Outsourcing as liberation: the case of hotel services in the NHS

Mabel Joshua-Amadi

Harrow Business School

Outsourcing as liberation: The case of hotel services in the NHS

A thesis submitted to the University of Westminster

For the degree of Doctor of Philosophy

January 2008

Mabel Joshua-Amadi

Harrow Business School

University of Westminster

ACKNOWLEDGEMENTS

All glory, honour and gratitude belong to my heavenly Father for His mercy and grace that guided, protected and sustained me throughout the years of studies and favoured me to complete another academic endeavour.

This thesis would never have been written without the belief, support and encouragement of my supervisors, ALISON RIEPLE, who stood by me through the stormy waves of higher academic studies and RICHARD HARDING, whose patience and persistent effort enabled me to complete it. I also thank KATHY TYLER, who introduced me to and taught me the basics of social research and ADRIAN HABERBERG, whose constructive, insightful and timely comments and recommendations helped me to recast the thesis into what proved to be a more appropriate theme and an enjoyable journey of discovery. Thank you all.

However, without the assistance and willingness of the contributors from the different trusts, whose views and perceptions form the basis of this study, it would not have been completed. Therefore I thank all the people in the different hospitals who gave their time and made the effort to contribute ideas, stories and wit in making this work a reality. My gratitude also goes to all the staff in the various administrative departments and resource centres who helped me find things and generally smoothened my path on this journey of discovery to make it an enjoyable and pleasant one. Among them, I thank Catherine Ossei especially for her moral support, encouragement and prayers. My special thanks goes to my family and friends who also encouraged, supported and endured the days of seclusion for reading, writing, editing or studying that are the essence of serious academic pursuit.

Finally I thank all the teachers that the Lord has used over the years to bring me to this level of academic endeavour, my first principal, M.F.V. WALL, my dear teacher, EDNA WHITEHOUSE and my special Teacher, instructor, guide, mentor, motivator, encourager, counsellor, champion, reminder, helper and great comforter— a very special thank you.

DEDICATION

This thesis is dedicated to the memory of my beloved mother, HULDAH AMADI, who believed in me when no one else would. You prayed us into the kingdom and struggled to get us all educated in our chosen fields of endeavour. Mama you succeeded—thank you

THESIS ABSTRACT

This thesis investigates and compares how the people directly involved in different levels of hotel services outsourcing relationships structure their experiences. The thesis is based on the perceptions of those directly involved in the outsourcing interaction between the private commercial services providers and their public sector clients. The research is informed by literature from outsourcing, resource acquisition theories, Transaction Cost Economics, interaction relationship model and structuration theory. The study describes eight exploratory case studies from selected NHS trusts in the Greater London area and explains the themes behind the structured experiences of those directly involved in these public-private sector outsourcing contractual relationships.

The thesis contributes to our understanding of interaction and relationship model but takes its point of departure from networks to extend its focus from reducing transaction costs and safeguarding investments to adding value through learning and innovation. The thesis also extends our knowledge of structuration theory from a sensitising device and a theory of action to a theory of liberation through the power of agency in using resources for change. The study also suggests areas where public-private sector management theory could be refined for mutual benefit. It demonstrates the validity of resource acquisition theories and services outsourcing framework and the suitability of interaction model and the relational aspect of Transaction Cost Analysis as governance frameworks. The thesis also proposes a wide range of future research agendas to compliment the work done here.

RESEARCH QUESTION

How do the key people involved in the hotel (support) services outsourcing relationships structure their experiences?

DISCLAIMER

All the names of place, people, hospitals, cases and companies used in this thesis are anonymous and fictitious. Any similarities or relationships to known places, people, cases companies or organisations are purely coincidental. All the data used in this study are confidential and non-attributable to any contributor. This is in accordance with the University's Code of Practice Governing the Ethical Conduct of Investigations, Research, Demonstrations and Experiments and the Code of Research Good Practice 2007/2008.

TABLE OF CONTENTS

LIST OF ABREVIATIONS

CABE	Commission for Architecture and Built Environment
CBP	County Borough Partnership
CH	County Hospital
CMH	Charlston Memorial Hospital
DMH	Dickson Memorial Hospital
FH	Featherstone Hospital
FM	Facilities Management
IM	Interaction Model
ISO	International Standards Organisation
KH	Karena Hospital
KOYOTO	December 1997 treaty in Japan, to reduce greenhouse effect /global warming
NHS	National Health Service
PASA	Purchasing and Supply Agency
PFI	Private Finance Initiative
PPP	Public Private Partnership
RBV	Resource-based View
RDT	Resource Dependent Theory
RH	Reinhard Hospital
SOP	Standard Operating Procedure
ST	Structuration Theory
TCE	Transaction Cost Economics
TH	Theresa Hospital
TUPE	Transfer of Undertakings for the Protection of Employees Regulation
VH	Victoria Hospital

TABLES

FIGURES

Chapter 1 Introduction

1.1 Introduction

This chapter provides a brief introduction to the work presented in this thesis and outlines its structure and layout.

The thesis is based on the studies of eight selected National Health Service (NHS) trusts in the Greater London area with respect to "hotel services" outsourcing that includes cleaning, catering, laundry, portering and housekeeping. These are also called support services. Both terms will be used interchangeably as the interviewees used them. The economic recession of the 1970's may have forced many companies to focus inwards on their basic businesses (Möller and Wilson, 1995), in favour of outsourcing and alliances to leverage resources for sustainable competitive advantage (Cross, 1995; Das and Teng, 2000). Outsourcing refers to 'subcontracting construction components, sub-assemblies, products or services to another company for results' (Fill and Visser, 2000; Jennings, 2002). For services outsourcing, results become a quest for a continuous, reliable, uninterrupted service (Cross, 1995; Fill and Visser, 2000). A resource is defined as an asset or input to production that an organisation owns, controls or has access to (Helfat and Peteraf, 2003:999). Thus, outsourcing of non-critical functions enables companies to focus on their core businesses, enhance specialisation or build capabilities[1] for competitive advantage (Nelson and Winter, 1982; Prahalad and Hamel, 1990; Teece et al., 1997).

There is a growing interest in outsourcing as a potential source of competitiveness and value creation (Grimshaw and Miozzo, 2006; Huber, 1993; Leavy, 2004; Sveiby, 1997). Areas outsourced have burgeoned from information technology (Cross, 1995; Lacity et al., 1995) and non-core activities like administration, security, product marketing, cleaning, catering and payroll (Davis, 2004, IPD, 1998, Rock, 1999; Quinn et al., 1990), to skilled personnel (Peisch, 1995), logistics (Lewis and Suchan, 2003), funeral service (Grossberg, 2004), capital projects and total facilities management (Alexander et al., 2004).

One of the most exciting trends in organisation and management studies has been the sustained interest in resources for enduring competitive advantage. A stream of studies (reviewed in chapter three) show how organisations attempt to meet their internal resource needs through inter-organisational relationship such as strategic alliances and outsourcing that enable some to refocus on core activities and develop them as sources of sustainable

[1] Capability refers to a firm-specific attribute "to perform coordinated set of tasks utilising organisational resources (assets or input to production) for the purpose of achieving a particular end result" (Helfat and Peteraf, 2003:999).

advantage. Studies in alliances and outsourcing stress the importance of business relationships but few are focused specifically on hotel services in public organisations like the NHS. The notable ones are studies in hospital accounting in New Zealand (Lawrence, et al., 1997), a collaborative research in Palestine (Hardy et al., 2003) and a study in the effectiveness of Transfer of Undertakings (TUPE) in employment relations of those being transferred from public sector employment to the commercial sector (Cooke et al., 2004).

The Industrial Marketing and Purchasing Group (IMP) have studied and advanced our knowledge on buyer-seller dyadic relationships and networks (Ford, 2002; Håkansson and Snehota, 1995). However their focus has been on providing a framework for safeguarding specific investments and reducing total transaction costs through long-term relationships. This thesis does not involve itself with the myriads of relationship networks on either side of the contractual relationship between services providers and their clients but the thesis validates the work of the IMP group in the context of outsourcing and advances their interaction model to adding value to services offering through innovation and learning.

Through outsourcing interaction between purchasing managers and services providers there is a perception of mutual learning and the transfer of knowledge and skills that enable managers and workers, as agents, make a difference. Ancillary workers have been trained and developed, equipped with knowledge, skills, competence and improved self-image to liberate themselves from manual workers to professionals in support services. Some purchasing managers have used provider investments to liberate themselves from the dungeons of the basement to better facilities, which some of them manage, control and maintain. Many have transformed their roles, position, departments and ultimately their organisations. Consequently, managers and the workforce have been enabled to enhance their roles, jobs and departments through support services outsourcing relationships.

Structuration theory (reviewed in chapter four), accords such managers and workers the capability of knowledgeable agents, able to use resources like outsourcing and contractor investments as opportunities to make a difference in pre-existing state of affairs (Giddens, 1979, 1984). The perceived changes in the roles, jobs and positions of managers and workers documented here are testaments to such a difference. Agents are knowledgeable by virtue of what they can do (know-how) and not what they know, hence shifting the emphasis from theory or mechanisms alone to practice (Pleasants, 1999; Stones, 2005).

Thus, this thesis extends our knowledge of structuration theory from a theory of action and a sensitising device to a theory of liberation through the capacity for action (power) of agents to use resources to make changes that transform them.

My choice of structuration theory (Giddens, 1979, 1984) as a philosophical underpinning for this thesis stems from the episodic nature of changes occurring in the health service which suggests that structuration theory may be a suitable interpretive tool. The ability of structuration theory to bridge the philosophical divide of subjectivity and objectivity (Burrell and Morgan, 1979) and other dualisms identified in social research, eliminates the restriction placed on social research by a purely Positivist or Contructionist study.

Structuration theory (Giddens, 1979, 1984) charts an epistemological middle ground by combining concepts from other disciplines and schools of thought. Human activity, to my mind, cannot be seen as purely pre-determined or voluntaristic. The actions of human agents are not programmed by structural forces to produce predictive outcomes but are the interplay between agency and structure[2], hence Giddens' notion of "duality of structure", which constitute social structures that are the very medium of this constitution. For example, support services managers and the workforce have access to organisational rules and have been equipped with resources they can draw upon at interaction with services providers to enable them make a difference to their roles, jobs, departments and transform their professional image. However, because human knowledgeability is always bounded (Giddens, 1984), the action of these agents produces unintended consequences.

These unintended consequences create the foundation for new action that enables agents to make changes (Kaspersen, 2000). Thus, this thesis uses structuration theory (Giddens, 1979, 1984) as a flexible philosophical lens to identify and explain the underlying generative mechanisms[3] that produce social structures, which are both the medium and the outcome of interaction. These structures are rules and resources— knowledge, skill, expertise and experience services managers routinely draw upon during interaction with contractors to enable them apply the rules of conduct in deploying organisational resources to transform hotel services, the workforce and in some cases, their institutions.

