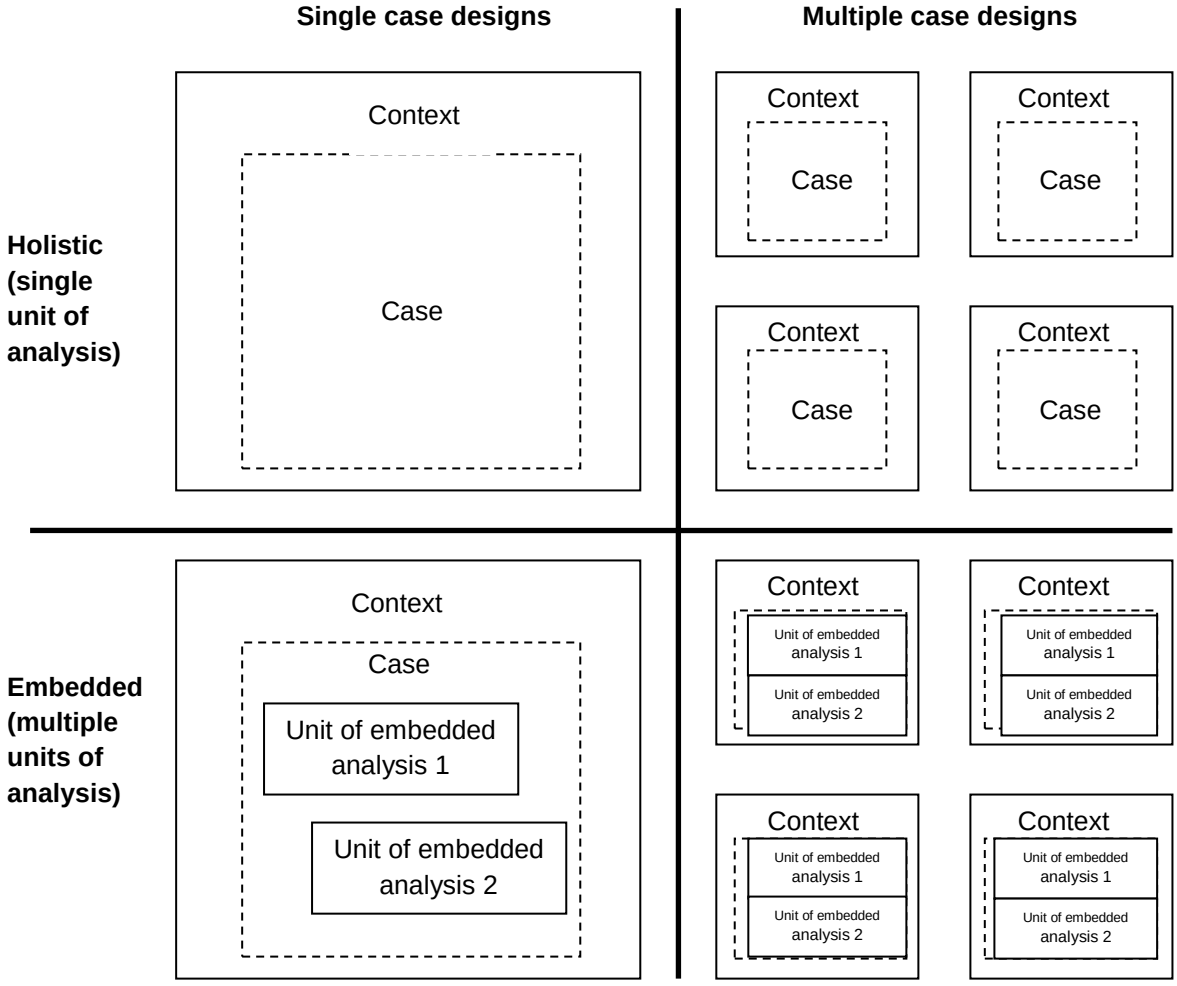
Methodology

The research aimed to understand the new ward housekeeper role from the perspective of senior facilities and estates staff, NHS ward nurses and the ward housekeeper. The context of the implementation of the role was also deemed a necessary feature, particularly to understand the organisation structures. In this case the context being the NHS hospital and the underlying mechanisms in place such as local recruitment and retention issues.