---

[2] Structure is regarded as rules and resources (tacit knowledge) agents draw upon at interaction. Structure and agency are not two individual phenomena as in dualism but a duality that is both enabling and constraining (Giddens, 1984)

[3] Generative mechanisms are stocks of mutual knowledge drawn upon by actors in their daily interaction to enable them to go on (Giddens, 1984)

Structuration theory links human knowledge with a process of action in specific contexts. Action here depends on the capability of individuals, as knowledgeable agents, with access to resources to intervene or refrain from intervening in a specific process like outsourcing and make a difference to change and transform their contexts of operation. Structuration theory deals with concepts of power and control in novel ways. It considers the "dialectic of control" as built into agency and the reciprocal autonomy and dependence agents reproduce in the context of their daily interaction. Domination is produced through conflicts and contradiction in resource deployment, which is one basis of power comprising structures of control and domination drawn upon by the parties to interaction. Hence control or domination in complex institutions is never total, negative or punitive as subordinates, agents and stakeholders are adept at circumventing oppressive situations and directives through distancing, absenteeism or exit.

Outsourcing in the NHS involves internal power relations in the deployment of resources and external power plays in relationship management with services providers. The level of outsourcing and the resultant consequences reflect the choices, competence and power of agency on the part of support services managers, their workforce and services providers in overcoming organisational and departmental constraining politics and the status quo to manage their departments and outsourcing relationships for mutual benefits. Thus structuration theory is suitable as a flexible philosophical lens or interpretative tool for understanding, analysing and explaining services outsourcing outcomes in this thesis.

Structuration theory has been adopted in management and organisation studies involving change (Akgün et al., 2007; Lawrence et al., 1997) through innovation (Chanal, 2004) and information technology in logistics (Lewis and Suchan, 2003) and knowledge transfer (Pleasants, 1999). Other areas include the concepts of structure (Ranson, et al., 1980) and its relatedness to and dependence on agents (Stones, 2005; Whittington, 1992), organisational culture (Riley, 1983) and structure as a source of domination and control (Reed, 1996; Xavier, 1996), where workers struggle for liberation. Thus, the structured perceptions of those directly involved in hotel services outsourcing and the perceived changes to their jobs, roles and departments can be studied, analysed and explained using the analytical tools offered by structuration theory.

The main objective of hotel services outsourcing in 1983 was threefold. Firstly, to refocus the health service on its core activity of providing free healthcare for the nation, secondly

to improve the performance effectiveness and operational efficiency of the service through managerial association with private commercial services providers and thirdly to improve managerial accountability in the deployment of public scarce human and financial resources and hence reduce the dependence of the health service on Government funding alone. Successive Governments since then have attempted to reform and restructure the health service through the internal market mechanism and collaborative arrangements in search of cost containment and efficiency in deploying resources to achieve organisational goals.

The findings of this thesis suggest that the contractual partnership between commercial services providers and their clients has been mutually beneficial. For example, one of the perceived results of outsourcing has been the transfer of commercial ethos through learning that has enabled some NHS trusts to gain financial independence and autonomy as foundation trusts through the Private Finance Initiative (PFI). Many more are poised to go the same way. Foundation status liberates an NHS trust from budgetary constraints and enables some managers to regard and operate healthcare as a business, releasing the trust from Government control through financial bailouts and handouts while the services providers increase their remit. Consequently one of the aims of hotel services outsourcing is perceived as realised by those directly involved.

Services outsourcing continues to generate extensive debate, which can be healthy for those involved. Observers divide outsourcing into three parts—motivation or strategic reasons for outsourcing, the process and benefits of outsourcing. Most studies are on outsourcing process resulting in un-quantified benefits or impact (Jiang and Qureshi, 2006; Lin et al., 2007; Linder et al., 2002; Nordin, 2006). Researchers note that there is little research in the motivation for outsourcing and in mixed model studies comparing both in-house and outsourced services (rather than purely outsourced or in-house operations). The notable exceptions are studies in strategic reasons or motivation for outsourcing with the attendant risks and rewards (Harland, Knight and Lamming, 2005; Zhu et al., 2001) and an attempt at quantifying the economic impact of outsourcing (Jiang et al., 2006). But none of these studies are in support services. This thesis combines and compares both in-house and outsourced support services, deals with and documents the motivation, process and benefits or impact of support services outsourcing. Thus the results of this thesis can help to fill some of the gaps left by the scarcity of similar studies in the literature.

Many studies agree that there are reasons for outsourcing other than cost saving benefits whose impact are difficult to quantify. Consequently, most studies, including this thesis, focus on the perceptions of the key people involved in services outsourcing. Furthermore, the results of services outsourcing are contextual and reflect the work content, experience and perceptions of those interviewed. For example, Harland, Kinght and Lamming (2005) studied the strategic motivation, risks and benefits of outsourcing information technology from a senior management, policy decision-making point of view. Consequently, their results reflect the views of senior management with regards to policy and strategic impact. This thesis is based on the perceptions of the key people involved in support services outsourcing (middle managers, workers and stakeholders) and hence reflect their day-to-day lived experience with the work context and content they find themselves in. Other researchers proffer the same reasons for the variety and diversity of outsourcing findings in different contexts. For example, Jiang and Qureshi (2006) comment that middle managers talk about their field of work or departments and their daily struggle to manage their departments and not about the whole organisation or financial impact on the firm. Harland, Kinght and Lamming (2005) also comment that while proponents of outsourcing focus on economic arguments, opponents major on the social (unintended) consequences of outsourcing making it difficult to compare results. Consequently, result findings reflect the different levels of people interviewed, the context of operation, management fashion and ideology. Thus services outsourcing findings are diverse and different but healthy as the extensive debate helps to broaden and enrich the phenomenon under study.

There is also a scarcity of studies aimed at theoretical model building within services markets, especially in the health service (Fishbacker and Francis, 1999; Robinson and Le Grand, 1994). This study provides an alternative view of outsourcing outside patient care that can increase the stock of knowledge towards a more comprehensive model of inter-organisational relationships and may help to fill the gaps left by these scarcities.

1.2 Contribution of this thesis to the stock of knowledge

What is knowledge?

Knowledge is a critical resource of individuals and collectives like healthcare organisations and a source of power, livelihood and competitive advantage (Lam, 2000; Starbuck, 1992). Human knowledge exists in different forms. It can be articulated explicitly or manifested implicitly as tacit knowledge. While explicit knowledge is easily communicated and can be transferred without the knowing subject, tacit knowledge is intuitive, cannot be articulated,

used or understood without the knowing subject (Popper, 1972; Lam 2000). However both tacit and explicit knowledge, are exhaustible but through sharing can dynamically interact to create new knowledge (Polanyi, 1962) that is transformative and renewable in nature and can contribute to a firm's competitive advantage through innovation and technology (Akbar, 2003; Huber, 1999). Thus, knowledge can be transformed and expanded into a renewable resource for individuals, groups and organisations for competitive advantage.

Explicit knowledge is gained through formal study and is exemplified as the ontology or locus of knowledge in the know-what, which is objective, embrained in individuals or formalised and codified in organisational routines, procedures and practices (Lam, 2000). On the other hand, the epistemological expression of tacit knowledge as know-how is subjective, experience-based and accumulated through observation and practice. It is internalised through active involvement in contexts and embodied in individual's skill and expertise or embedded in organisational members' work, roles, authority, structures of coordination and communication mechanisms that enable them mobilise and integrate different forms of knowledge to meet organisational objectives (Lam, 2000; Starbuck, 1992). Thus both forms of knowledge can interact and combine to create new knowledge in the know-why of understanding cause and effect relationships and the sense-making of perceptions of agents expressed through the application of their cognitive and behavioural knowledge and transferred through mutual learning and apprenticeship and communicated as in this thesis (Akbar, 2003; Huff, 1997; Polanyi, 1962, 1983; Quinn et al., 1996).

Therefore, new knowledge is created, to my mind, through my interaction with agents in the context of this research to aid understanding and explanation of events observed and data collected. Consequently, healthcare practitioners and researchers can creatively use insights and views expressed in this thesis from both the secondary (literature review) and primary research as a stock of knowledge to transform their units, jobs or craft competitive advantage for their services to liberate themselves or to engage in future research.

From knowledge acquired through familiarity with previous relevant research my prolonged participant observation in the context of NHS trusts' support services investigated over five years and the variety of personal experience of the research context combine to create a new understanding in applying knowledge to current issues. These experiences enable me to contribute to stock of knowledge here and to continue contributing to knowledge through information sharing in future research endeavours.

1.3 Original contribution of this thesis to knowledge

This thesis provides a timely study of hotel services outsourcing in the UK health service. The study documents and provides useful information on the perceptions of the personnel directly involved in hotel services outsourcing and has attempted to shed more light on the progressive role of health services outsourcing, its impact on the changing roles of purchasing managers, contractors, support services workforce and patients' experience. It is hoped that it will encourage further research in the expanding area of health services outsourcing and facilities management.

The literature indicates a need for more qualitative research in the growing area of exchange business relationships to improve understanding and theory generation in this important area of successful business operations (Bradley, 2005; Eriksson and Laan, 2007; Maxwell, 1996; Osarenkhoe and Bennani, 2007; Wilding and Humphries, 2006). Business relationship is defined as a mutually oriented interaction between reciprocally committed parties, based on resource exchange for economic benefit (Ford, 2002:162). The Industrial Marketing and Purchasing Group (IMP) have extensively studied to extend our knowledge and understanding on business networks based on successful dyadic relationships (Ford, 2002, 2003; Häkansson and Snehota, 1995, 2000). However their studies are mainly focused on relationship as a complementary governance framework for reducing total transaction cost and safeguarding specific investments for competitive advantage (Dyer and Singh, 1998; Kleinaltenkamp and Ehret, 2006). These studies tend to neglect the value adding benefit of such business relationships through innovation, mutual learning and knowledge transfer (Bradley, 2005; Huber, 1999; Khong, 2005).

This thesis documents the beliefs of those involved that a bundle of value-adding benefits emerged from successfully managing their contractual business relationships for enduring personal, economic and mutual organisational benefits resulting in the expansion of health services outsourcing to other areas like clinical imaging, patient appliances, information technology and sterile supplies. Thus this thesis validates and extends the interaction model to a value-adding framework in the context of contractual services outsourcing.

This thesis builds on other work using structuration theory in organisational analysis. By identifying and explaining the structures that emerge from the perceptions of those directly involved in outsourced hotel services. The thesis adds weight to the central point of structuration theory that knowledgeable agents with access to resources like finance, skill,

training, managerial expertise and experience can make a difference by changing their status, image, position, power differential and employability. The ancillary workers have been trained and developed from manual workers to professionals. Some procurement managers have been liberated from the dungeons of the basement (while the procurement managers in in-house operations are still in the basements) to own, manage and control creative facilities where NHS trusts are tenants and the image of support services has been enhanced by the professionalism of services providers. Thus workers and managers have liberated themselves to reproduce their institutions and the social world in which they are situated. The thesis further advances the concept of structuration theory from a theory of action and a sensitising device to a theory of liberation for individuals and collectives.

An interesting aspect of this thesis is the contribution of facilities management (FM) as a catalyst in the evolving change process of the health service. Facilities management is a new profession and discipline with few theories (Alexander, 2003). There is a challenge to secure the future of FM as a credible discipline built on strong theoretical foundation and dedicated to understanding and developing the discipline (Jones, 2000; Ventovuori et al., 2007). By documenting the creativity in workplace design, organisational transformation and community renewal made possible by new facilities (chapter 2) in totally outsourced services in NHS trusts like Theresa and County hospitals and the cost effective use of healthcare real estate occupancy elsewhere, this thesis provides evidence for the establishment of healthcare corporate real estate as a valuable resource to generate revenue, enhance NHS public image, motivate workers and benefit patients.

The thesis enlarges to enrich our knowledge on the problems of achieving organisational change and transformation prompted by economic uncertainty. The perceived changes documented here occurred through the public partnership relationships with the private commercial sector and their willingness to invest in human capital development in the context of Private Public Partnerships (PPP) through support services outsourcing.

This thesis adds something to the substantial body of work on perceived power balance in institutional change this time within the health service but outside patient care. Outsourcing is a major shift in the organisational structure of the NHS and brings with it significant shifts in institutional power. The perception of this shift clearly emerges from this thesis. Through the ownership and total facilities management, the professionalism and the self-perception of purchasing managers and services providers, a low-status ancillary services function

like support services, has been transformed into a competitive services provider and its workers into resourceful professionals. This study indicates that outsourcing is having a real impact on the working lives of those engaged in the NHS trusts' support services.

1.4 The thesis is laid out as follows:

Chapter two is a review of the NHS as an institution, with its historical and economic background leading to outsourcing and subsequent developments, reflecting the episodic nature of changes from internal collaboration to partnerships with the private sector. A limited profile of facilities management is presented to complete the research context.

Chapter three is a literature review on outsourcing, resource-based view of organisations and strategic alliances as routes to attaining comparative advantage with other trusts and explanations from relevant theories and schools of thought intrinsic to this thesis.

Chapter four deals with methodology and methods used in this research with some critique of structuration theory, as a sensitising device and its use in social studies.

Chapter five presents the data analysis of the four categories of outsourcing identified namely: completely outsourced, two partially outsourced and in-house operations. Since my unit of analysis is the relationship of the purchasing managers and their services providers within the context of "hotel services" rather than whole individual NHS trusts, the four categories of outsourcing provide a better way of comparing and contrasting to elicit structural mechanisms impacting those involved with respect to hotel service outsourcing. The perceptions and resultant structuring of the experiences of those directly involved in hotel services outsourcing is presented in each of the eight NHS trusts investigated and then compared and discussed with reference to extant theories.

Chapter six summarises and concludes the thesis with managerial applications and identifies areas for future research. References, appendices of those interviewed, summaries of foundation hospitals and the Private Finance Initiatives (PFI) are included.

Chapter 2 Literature Review

2. The UK National Health Service (NHS)

2.1 Introduction

The UK National Health Service (NHS), was founded by the Labour Government on 5 July 1948 (figure 2.1), to provide all citizens with healthcare, free at the point of use, according to need and not ability to pay (Klein, 2001:1; NHS Plan, 2000:2). The aims of the founding fathers were firstly, the provision of a comprehensive health service of universal coverage for the population with equity of access. Secondly, the system was to be financed mainly from taxation and thirdly, both doctors and patients were to have freedom of choice. Doctors could choose how to treat and patients could change doctors without proffering reasons (Klein, 2001; Leathard, 1990). But private medicine should remain on the margins. However, from inception the cost of running the system from taxation alone has burgeoned beyond the expectation of the founders (Klein, 2001; Lawrence, 1988; Leathard, 1990; Powell, 1966). By 1950, the system was stereotyped as a "spendthrift organisation" (Klein, 2001:31). Margaret Thatcher called it a "bottomless financial pit" (Holliday, 1995). Indeed, Leathard (1990:141) and Levitt et al., (1995:25) commented that the organisation made "insatiable demands" for state funding to meet the "relentless growth for costs" due to the inexorable demands for more and better medical care for an aging population that is living longer, which the founding fathers could not have envisaged (Le Grand, 2006; Portillo, 1998:33).

Consequently successive Governments have restructured and reformed the health service in an effort to reconfigure appropriate administrative, managerial and market frameworks to contain costs and improve accountability, efficiency and organisational effectiveness in meeting healthcare objectives. Organisational effectiveness refers to the "ability to produce an acceptable outcome" (Collins, 2003), or meet the demands of the varied stakeholders.

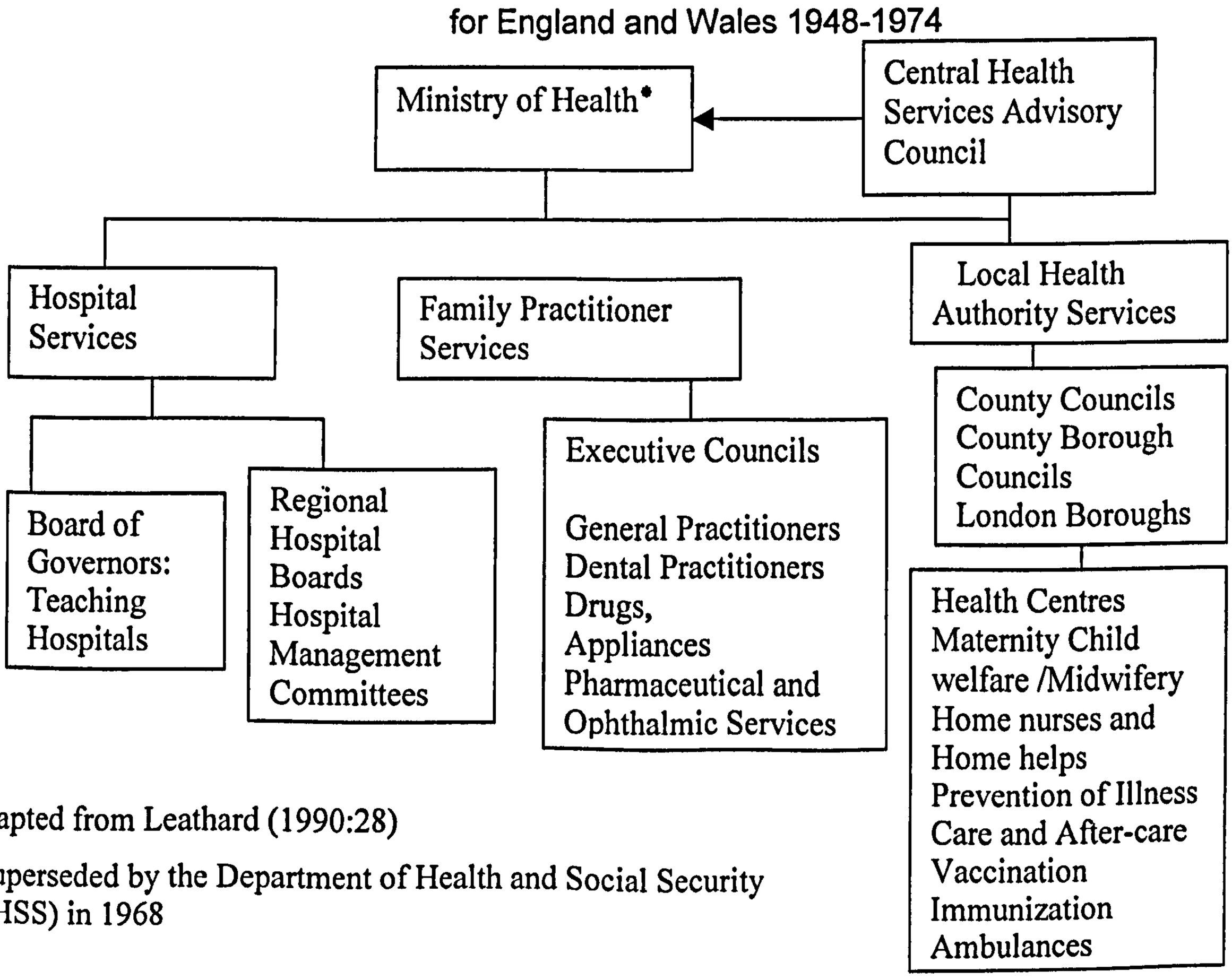
Similarly, the complex dynamic influences of policy makers, academia, stakeholders and NHS management have also centred on improving performance and operational efficiency of the system (Klein, 2001; Laing et al., 2002). Healthcare efficiency is here defined as "squeezing the greatest possible output out of an inevitably limited input of resources" (Klein, 2001:49). With limited national income and other competing sectors like education, transport and social services, this "efficiency squeeze", to date, has been elusive but remains a constant objective (section 2.5 below).

2.2 NHS Reorganisation 1974-1997

Against this backdrop of escalating running costs for the NHS, the Ministries of Health and National Insurance were amalgamated in 1968 into the Department of Health and Social Security (DHSS), mandated to administer all health and social matters (Klein 2001:51). Subsequently, the biting inflation and recession of the 1970's led to a reorganisation of the system (figure 2.2) in 1974, in line with DHSS (1972) management arrangements. This was an administrative reform to unify the hitherto fragmented services especially the community services run by local authorities and to facilitate the equitable allocation of scarce resources (Leathard, 1990; Levitt et al., 1995:16). The 1974 reform was also aimed at managing the external pressure of scarce resources with the internal demands of healthcare provision through managerial efficiency (Klein 2001; Leathard, 1990). Thus, a consensus administration of medical, nursing and administrative multidisciplinary team was set up to improve efficiency through decentralised hierarchical tiers of bureaucracy (Klein 2001: 76). This arrangement may have introduced weakness into the health service through the "hegemony (political domination) of civil servants" with what Klein (2001:75) calls "bureaucratic complexity in every tier" to effectively implement national policies.

Figure 2.1. Structure of the National Health Service (NHS)