Studies adopting an interpretive approach are widespread in the NHS. Social sciences and the study of social phenomenon is important in the NHS. The staff resource in the NHS is one area that is often studied using an interpretive approach (for example Morley and Petty, 2010; Sauer and Anderson, 1992;) or user involvement with services (for example Williams et. al., 2003; Trivedi and Wykes, 2002; Curtis et. al., 2004) and quality/systematic reviews (for example Donovan et. al. 2002; Dixon-Woods and Fitzpatrick, 2001; Kalso et. al., 1997). Using qualitative research in nursing studies is also not uncommon. Qualitative research adopts a person-centred and holistic approach. This helps develop an understanding of human experiences which is important for health professionals who focus on caring, communication and patient interaction (Holloway and Wheeler, 2010).

A case study methodology was adopted for this study. The case study methodology concentrates on a specific entity or phenomenon that has identifiable boundaries. The entity taken as the case should normally be studied in its natural setting, using a holistic approach and employing multiple methods (Stake, 1994; Hakim, 1987; de Vaus; 2001). The case can be confined to one example (single case study). Alternatively multiple case studies can be used to highlight a common but different experience and then lead to an explanation of these differences. The case study for this research was that of the new ward housekeeper role. This research used multiple cases to explore the differences between hospitals. The boundaries for each of the multiple case studies were the individual NHS Hospital Trusts - or in some cases individual units or wards in NHS hospitals, this was dependent on the scale of implementation of the ward housekeeper service. Yin (2009) summarises case study design into four different types based on a 2 x 2 matrix. As already discussed above, he makes a distinction between single case study designs and multiple case study designs. He then further suggests that case studies can either be holistic or include embedded units of analysis. This results in potentially four different case study designs. These are illustrated in the figure below.

Figure 1 - Basic types of designs for case studies (Yin, 2009, pg.46)



For this study, the case study design was based on the holistic multiple case with single units of analysis - i.e. in the top right quadrant of the matrix. This is where the same study contains more than a single case. The evidence suggests that multiple cases are regarded as more robust (Herriott and Firestone, 1983).

The primary methods to collect the data were through semi-structured interviews, a review of documents (for example job descriptions for the ward housekeeper) and some observational work alongside the ward housekeeper. Face-to-face semi-structured interviews were undertaken with staff in each of the selected wards. Interviews were conducted with ward housekeepers, ward managers, health care assistants and nurses. Semi-structured interviews were also undertaken with the facilities director, hotel services manager and housekeeping manager at each trust. Where the NHS hospital contracted out hotel services, including housekeeping arrangements, a representative from the supplier/partner was also included in the interview schedules. The selection of NHS Hospitals as case studies for the research was based on the replication approach (Yin, 2009). The study used the NHS Estates Ward Housekeeper guidance as the framework to select cases based on contrasting conditions and environments. Table 1 below shows the case studies, type of hospital/trust and some notes on the main characteristics of the housekeeper role or housekeeping services. The table also illustrates the type of housekeeper for each case study.