for England and Wales 1948-1974

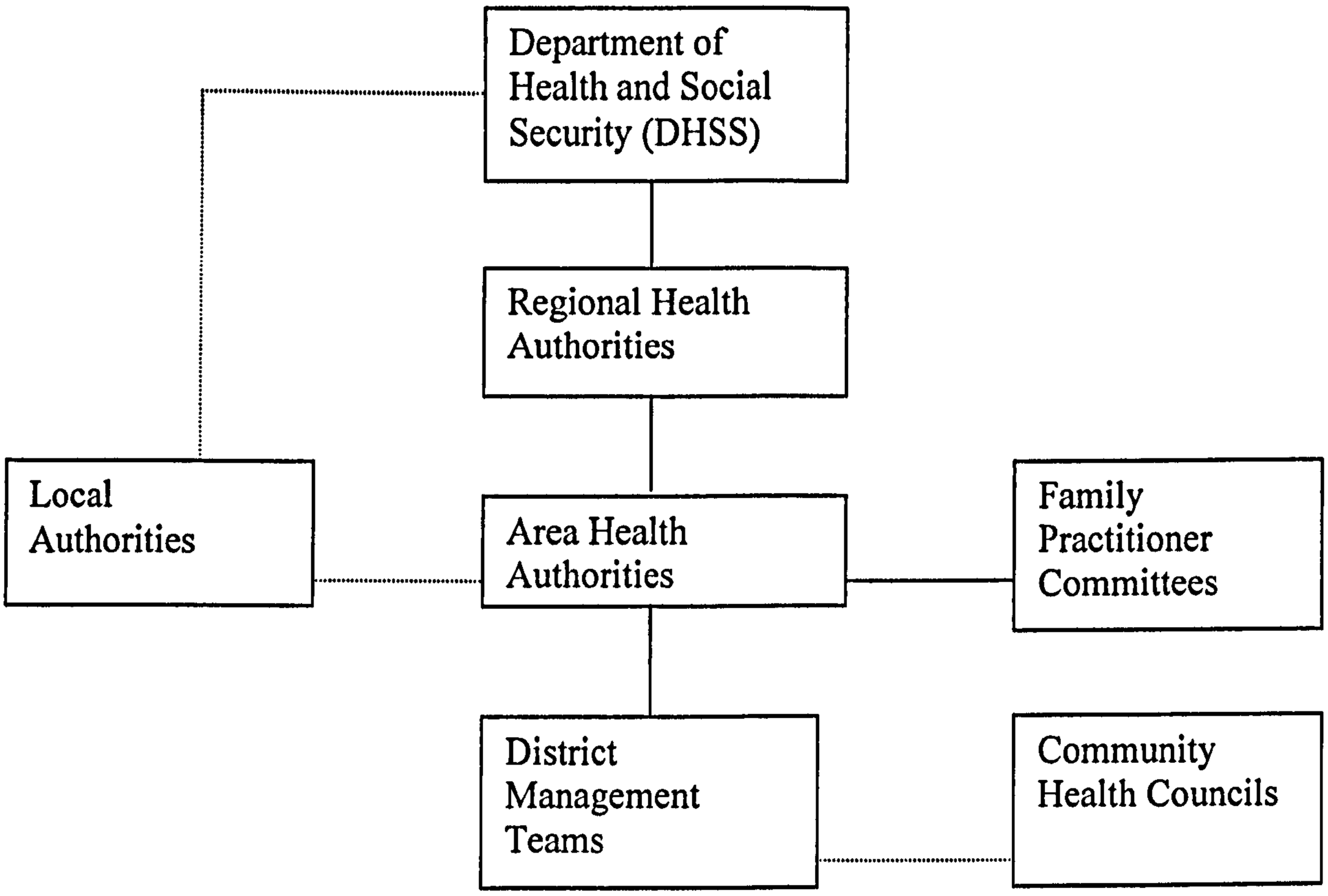


Adapted from Leathard (1990:28)

*Superseded by the Department of Health and Social Security (DHSS) in 1968

Figure 2.2. The Structure of the NHS in 1974

(Adapted from Leathard (1990:54)



Subsequent to the "winter of discontent", the new Conservative Government of 1979, (Klein, 2001; Leathard, 1990) began an urgent review of Government institutions such as the NHS, culminating in Sir Ron Griffith's report of 1983, which was highly critical of how the NHS was operated and managed where no one seemed to be in-charge or indeed accountable (Klein, 2001; Leathard, 1990; Laing et al., 2002; Webster, 1988). Following this report, the Government set out a strategy of minimal state intervention and an avid commitment to reduce public spending, return the depressed economy to market forces and defeat ravaging inflation. Thus, financial cuts were imposed across the public sector and Government instituted a general management framework to increase decision-making responsibility, improve efficiency and performance effectiveness by eliminating pockets of inefficiency, wastage, wasteful and ineffective or inappropriate practices from the system (Levitt et al., 1995; West, 1988).

It was this policy that led to hospitals and Health Authorities being allowed to outsource their cleaning, laundry and catering services to private contractors through competitive tendering (The Health Services, 1983). The objective was to secure cheaper and more efficient service than direct labour (DHSS, 1983; Thornton, 1999). Outside contractor

managers were deemed more efficient and productive due to their better incentive structures, which in-house ancillary workers lacked (West, 1988). Special Health Authorities, NHS Logistics and a purchasing agency, Purchasing and Supply Agency (PASA), were also created to help hospitals coordinate services contracting across the NHS (Leathard, 1990; Levitt, et al., 1999; PASA, 1998). At the same time, private hospitals, voluntary health organisations and "informal carers" who care for their chronically ill relatives and family members were forced to share in caring for the sick (Leathard, 1990:58). Thus, a system of welfare pluralism emerged between the private sector, voluntary organisations, family members and the NHS.

The involvement of the private sector in healthcare was not without opposition. Robinson (1984) called it "privatisation of the welfare state". Ray Whitney, (1988:79), from the Department of Health and Social Security (DHSS), said it was a "flawed report" that failed to deal with the main issue of relationship between managers and Health Authorities. Opposition was also rife in the sub-contracting of in-house services to outside contractors. Labour unions demonstrated with strikes and labour unrest arguing that competitive tendering challenged the monopoly of in-house services and that cleaning standards were declining (Thomas, 1985). Subsequently, the Audit Commission investigated the union claims (Audit Commission, 1987). The commission reported that standards had declined but contractors have also lost interest in tendering for contracts (West, 1988:55). Despite all opposition, the Government plans went ahead. Thus, contract arrangements for non-core activities like hotel services (initially cleaning and catering) began in the NHS.

To help civil service managers and doctors improve performance effectiveness (Levitt et al., 1995:26; Carter et al., 1992), Fulton's Report (1982) was used to usher in the use of performance indicators across the civil service (Klein, 2001:117). Annual reviews were also introduced (Allen, 1982) as were cost improvement programmes in 1985. But as Whitney (1988) observed, the lack of in-built cost containment mechanisms with the imposition of resource restraint alone, left the system with slack and inefficiencies. The Social Services Committee reports (1988) confirmed these findings.

In 1985, the American health economist, Professor Alain Enthoven, visited Britain and noted that the NHS lacked market discipline and managerial incentives for performance effectiveness and financial efficiency that could reduce recurrent Government intervention in the health services (Levitt et al., 1995:25). Based on this observation and Griffith's

(1988) recommendations for community care, which was not implemented, the Government set out a White Paper (1989), *Working for Patients.* This paper introduced competition into healthcare and resulted in major changes. The aim was to stimulate efficiency, enhance consumer choice and promote quality of care by separating health demand from healthcare provision (Robinson, 1989; Levitt et al., 1995). The providers of healthcare were to be the local and teaching hospitals, District Health Authorities and private hospitals. The purchasers were fund-holding general practitioners (GP's) and Local Authorities. It was thought that competition, or an "internal market" mechanism which was a purchaser-led rather than provider-led service would provide the incentive for efficiency improvements and a high quality cost effective health service (Laing and Cotton, 1996; Laing et al., 2002).

However, the result was the "internal market" which elicited diverse comments from observers. Best (1989:167) called it "an exciting journey into the unknown". He questioned the overall management and how service quality would be rated since there was no precedent. Ham and Judge (1989) said the exercise was a "managed competition" since hospitals could not be allowed to go bankrupt. Klein and Day (1989) argued that it was "competition with conflicting objectives" since the advocate of the exercise, (American economist, Enthoven) has failed to achieve the same comprehensive healthcare provision at low cost in America.

From the medical viewpoint, an NHS physician said that healthcare was a service and not a business to be driven by profits (Elkeles, 1989). He further contended that, "the cash register may drown out the sound of the ambulance" if competition for profit became the norm. The Lancet (1989) said it was an attempt to dispense with unproductive health services. The chairman of the Commons Social Services Committee, Frank Field (1989), called it 'a time bomb set to blow the NHS apart'. Opposition ministers saw the white paper as a step towards privatisation and commercialisation of the NHS (Cook, 1989; Owen, 1989).

Meanwhile the health secretary, Kenneth Clarke, announced that the next step was to allow individual hospitals to become self-governing trusts while remaining in the NHS (Clarke, 1989; DoH, 1989). The Health Service Journal (1989a) called it a 'flawed' step and commented that self-governing trusts 'flew in the face of unity'. The incentive for hospitals to reduce cost and the ability of the NHS and local general practitioners (GPs), to

provide quality care at stable prices were questioned (Maynard, 1989). But some thought that it was a step in the right direction (Green, 1989), since trust status would be optional (Willett, 1989). However, the introduction of medical audit (Lancet, 1989) in what Theodore Porter (1995) called 'control through quantification' was well received by some doctors.

Medical audits are used to assess cost of patient treatment, which are then compared across the NHS. It is an aid to justify autonomy and accountability (Klein, 2001:50). But some NHS trusts may have used such audits to benchmark their performance against under-performers and take comfort from their mediocre achievement and so have become complacent and resistant to change (Fraser, 2002; Hailey et al., 2005; Purcell, 1999). Meanwhile some trusts used such audits to demand more funding from the Government and become dependent on state funding for projects, training and refurbishment of decaying buildings (Enthoven, 2000; Moore, 1992). Meanwhile some medical consultants continue to flex their hegemonic muscles as controllers of the health service by refusing to engage in such medical audits, which they regard as hidden surveillance (Maynard, 2005).

The internal market, proposed in 1989, became operational in 1991, with a framework for competition. In the same year, the purchasing agency and NHS Logistics, hitherto created as special Health Authorities, were renamed NHS Purchasing and Supply Agency (PASA) and NHS Logistics respectively (Cabinet Office, 1998:26). They were to help the newly formed hospital trusts manage contractual purchasing and supplies. The agencies were mandated to standardise, coordinate and improve all purchasing and supplies across the NHS and help the internal market function seamlessly (NHS Procurement Review, 1998). Furthermore NHS Logistics was to help NHS trusts with bulk purchasing, warehousing, transportation and goods delivery to reduce total costs of using multiple contractors for purchasing, warehousing and logistics (Arminas, 2001; NHS Procurement Review, 1998).

2.3 NHS trusts

The internal market arrangement, outlined in the white paper—'*Working for Patients*' (DoH, 1989a), became an act of parliament the following year. The provider/purchaser split was an implementation instrument of the internal market. NHS trusts came into being in 1991 and by 1995 all hospitals in England have become part of an NHS trust (Thornton, 1999). NHS trusts provide a range of health services to patients. A trust may be a single acute hospital or a group of hospitals or indeed community services provided in health centres, clinics and homes or ambulance service.

Types of trusts

- Acute trusts providing acute or specialist medical care
- Integrated service trusts, provide acute community services and in some instances, mental health services
- Community trusts in some areas incorporate mental health services and elderly care with learning disability
- Mental health trusts can include services for the elderly with learning disability

A trust is a self-governing public organisation with its own board of directors. These executive and non-executive directors are charged with making decisions on local policies and setting the strategic direction of trusts. A trust has a financial duty to break even, realise a 6% return on capital and live within its budget limit set by the Secretary of State for Health. A trust is mandated to work in partnership with local Health Authorities as well as with its network of services providers (Levitt et al., 1995:82; Thornton, 1999).

Commenting on the creation of NHS trusts, Harrison (1995) noted that trust status brought hospitals freedom to innovate at the local level. However Robinson (1996) observed that trusts lacked financial independence since they could not go bankrupt but were always subject to soft budget constraints. Others confirmed this and noted the constraining effect of state ownership on NHS trusts (Moore, 1992; Portillo, 1998). Such constraints range from subordinating health services' interest to political will and timetable, interfering with internal workforce arrangements through policies that observers say result in resentment and human misery of redeployment and may inadvertently contribute to inefficiency and poor performance of some NHS trusts (Enthoven, 2000:1329; Moore, 1992:117). However, NHS trusts have since been allowed to seek and achieve autonomy through Foundation status of self-determination and observers watch to see how this newly found freedom and determination play out in the highly competitive commercial arena.

The Health Service Journal (HSJ, 1989:135) noted that hospital trusts were empowered by statute to enter into contracts to provide services and were able to form alliances with the private health sector in order to share facilities, running costs and risk for mutual benefit. Thus, competitive tendering was extended from non-clinical support services to clinical care. By this move, the health minister, Kenneth Clarke, observers say, gave notice to the two powerful groups, the treasury and the hospital consultants who hitherto controlled the budget and what happened within it respectively (Leathard, 1990:176; Klein, 2001:64;

Strong and Robinson, 1990). It was the turn of managers and competitive market forces to shape the NHS through the internal market mechanism.

During this internal market era, the health service was fragmented to aid competition and hence improve the efficient use of resource allocation through market exchange (Laing and Cotton, 1996). Through the fragmentation of the bigger hospitals, many hospitals gained trusts' status as healthcare providers having local accountability and a budget to engage contractors for services (Laing et al., 2002). But soon after, in 1992, problems arose with the competitive framework and led to a commission of inquiry into London health services (Thornton, 1999). However, these problems continued until the Labour Government came into office in 1997. Subsequently, the New Labour Government replaced the internal market mechanism with integrated care, based on partnership, driven by performance, with emphasis on value creation through collaborative cooperation (The New NHS, 1997; The NHS Plan, 2000). Thus, a fragmented, hierarchical bureaucracy deemed wasteful, inefficient and ineffective and unable to contain costs was replaced with a "third way" (Giddens, 2000) administrative framework. The tenets of this arrangement being increased investment for reforms, incentives and sanctions for improved efficiency, better performance and high quality care (The New NHS 1997).

These reforms of investment and private sector partnerships are aimed at restoring fragile public confidence in the health sector but may have impacted healthcare services in other ways as seen in this study (The NHS Plan, 2000). The impact is the willingness of services providers to invest in developing ancillary staff into more resourceful professionals and in the design, build and maintain creative hospital facilities that transform the public image of hospitals, motivate workers and renew some community landscapes.

2.4 Impact of the internal market

The internal market exercise may also have made the health service less provider-led as purchasers were allowed to have a voice in where, when and how they were treated. It also helped purchasers and providers negotiate, share and collaborate over contract arrangements and commissioning (Shapiro, 1994).

The internal market, argues Ham (1994), gave NHS staff, not managers, the opportunity and freedom to shape the service. NHS staff was able to negotiate improvements to services secondary to their purchasing power to back up any threats of withdrawing their custom. This improved prescribing habits by using generic names of drugs to save money.

In studying the NHS, Robinson and Le Grand (1994) note that the major problem of trusts is the lack of appropriate models of behaviour and organisational models. This lack of appropriate models and the diversity of relationships and power coalitions engendered in healthcare delivery makes it more difficult to study trusts as organisations (Fischbacher and Francis, 1999). For example, there are as many professional bodies, medical, non-medical or ancillary support staff within NHS trusts as there are outside them. All of them work in delivering healthcare and hence compete for their departments from the same state budget. This multiple, complex and dynamic nature of interactions at many different levels in healthcare derailed the internal market arrangement due to the difficulty of gaining consensus for action (Laing and Cotton, 1996; Øvretveit, 1995).

Øvretveit, (1995:113), noted the lack of clear purpose or objectives and usefulness in measuring performance outcomes (effectiveness) and how other competing services and factors (waiting lists, costs, information asymmetry, personnel) may overlap and impinge on results making performance difficult to measure.
Outcome refers to the 'effect attributable to an intervention' (Øvretveit, (1995:114). But he saw contractual arrangements in healthcare as a means of improving healthcare delivery and preventing disease. However, the success of healthcare contracts depends on effective collaboration and partnerships within and outside their administrative boundaries.

The internal market also gave general practitioners, the opportunity to be innovative and drive change in healthcare provision (Holliday, 1995; Øvretveit, 1995). These general practitioners, hitherto ignored by their district Health Authorities and disdained by their consultant colleagues were now being sought out for their patronage (Levitt et al., 1995)! Healthcare contracting allows an NHS trust to concentrate on its core competence, namely providing healthcare for all at the point of need, where it is capable of adding value to patients' offering (Prahalad and Hamel, 1990) not managing hospitals (White, 1993).
These partnerships (relationships) can develop into a network of relationships and help manage conflicts through mutual orientation and long-term cost savings (Øvretveit, (1995).

The internal market helped in building a cooperative ethos in healthcare, by allowing erstwhile adversarial attitudes to give way to a more supportive and negotiating environment (Deffenbaugh, 1998). It also provided clinicians with what Llewellyn (2001) calls alternative 'windows' to become managers thus learn the economic consequences of their preferred treatment and healthcare decisions.

However some comment that the internal market competition had a "perverse" effect on the NHS. They argue that while the benefits of market competition may be clear in certain markets, in the NHS competition reinforced the desire to protect or expand services without justification or staff expertise (Beddow and Cohen, 2001). This, they also argue, encouraged secrecy about financial performance (Craft, 1994; Jones, 2000a) and the intentional manipulation and distortion of performance figures (Manning, 1982:122) and the needless duplication of specialist services.

In her study of the provider/purchaser relationship, Zolkiewski (1999) concluded that the internal market led to many changes in healthcare provision. There is more willingness for collaboration between different providers whether private or public. For example, services outsourcing and partnership with providers now give patients better choices of menus and treatment centres. On the contractual front, she contends that many lessons were learnt and negotiations are less adversarial and more cooperative through partnerships.

Although opinions are divided on the overall impact of the internal market, it led to at least three long-term effects on the NHS. Firstly, it forced NHS trusts to identify their core competence or business as providing healthcare and enabled them to select, bundle and package elements of that business as resources to market for survival if not financial gain. Secondly, it provided a major shift in ideology for managers hitherto charged with providing healthcare for the nation at public expense to engage in identifying their internal resources and operating like commercial organisations in meeting their resource needs through efficiency drives, effective marketing, outsourcing, alliances or collaborative partnerships. Thirdly, it allowed the mistakes and fragmentation of the health service to come to the fore. At least six hundred different types of contract arrangements were identified in the entire service (PASA, 1998). NHS Logistics and PASA have since helped to coordinate economic activities more effectively and efficiently within the available resources for the entire health service (DoH, 1997; Laing et al., 2002).

The function of NHS Logistics is mainly to act as a warehouse and delivery to the health service to enable them purchase goods in bulk at reduced prices and be a centre for just-in-time delivery of those goods. Thus it helps NHS trusts' internal supply channels realise efficiency, speed and cost savings in warehousing and delivery. Indeed NHS Logistics saved and redistributed £5million to NHS trusts in its first nine months of operation (Arminas, 2001).

PASA on the other hand was charged with streamlining the purchasing of goods and services contracts to comply with European Union, environmental considerations and to produce a template for outsourcing contracts. It has since vetted suppliers and services providers, produced standard procedure for tendering and an approved list of services providers. Consequently, purchasing managers are enabled by the activities of PASA in negotiating best contract terms, engage services providers that add value with their offerings, have better relationships with suppliers and are saved time, effort and money as PASA helps them eliminate needless waste through uniformity of information, training and better purchasing practices. Thus PASA acts as a knowledge repository for NHS trusts.

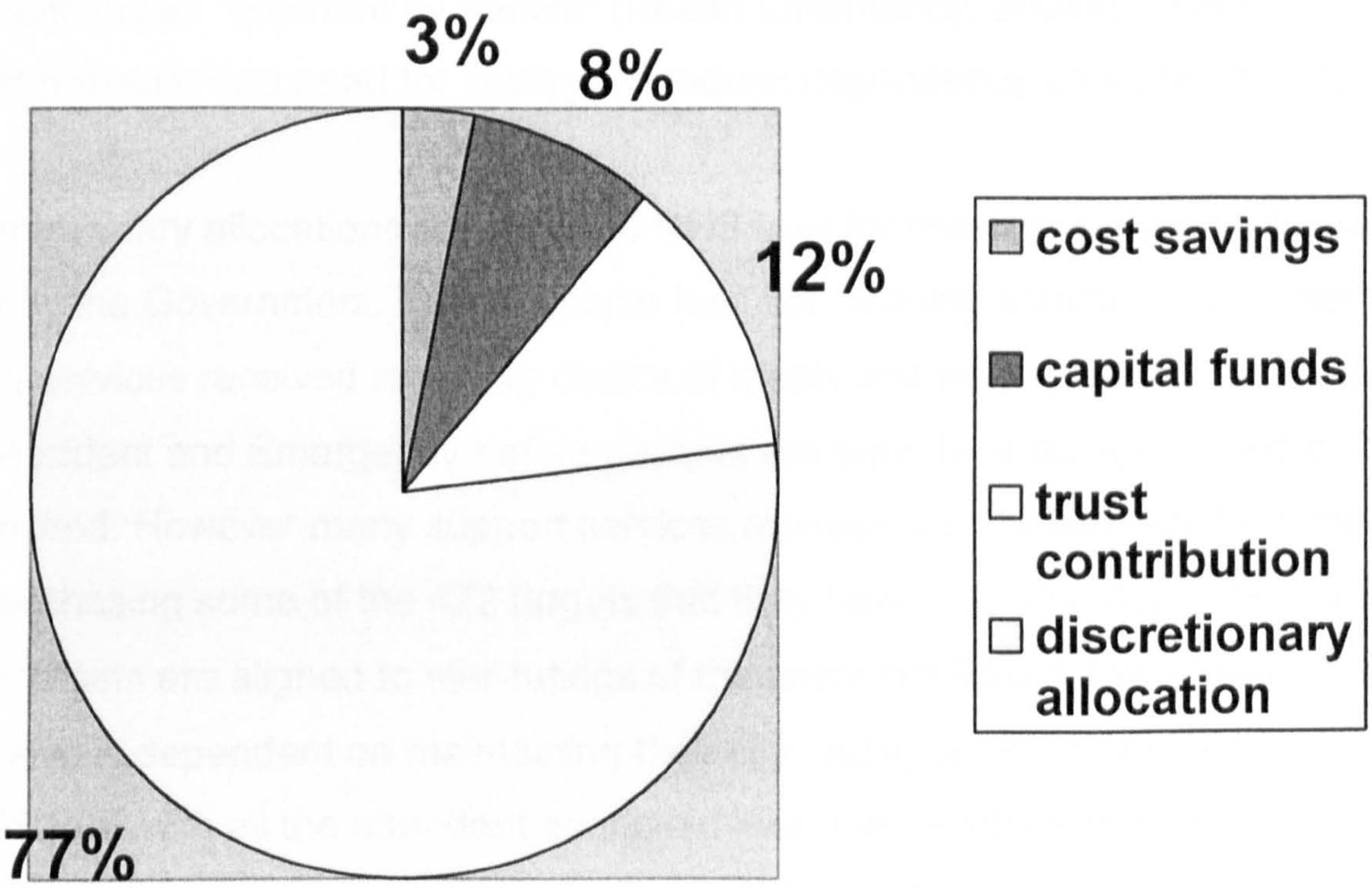
In total, the internal market was unpopular like most change initiatives that force people to work differently but it laid the foundation for a marketing concept in the health service. There is now internal generation of revenue through creativity or provider innovation, uniformity of contract tendering and better purchasing practices standardised and encoded in procedures, training of purchasing managers in contract negotiations and persuasion, team-working and relationship management that has equipped some of them to deal more effectively (Reeve and Warren, 2004) with the current Private Finance Initiatives (PFI).