Table 1 - Summary of Case Study selection

Case Study	Hospital Type	Main characteristics of housekeeper	Type	Location
1	General	Mainly catering related work, but also responsible for the laundry cupboard, replenishing stores and general tidiness.	Basic ward housekeeper	Yorkshire (Town)
2	Acute	Purely catering work i.e. ordering and serving patient meals and the clearing of the crockery and cutlery afterwards.	Basic ward housekeeper	East Midlands (City)
3	Acute	Supervisory role, responsible for overseeing all non-clinical work on the ward.	Basic ward housekeeper	Yorkshire (City)
4	District	Serving meals, cleaning and tidying the ward, making beds.	Basic ward housekeeper	South West (Town)
5	Community	Mainly catering related duties such as ordering and serving patients meals. Some general work such as bed making and checking linen trolleys	Basic ward housekeeper	East Anglia (City)
6	Acute	Mainly focused on cleaning the ward, however they are responsible for serving hot drinks.	Basic ward housekeeper	East Anglia (Town)
7	Mental Health and Learning Disabilities	Using housekeepers in acute/long stay in-patients wards and community extended care units.	Ward housekeeper in mental health environments	North East (City)
8	Community and Mental Health	Using ward housekeepers in acute adult inpatient wards and elderly mental illness wards.	Ward housekeeper in mental health environments	East Anglia (City)
9	Primary Care	Using a single ward housekeeper on an adult inpatient mental health unit.	Ward housekeeper in mental health environments	Midlands (Town)
10	Support Service Organisation	The Trust has a children's and adolescent inpatient unit which has one housekeeper.	Ward housekeeper in mental health environments	North Yorkshire (Town)
11	Acute	Large acute hospital Trust - approx. 900 beds. Implemented SWHs 2 years ago, including in the A & E department.	Development of the senior ward housekeeper role	South East Coast (City)
12	General	General hospital Trust - approx. 500 beds. Operating 2 parallel housekeeping models.	Development of the senior ward housekeeper role	Midlands (Town)
13	General	General hospital Trust - approx. 500 beds. Implemented SWH 2 years ago across 85% of the Trust.	Development of the senior ward housekeeper role	Midlands (Town)
14	Acute	Same as case study 11 - repeated as part of the evaluative, longitudinal study.	Evaluative longitudinal case study	South East Coast (City)
15	Acute	Same as case study 3 - repeated as part of the evaluative, longitudinal study.	Evaluative longitudinal case study	Yorkshire (City)

Findings

The findings from the study led to a set of themes identified. The original key themes as central issues for the implementation of the ward housekeeper were: Role; Recruitment; Induction; Training: Integration; and Management (see May and Smith (2003) and May and Suckley (2005)). Later case studies, including those that were included as part of the longitudinal repeat visits, suggested other issues that became apparent over a longer period of time. The initial case studies 1 to 13 were conducted over a three year period. The later case studies as part of the longnitudinal visits were completed six years later.

Two of the new themes are discussed below. The findings from the two themes enabled the development of a model to illustrate the working relationships between FM departments and clinical ward teams. The new model is presented in the Discussion section.

New theme one - A developing tension between FM and ward staff

The original set of case studies revealed a tension, borne out of nervousness and a lack of understanding of the new housekeeper role. The apprehension was from other support staff, for example domestics / catering assistants and from nursing auxiliaries. These groups of staff perceived a threat to their role, position and standing within the ward dynamic.

In the hospitals where they had implemented a new housekeeper role, as opposed to those who attempted to re-badge existing domestics, the FM departments reported dedicating much of their time during the project planning stages to communicate the changes as a result of the new role. The aim of this was to alleviate any fears or concerns from staff who may have felt threatened.

The original key themes did allude to the planning put in place to combat the tension between existing staff and new housekeepers. For example, clear management lines needed to be established to avoid confusion and involving all stakeholders. Effective communication with clinical and non-clinical staff was cited as important, although it may sound obvious, some hospitals neglected to involve the necessary staff during the planning and integration of the housekeeper role. One hospital used the idea of a "buddy" system to help integrate housekeepers within the ward teams.

Any original animosity felt towards the housekeepers from other staff was not reported by participants during the later case studies used to evaluate longitudinally. One potential explanation was that staff no longer viewed the housekeepers as new or novel and over a period of seven years had fully accepted them into their respective teams. They had become part of the fabric of the ward team and through integration had found a role within the service.

Instead, there was however, a new tension. This time it was not centred on the actual role itself, but because of the role. The two later case studies illustrated an undercurrent of tension between ward teams and the FM departments, both for different reasons. For example, one Modern Matron, who was a key proponent of the housekeeper role, was unhappy at their lack of involvement during the recruitment of housekeepers. The Modern Matron had originally been a member of interview panels and had an interest in "getting the right person for the job." They were no longer involved at this level. The Domestic Services Contractor and their on-site management team were responsible for recruitment and once appointed would take new housekeepers to meet their Modern Matron. This was causing resentment. At the same hospital there was further strain put on the relationship between ward teams and FM department over requests made to the housekeepers which were not included as part of the SLA. Housekeepers reported feeling "in the middle" as a result of requests made by nursing staff to complete work that fell outside of the SLA. They also had a sense of obligation to their employers - the Domestic Services Contractor - who had a commercial arrangement with the hospital.