In summary, the NHS was created as the greatest post-war reform liberating the citizens from fear of ill health and the inability to pay (DoH, 2002). It was to provide comprehensive healthcare for all citizens, free at the point of use and not ability to pay. Thus it will relieve suffering and improve the health of the nation. But the service has gone from consensus administration through general management framework to a market mechanism during three major reforms in 1974, 1982 and 1997 (figure 2.4), which are episodic in nature being sequential, with a beginning and an end. The introduction of market competition (1991) was a major cultural shift as was the collaborative partnership with the private commercial sector in 1997. But, despite its financial constraints, mammoth changes and deficits (Chapman et al., 2006; Lloyd, 2006), the NHS remains operational. NHS trusts created in 1991, have fully become autonomous and accountable with budgets to engage in contracting services from outside specialists. This contractual arrangement introduced in 1983 for support services now extends to clinical services with varied outcomes.

2.5 Financial allocation to NHS trusts: (Annual plan 2003 — (VH) figure 2.3)
Since the introduction of managed competition in 1997 trusts receive allocation (regarded as investment) directly from the Treasury (trusts opted out of Health Authority control).

This accounts for 77% of its revenue as cash limited (discretionary) allocation. Part of this is 'earmarked' for specific 'NHS Plan' activities like reducing waiting times and elderly care. A trust has an external financial limit (EFL) of 8% set by the Treasury for capital development. This money must be used or returned to the Treasury. A trust must therefore raise 12% of its revenue through private patient care and the sale of equipment or land (through local facilities management). Trusts must also make 3% efficiency gains and a 6% return on the 77% revenue allocation (treated as an investment). Thus, a trust must generate 15% of its revenue and make a 6% return on the 77% discretionary allocation annually to be viable.

Figure 2.3 Financing NHS trusts



Key:

Discretionary allocation 77%
Trust contribution 12%
Cost savings 3%
Capital funds 8%

Example of a typical NHS trust would be:

Operations: Gained trust status in1999 through the amalgamation of three hospitals.

Employs: 4,500 staff (excluding contract workers numbering over 600)

Total revenue: £213million (15% = £31.95million)

Bed capacity: 800 beds. Annual admissions: 20,000 patients

Therefore this trust must find the sum of £31.95 million and a 6% on its 77% allocation.

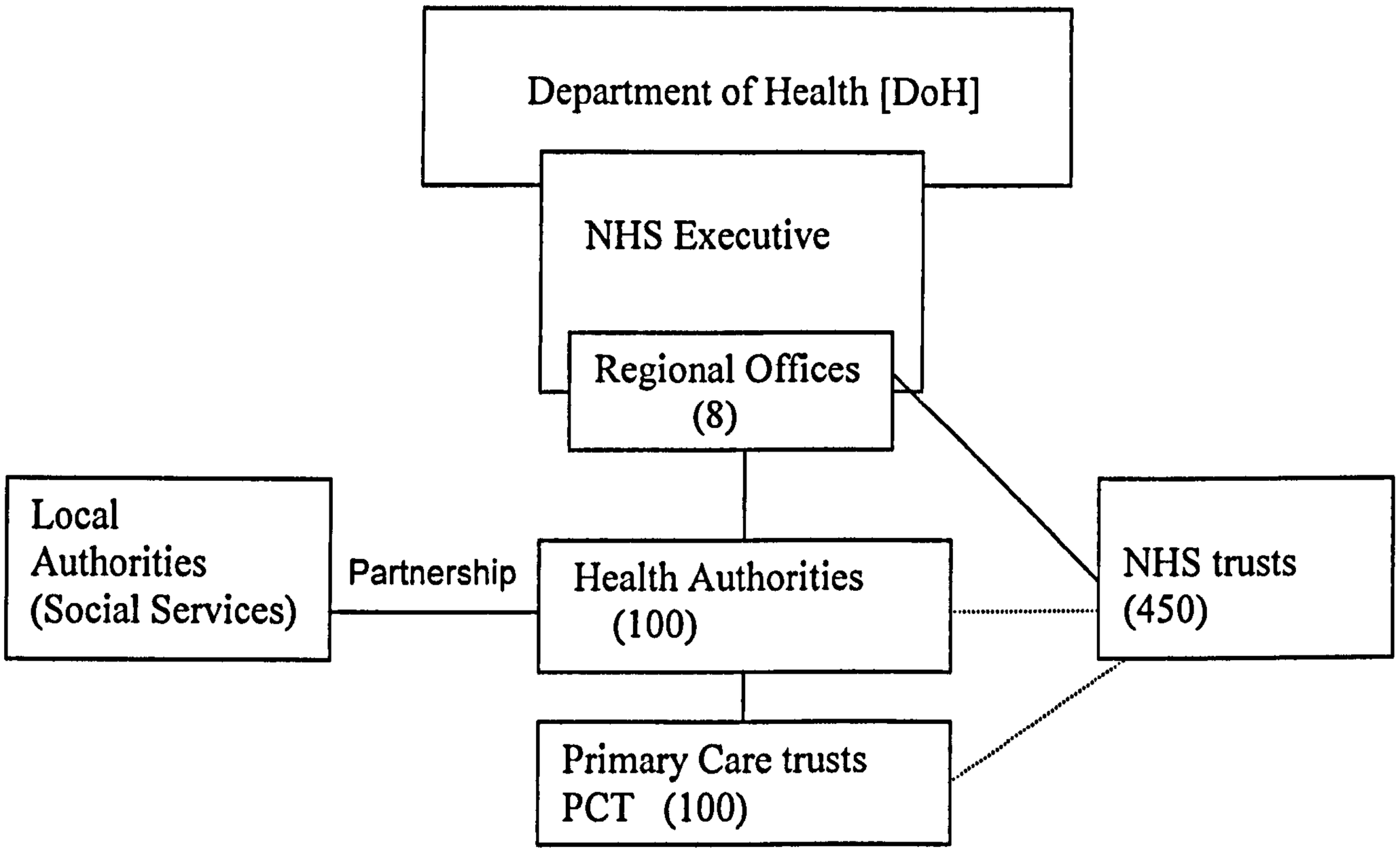
Income is mainly from clinical services offered to Health Authorities, General Practitioner referred patients, private patient care and numerous Government bailouts from unbalanced budgets and financial deficits experienced by some NHS trusts.
Cost savings can come from the sharing of facilities with private medical centres, savings through outsourced services like support services, reducing bureaucratic waste and using generic drug prescriptions (Øvretveit, 1995). For major capital projects like new hospitals, some trusts engage in Private Finance Initiatives (PFI), with all the attendant relationship management issues and organisational constraints engendered in external funding (Health Emergency, 2004a; Øvretveit, 1995). Consequently many trusts are under constant cost pressures and some run into financial difficulties in balancing their budgets (Beattie, 2005; Health Emergency, 2004a; Wilson, 2005). From April 2004 trusts received discretionary allocations as "payment by results" (Health Emergency, 2004a). This further increased the cost pressure and need for savings to reduce dependence on state bailouts and handouts.

Discretionary allocations are made to NHS trust for meeting certain performance targets set by the Government. These include hospital cleaning standards, in-patient satisfaction with services received including choice of meals and waiting period of less than four hours in Accident and Emergency before patients are seen by a doctor and either discharged or admitted. However many support services managers complain that they spend so much time chasing some of the 472 targets that they have less time doing their work. Because the targets are aligned to star-ratings of the entire NHS trust, the allowance NHS trusts receive is dependent on maintaining their star-rating or being deemed an under-performing NHS trust with all the attendant economic loss, media attention and budgetary deficit necessitating Government bailout with funds to meet their budgetary need. Thus payment by results necessitate cost savings or revenue generation to reduce pressure on NHS trusts to meet targets and get the extra allowance to balance their annual budgets.

Since dismantling the internal market, the new market framework focused on collaborative mechanisms based on partnership driven by competition and performance, have their critics. They have noted the "toxic incentives" and unrealistic "performance targets" (Appleby, 2002; Demos, 2002; Harding, 2005a; Lloyd, 2005a; Walker, 2005).
Nevertheless, on the positive side, some NHS trusts have achieved these same targets and gained the requisite incentives to enable them attain autonomy and self-determination as foundation trusts (Goldman, 2005; Timmins, 2007).

To the relief of some managers, performance targets were withdrawn by the Department of Health in March 2006 due to "miscalculations" that resulted in financial problems, massive deficits and notable staff resignations (Harding, 2006; HSJ, 2006; Martin, 2006).

Figure 2.4. Structure of the NHS in 1997
(Adapted from The New NHS (1997:8)



Key: ——— Represents lines of managerial authority

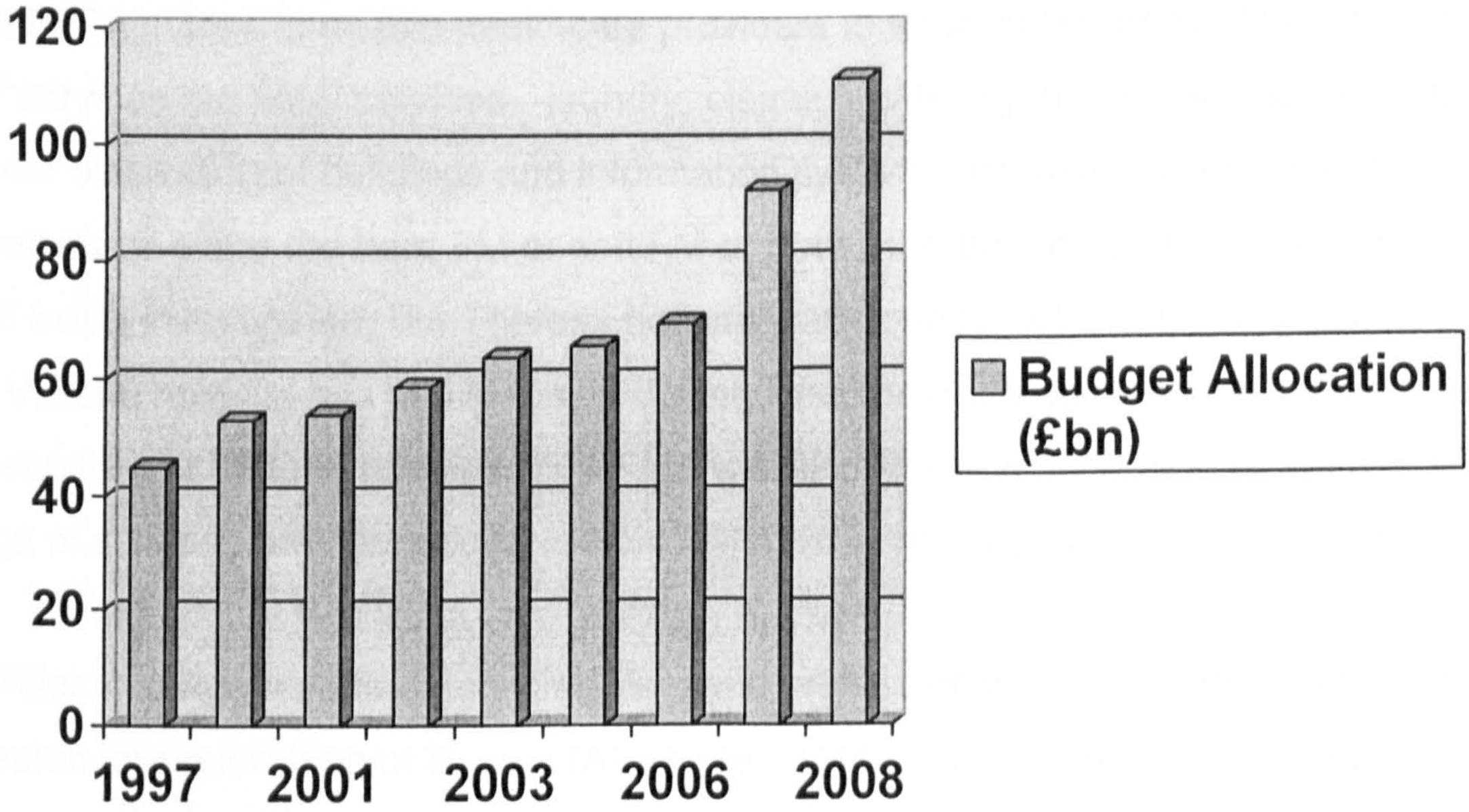
..... Represents lines of consultative/coordinating relationships