Another case study revisited for the study revealed a tension between the ward teams and the FM department due to a different set of circumstances. Participants reported that the housekeeper role had been fully embraced on the wards where it had been implemented. This appeared to be a combination of strong clinical leadership from the Modern Matrons who had demonstrated a commitment to the role and also a clear direction from a Facilities Director who had a passion and vision for housekeepers. The success of the role had lead to the ward teams taking full ownership of their respective housekeepers and starting to recruit new staff without involving the FM department. Representatives from the FM department and Domestics services were uncomfortable with this and considered they had an important part to play during the recruitment of new housekeepers. They could provide FM related advice and specialist knowledge that ward teams were unqualified to do.

To conclude, the longitudinal nature of this study had uncovered a sense of tension. This had shifted from a tension from existing staff towards individual housekeepers. The new tension was as a consequence of the role and a potential power struggle between the ward teams who manage housekeepers on a day-to-day basis and FM departments who had an advisory role to play.

New theme two - Lack of national support and co-ordination

Not long after the national implementation of ward housekeepers there was a major and significant (for the discipline of facilities and estates in the NHS) change in how facilities and estates was co-ordinated at a national level by the Department of Health. NHS Estates was the arm's length body (ALB) and executive agency representing the Department of Health responsible for co-ordinating policy and implementation of projects related to facilities, estates and the environment in the NHS.

The aim of this study wasn't to focus and discuss the national situation. However, it did provide an important context to the study and worth reflecting on for future developments. In at least one of the case studies, FM departments and Hotel Service teams were concerned at the situation nationally.

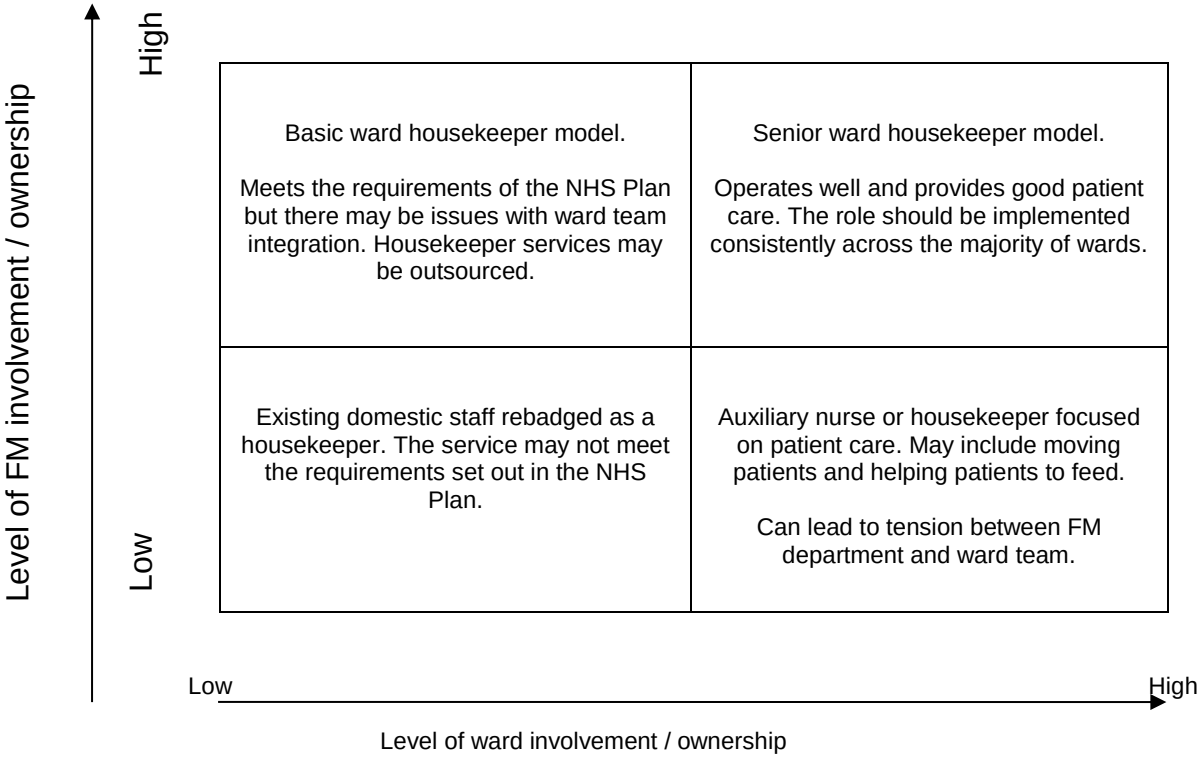
The NHS Estates were responsible for overseeing the implementation of the housekeeper project and supported hospitals during this period. The ward housekeeper project was widely acknowledged at the time to be a success for the agency. During the original implementation period, training events, conferences and workshops were organised, along with the publication of the Housekeeping Guide (NHS Estates, 2001a) to support hospitals. As part of the review of ALBs, the NHS Estates was abolished in 2004. Since then there has been relatively little attention given at national level to the ward housekeeper project. For respondents in one of the case studies the problem centred on the lack of guidance, training events, career structure and general national level support for the housekeeper initiative.

Arguably without a national invention to support or act on behalf of FM departments for the cause of ward housekeepers, then there is a danger of seeing the role fragment. This was already evident in one case study where the success of the project had lead to the ward teams fully embracing it and therefore excluding the FM department from decision making. There was also the risk that hospitals would move away from the original role description and develop new models without any involvement from FM departments.

Discussion

The discussion section proposes a model to show the level of involvement from FM departments and ward teams when managing the housekeeper role. This is based on the initial six key themes (Role; Recruitment; Induction; Training: Integration; and Management) and the two new themes presented above. This model is untested, but does provide the opportunity for future research. In addition, as the model is yet to be tested, it cannot be proposed as best practice. Instead, Model A is a template which NHS hospitals may wish to consider when either implementing the housekeeper role or re-designing their existing services. The model interprets the various case studies and summarises the level of involvement from the FM departments and ward teams in relation to the ward housekeeper role. It also draws upon literature already discussed in the theoretical framework. The areas of power, conflict and overlapping authority are relevant for the suggested model. Power, in the sense of how groups and departments exert power over others (French and Raven, 1958), in this case primarily the FM department and ward team. Conflict is relevant for Model A as NHS Trusts are pluralistic organisations (Fox, 1966; Fox, 1973) and consist of a collection of groups with their own interests. The concept of overlapping authority is also evident in the model which leads to demarcation disputes (Huczynski and Buchanan, 200&). Model A is illustrated below in figure 2.

Figure 2 - FM department and ward team involvement in ward housekeeper services: a proposed model (Model A).



Where there has been low involvement or ownership from FM departments and a low level of engagement from wards then the housekeeper is placed in the bottom left segment of the model. Hospitals operating in this area may encounter poor integration of their housekeepers into ward teams. One of the case studies demonstrated where a hospital had rebadged an existing domestic role. Here the reported integration into the ward teams was poor. Another case study showed where a lack of engagement from the FM department had lead to inconsistent housekeeping models being implemented across the hospital. The housekeeping staff in this case study were not dedicated to any one ward, which could also impact on integration. Arguably ward housekeepers implemented in this situation do not meet the requirements of the role and are little more than a rebadged domestic.

Hospitals that had low levels of engagement from FM departments but high levels of engagement from ward teams will have their housekeeper role situated in the bottom right segment. A housekeeper role reflecting the characteristics in this type of environment may be closer to a typical healthcare assistant or nursing auxiliary. The housekeeper may still undertake and be responsible for the tasks suggested in the NHS Estates skill mix - food, cleaning and maintenance. It is also likely that the ward staff or teams will ask them to do other duties that are not classed as "non-clinical." For example: - moving patients, helping patients to feed and taking patients to the toilet. Hospitals using housekeepers in this segment may see their model move away from the original guidance set out by the NHS Estates. Furthermore, as the involvement from the FM department is relatively low, there may be tension and conflict created between the FM department and ward team regarding the housekeeper role. This can be seen in one case study where the involvement from the FM department was not low - in any absolute manner - however it was relatively low compared to the involvement from the ward team. This had led to a tension between the two after ward teams starting to ask their housekeepers to undertake work that was considered to be of a clinical nature. The ward teams were also starting to recruit new housekeepers without involving the FM departments, again leading to tension.