2.6 Changes since dismantling the internal market 1997-2006

The fundamental change and reforms in the NHS since 1997 has been a quest for performance effectiveness and operative efficiency in deploying financial and human resources to meet healthcare needs. During his revisit to Britain, in 2000 the American economist, Alain Enthoven revisited the subject of efficiency in the NHS and commented that Britain lacked needed resources and competition to achieve her healthcare objective of operational efficiency and performance effectiveness fit for the 21st Century (Enthoven, 2000). This is largely due to chronic under-funding (Portillo, 1998) resulting in observable decay in the buildings and shortage of staff and equipment, the inefficient use of available resources, wastage and the variations in performance across the health service.

Subsequently, health service funding has increased to unprecedented levels (20% of total public service spending or 8.9% of 2006 GDP) as shown in figure 2.5 below (Appleby and Boyle, 2000; Eaton, 2007; Ferriman, 2000; Kaletsky, 2008; Watson, 2006), causing fears and worries among commentators (Crook and Blitz, 2004; Parris, 2004; Wilson, 2005). The Government has also produced a plan of action for reform with a coherent strategy, mechanisms for monitoring with incentives for better performance and sanctions for under-performing trusts (Appleby and Thomas, 2000; Dixon, 2000a). Thus the Government has taken a somewhat decentralised approach, preferring to set standards, allocate resources to ensure equity and transfer power to local frontline staff to meet local need (DoH, 2002). But there is state reliance on incentives and monitoring of effectiveness by regulators to energise NHS trusts' managers to be accountable and more efficient in resource use while private contractors continue to be used in support services (Arie, 2005, Blair, 2005).

Figure 2.5 Public Spending on the NHS1997-2008 (Watson, 2006:60)



The present collaborative framework allows access to sharing of information, knowledge, learning and cost reduction from external others. The concept of partnerships developing into network of valuable relationships has been suggested (Levitt et al., 1995:82; Thornton, 1999). The advantages of negotiated agreement between collaborating partners in reducing conflict and cost of monitoring in long-term partnerships (Øvretveit, 1995) and the difficulties of studying the NHS as an organisation have also been highlighted (Fischbacher and Francis, 1999; Robinson and Le Grand, 1994; Øvretveit, 1995). The sequential and episodic nature of changes in the health service is well documented.

This thesis now explores the aims, objectives and activities of hotel services providers through their collective function in facilities management (FM) to provide a rounded picture of the agents involved in support services interaction.

2.7 Facilities Management (FM)

Facilities management originated in the United States of America (USA) in the 1960s, with banks outsourcing the processing of credit cards transactions to a central pool to focus on their main function of serving banking customers (Alexander et al., 2004; Nelson, 2004). From the 1980s it progressed to coordinating, developing and controlling of non-core specialist services like hotel services. By the 1990s facilities management has become a process by which an organisation ensures that its buildings, systems and services support its core operations and processes and contribute by enabling it to achieve its strategic vision or direction in a changing dynamic business environment (Alexander 1996). Facilities management can entail total outsourcing in the design, build, operate, manage or maintain hospital facilities to facilitate optimal use of premises (hard FM) with non-core "soft FM" services to enable healthcare providers to focus solely on healthcare. The "soft FM" services are hotel services—laundry, cleaning catering, housekeeping, security, interior decoration of buildings and information systems. However organisations can chose to outsource either the hard FM or soft FM or both as in total outsourcing. Indeed some NHS trusts investigated, like Theresa hospital has gone for total outsourcing while others like Victoria hospital has totally rebuilt County hospital while retaining the outsourced soft FM services at Victoria hospital. Thus, there is flexibility in outsourcing as seen in the range of services providers' involvement within NHS trusts (see figure 2.6 below).

Facilities management is a new discipline and profession with few theories, academic research and publishing of its own (Alexander, 1996, 2003). There is a growing need to secure the future of FM as a credible discipline built on strong theoretical foundation and dedicated to understanding and developing the discipline in areas of total outsourcing, risk assessment and management or facilities management and maintenance (Lai and Yik, 2007; Okoroh et al., 2002; Rodney and Gallimore, 2002; Salonen, 2004; Walton, 2007). When facilities management is provided in the context of Private Finance Initiative (PFI), its risk assessment and management provide value for money in the efficient use of public resources and accountability from those involved (Ilozor et al., 2002; Jones, 2000). Thus through total facilities management, the problems of combining resources, sharing control

and adding value to contractual relationships through creative designs and innovative buildings that transform local landscapes can be addressed (House of Commons, 2003).

In the UK, the outsourcing of hotel services to commercial providers in 1983, invited the operators of facilities management, who are also multinational corporations (multinationals or MNC) into the health service as services providers (Gallagher, 1998; The Health Service, 1983; Thornton, 1999). Hotel service was a point of access for multinationals into the health service. Since then outsourcing has progressed to total outsourcing of both hard and soft FM, outsourcing of clinical imaging or information technology and major project funding through the Public-Private Partnership (PPP) and Private Finance Initiatives (PFI). Facilities management operators aim to deliver faster, better and cheaper services more efficiently and effectively than their competitors (Alexander, 1996; Gallagher, 1998). They also pride themselves with innovative ability to optimise the performance of their clients' business while adding value to business operations (Alexander et al., 2004; Vondle, 1989). By their activities, FM operators claim to enhance the public image of organisations they serve, develop a more productive work environment through better workplace design, help organisations attract higher calibre or more motivated employees and improve their ability to accommodate workplace changes now and in the future (McGregor and Then, 1999).

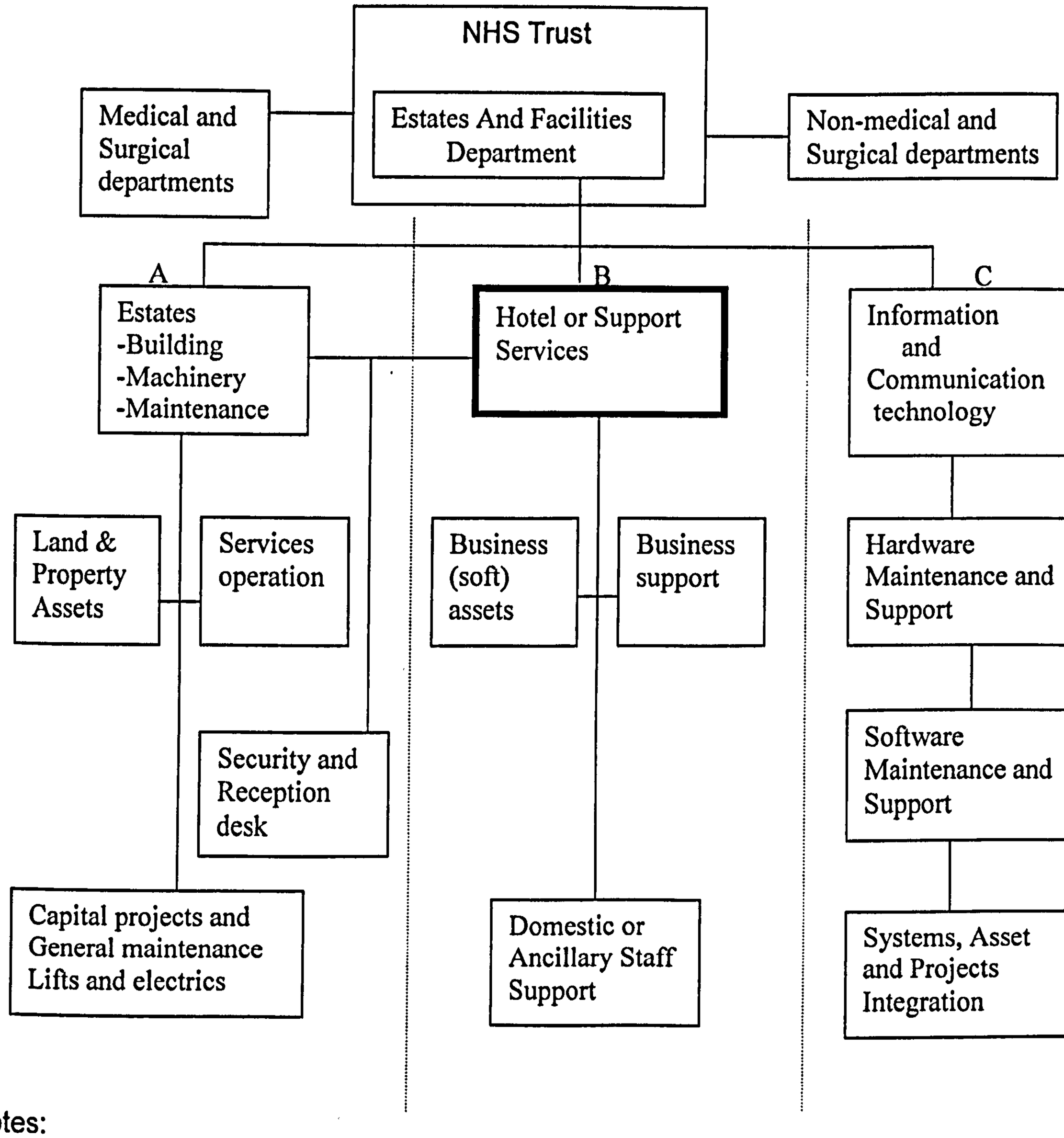
2.7.1 The Advantage of FM Operators

There is a large and varied literature on FM provision, ranging from contemporary journalism to academic studies. The multinational corporations that provide FM services are renown for possessing large resources, namely, finance, human capital of educated, experienced and skilled managers and personnel. Some of these are critical resources others organisations like NHS trusts need to provide them with uninterrupted support services for organisational survival or building capabilities like routines and processes for comparative advantage with other NHS trusts (Child, et al., 2000; Venables, 2005). Many of the old and dilapidated buildings crying out for funds have been replaced with creative design and workplaces improved for better working conditions (Ilozor et al., 2002).