The segment in the top left hand corner of the model shows a hospital where the level of involvement from the FM department is relatively high and the involvement from the ward teams is low. Hospitals implementing ward housekeepers within this environment do meet the requirements set out in the original guidance set by NHS Estates. The housekeeper role may have been successful, yet due to the relatively low involvement and engagement from the ward teams there might have been problems with integration. It is also likely that in these circumstances, there is less management from ward teams on a day-to-day basis. The housekeeping services in this example may be outsourced to a third party, therefore SLA arrangements in place and a less flexible approach to the services provided by the housekeeper. There may also be less scope to change the role or add additional services in the future. An example of this in one case study was a lack of commitment from some

wards resulted in only a partial integration of housekeepers. The role was also poorly communicated to ward teams which did not help. Another case study in which the housekeeping and domestic services were outsourced at this hospital, the day-to-day management of the housekeepers were conducted at ward level, yet issues surrounding recruitment, training and induction were handled by the contractor. Any strategic decisions made related to the housekeeper role were the responsibility of the hospital's Facilities team leading to a complex management arrangement.

Model A proposes that the optimum place for the ward housekeeper role is in this top right segment. This is where the level of involvement and engagement from both the FM department and the ward teams are high. This should be hospital wide, and the housekeeper role implemented consistently across the whole organisation. There should be commitment from both FM departments and ward teams, yet no one stakeholder should dominate thereby making the other a relatively low engaged partner. Although not explicit in the NHS Estates guidance, the concept of a "senior ward housekeeper" role had demonstrated good practice (May and Suckley, 2005). This was illustrated in one case study where the FM department were responsible for overseeing the implementation of the new role. Following this the day-to-day management of housekeepers had been taken by ward sisters and modern matrons. The housekeeper worked at a "senior" level and had a group of domestics and ward catering staff they viewed as part of their team. The hospital in this case study had also implemented the senior ward housekeeper across the majority of their wards, including within A&E.

Conclusion

The significance of this study emerges through the advancement of methodology within the context of facilities in healthcare and through the contribution to knowledge and practice as a result of the proposed model A. This was the first type of study to look in detail at ward housekeeping models, using an interpretive approach over a relatively long period of time. 15 in-depth case studies were completed to construct a representation of the ward housekeeper role across the UK since its introduction from the NHS Plan. Such a study had not taken place.

The study was also important due to the growing emergence of the need for NHS facilities and estates departments to demonstrate their contribution to health outcomes - i.e. their value to patient care. There is a case to make that the food and cleaning services are the two areas where the facilities departments in NHS hospital can really make a difference to patient care. The ward housekeeper plays a crucial role here. Therefore, by understanding in better detail and greater depth how the role should be designed and implemented, it gives facilities departments in the NHS a way to understand where they can make a difference to patient care.

Methodologically, the study was important as it was the first of its kind to apply an interpretive approach to investigate the ward housekeeper in the NHS. There have been other studies looking at the role (Clark, 1999; Akhlaghi and Mahony 1997). However these have been either mixed methods - with a focus on measuring impacts through quantitative based work - or practice based designs. The size, scale and interpretive nature of this work make it unique. Much of the evidence comes from the development of the role over a relatively long period of time. Without this some of the significant findings would not have been discovered.

The findings from the study are of significance for NHS facilities and estates departments and clinical stakeholders who have a responsibility for ward catering, cleaning and the environment. The original set of case studies provided important guidance and best practice related to the role, management, recruitment, induction integration and training. The later case studies raised awareness of the involvement/engagement between FM departments and the ward teams. This is demonstrated in model A. The ability to generalise the findings to a wider population is limited. However, the findings can instead be generalised to other settings - i.e. the best practice can be applied to other NHS hospitals.

Could the findings have wider implications in the discipline of facilities management? Arguably model A - which demonstrates the involvement/engagement between FM departments and the core business - could be applied outside of the healthcare context. In organisations where FM departments need to demonstrate their contribution to the core business or the impact on the organisational goals, once contextualised, model A is potentially a framework that would help them achieve this. Model A can also be contextualised in some of the wider management literature, for example the ASQ customer satisfaction work. In addition, overall the study mirrors the ASQ continuous improvement four step quality model - plan-do-check-act (American Society for Quality, 2012).

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