But NHS trusts have the option to outsource all or parts of the FM services on offer. They also possess expensive technology and information systems that aid management forecasting, decision-making and comprehensive record-keeping repository.

Figure 2.6 Scope of Facilities Management (FM) in the NHS

(Adapted from Williams, 2002:1.6)



Notes:

Facilities Management (total FM):—University College and Central Middlesex hospitals

A. Estates department deals with buildings, hard assets and machinery maintenance
B. Support or hotel services deals with catering, cleaning, laundry, portering and domestic staff. Most hospitals combine estates and hotel services as one unit
C. Information systems dealing with all systems data generation and storage, information dissemination and systems maintenance

Most multinationals, especially the United States of America based ones, have an aggressive entrepreneurial attitude to investments and the flexibility to adapt quickly in response to environmental change (Ferner et al., 2004; Venables, 2005). Hence they can combine resources to greater efficiency of resource allocation or mobilise them to where needed to effectively improve the productivity and performance of client organisations like NHS trusts. The multinationals have also become unparalleled positive instruments or catalysts for social change by helping organisations with diverse professionals, like the health service; to cooperate and weather economic downturns and cost pressures to achieve consensus on cost reduction plans and revenue generation methods. Thus, they have enabled outsourced NHS trusts to reduce their dependence on Government funding alone and removed the uncertainty of funding in these NHS trusts through investments.

Financial resources

All FM providers in this study, as multinational corporations, are involved in or associated with global banking, insurance houses and communication systems. They enjoy monopoly market position by setting up barriers to free trade and pooling risk capital away from other competitors (Child et al., 2000; Venables, 2005). For example, to form a consortium that can provide the total FM services needed by Theresa Hospital, Amek bought out Douglas to form Kingsland in order to combine support services with construction operations (Ralph, 2003:44). This is because traditional building construction alone is fraught with cost overruns and low margins while total FM with support services can generate revenues with interest over longer periods of thirty years, as is the case with the new facilities at Theresa Hospital. By their associations with international banks and Governments, and their competitive power in global economy, multinationals can easily obtain maximum tax breaks, circumvent local regulations and muster bargaining power in the policy-making arena (Venables, 2005). Because multinationals bring in scarce resources like technology, skilled personnel and investment funds in the form of Foreign Direct Investment (FDI), many Governments condone their activities to benefit from their wealth creative ability (Venables, 2005). For example, Multinationals gain entry into foreign nations through acquisitions of local firms (Child et al, 2000; Venables, 2005), licensing or agency contracts and alliance as the Japanese did in USA, Europe and Mexico (Ferner et al., 2004). Thus their deep financial pockets allow them to undertake total FM provision in design, build, manage and maintain facilities for NHS trusts and wait out the long service contracts of thirty-five years before they recover investments. They have reduced the dependence of NHS trusts like Theresa and County Hospitals, others on Government

funding for capital projects but may also have transferred the dependency of these trusts on themselves.

However their market dominance and financial resources deprive local and national FM providers the ability to meaningfully compete in the market place and so threaten their ability to contribute to national wealth creation (Salonen, 2004; Venables, 2005).
For example there are no local or national FM providers in this study dominated by multinational corporations. Perhaps this is a case for further studies to unravel why!

Cost management

Organisations gain competitive advantage through lower cost structure or differentiation in products or services (Haberberg and Rieple, 2001). Multinationals can access information on the cost structure of every element of equipment, product or service they use, buy or supply. They also understand details of their cost drivers and can utilise scale economies to reduce costs in energy utilisation, facilities repairs or maintenance (McGregor and Then, 1999; Lai and Yik, 2007). Thus, they can make more meaningful cost analysis and work to reduce total costs, generate revenue by avoiding surplus capacity or utilizing redundant spaces, hence provide support services at a lower cost or add value to customer offering as best value providers in order to increase profits or return on investments.

Furthermore through their global operations, distributions channels and integrated services multinationals enjoy lower inventory carrying costs by operating a just-in-time delivery, can reduce material cost by bulk buying or competitive procurement and through efficient fleet management, work order tracking and strict budgetary controls can gain cost advantage. Their materials and project management can reduce total costs through value engineering that eliminates all needless tasks and clients' demands that add no value to performance of primary function and so provide the required service at least cost (Williams, 2002). Thus multinationals as FM providers are able to compete favourably on cost advantage.

Human resource

Observers have long noted the relationship between development of human capital and firm profitability for competitive edge (Becker, 1993; Hope-Hailey, 2005; Ulrich, 1997). Facilities management work is said to be labour intensive and not too rewarding in terms of job satisfaction (Gallagher, 1998).

However the multinational FM providers have the resources to make the most of the theoretical advantages of work-force motivation. This is done through intensive on the job training, regular appraisals to determine personnel needs and a commitment to staff development. This raises the enthusiasm of a loyal workforce, who then use standardised, operating procedures and flexible working to achieve productivity and performance gains. The availability of equipment and automation also enhance workflow and reduces the time spent waiting for repairs or replacement equipments. Thus multinationals like other large conglomerates, understand the relationship between concern for the well-being of the workforce, development of human capital and the resultant higher productivity (Ferner et al., 2004; Ilozor et al., 2002; Venables, 2005). Through staff development and training, they unleash the commitment, loyalty and enthusiasm of the workforce to do and produce more even at lower wages than competitors. This was the case at Karena and Reinhard hospitals, where the services providers, paying lower wages than the health service, are still able to attract and retain ancillary staff better than the NHS did.

But multinational FM providers also engage in brain drain by enticing the competent and best personnel away from local entrepreneurs by offering them better jobs and choice of work abroad without strings attached. They also have better incentive schemes like employee of the month and year, visible management with less blame culture and a more cohesive workforce as seen in this study. Hence they can deplete national reserve of knowledge and manual or ancillary workers whom they train or educate to become valuable resources in their own rights. Perhaps this is why there are no local FM providers.

When organisations develop their personnel through intensive training, education and skill acquisition, they build human resource as valuable assets, by enriching other motivators of work apart from pay for better staff retention (Cappelli, 2000; Jolly, 2003; Savery, 1996). These dedicated personnel then deliver innovative, quality customer service, competitors cannot easily imitate as seen in some Japanese firms (Dyer, 1994; May and Suckley, 2005; Pfeffer, 1994a; Setlzer and Bentley, 1999). Consequently, by developing their human capital, multinational FM providers increase their resource base for competitive advantage. Even when staff members are retrenched, or reassigned, their training and skills acquired equip to liberate them for alternative employment or upward job mobility, as was the case in this study.

Physical resource

Physical buildings can enhance business profiles and proclaim organisational and worker identity to the outside world (Alexander et al., 2004; Hosking and Haggard, 1999). Office layouts and facilities control social contacts and relationships of those who work in them and define the nature of their daily contact (Becker and Steele, 1995; Walton, 2007). Furthermore, business buildings give a symbolic quality to an organisation to reflect business vision and reinforce the power structure within the organisation through status symbols, space and location (Alexander, 2003; Hatch, 1997). It provides workers with a symbol of permanence, a haven of security and allows them to give of their best to their organisations (Alexander, 2003; Ilozor et al., 2002). The aesthetic and functional quality of the building and surroundings help improve ease or convenience, and the psychological or spiritual well-being of patients in a hospital setting (Hosking and Haggard, 1999; Rodney and Gallimore, 2002). FM providers can assist this "cultural landscaping" helping to improve local ownership of the hospitals as residents culturally identify with their local or community hospitals as seen at County hospital with local cultural prints, murals and landscaping. Innovative designs are built for looks, form, functionality or fitness for purpose and flexibility for future use (Eriksson, et al., 2007; Jones, 2000c; Walton, 2007). Thus, "hard FM" providers have the resources to build hospital facilities with imagination, creativity, innovation and engineering efficiency to provide an environmentally friendly and sustainable facility fit for purpose now and in the future without the need for relocation.

This enhances the work environment and increases workflow for greater productivity from a less-stressed workforce (Munck, 2001; Okoroh et al., 2002). For example the facilities provided at Theresa and County hospitals are testaments to the ingenuity of facility design and aesthetic beauty that help project community spirit and aid regeneration. The open plan design aids workflow and working relationships. Those interviewed in both hospitals attest to their new environment being a source of motivation to get up in the morning for work and a centre of attraction in the community. Such innovative designs that optimise available space are associated with change improvements, and organisational profitability (Alexander, 2003; Jones, 2000c). For example, University College London Hospital sold a redundant real estate in central London to turn its deficit into surplus (Gainsbury, 2008). Thus optimising the use of a redundant space and making profit for the NHS trust.

The culture of preventive maintenance of buildings and machinery and the innovative use of land and vacant spaces can reduce the cost of managing buildings and increase

revenue generation or cost savings for NHS trusts served by these providers (Jones, 2000c; Lai and Yik, 2007; Rodney and Gallimore, 2002; Williams, 2002).
Any revenue generated is used to offset and reduce their total costs hence dependence on discretionary allowances to mitigate their cost pressures. Thus the FM providers, enable outsourced NHS trusts reduce cost pressures through preventive facilities maintenance and management and change their workings relationships and work environments.

2.7.2 Private Finance Initiative (PFI)

Private Finance Initiative (PFI) was introduced in 1992 and hailed as a far-reaching and radical change in capital investment in public service (HM Treasury, 1995; Payne, 2000). It was originally meant to help Local Governments finance the provision of social services and repair roads in their borough through private funding (DoH, 2003; HM Treasury, 1995). Their remit was expanded by the Labour Government to include a radical innovation in financing new facilities and support services in the NHS through partnerships (DoH, 2003). This dynamic change in the environment accorded the private sector the opportunity to finance, build and manage healthcare facilities and the attendant risks for the working life of such facilities (Rodney and Gallimore, 2002; Wiklund and Shepherd, 2003). The FM providers already have resources for investment and the trained personnel to carry out the projects, thus PFI afforded them the window of opportunity for growth and to maximize profits and return on investments as well as become change agents in NHS trusts served.

From these private investments, the public sector benefits through non-committal of their own capital, no risk to bear and the payment of one agreed set leasing price (Nutt and McLennan, 2000; Payne, 2000). Thus, physical property is no longer viewed as financial asset but a business service, hence helping to free up capital while reducing the total cost of building through partnerships and longer term investments (Harland et al., 2005; House of Commons, 2003). The freed up capital can be used to improve the quality of support services or healthcare business performance.
PFI arrangements have allowed multinationals extend their services offerings to include major project funding and hence the flexibility of total FM service provision for NHS trusts.

There is also an opportunity for those involved in the NHS trusts served to learn from their vendors in areas of resource combination, sharing ideas and knowledge to produce new knowledge that influence the innovative work place designs (Rodney and Gallimore, 2002; Salonen, 2005). There is learning in contract management and sharing of control through

interdependence for mutual benefits (Jones, 2000c). However the commercial operators have been in business much longer than their public sector counterparts. Consequently the learning curve may be steeper for services managers than originally envisaged (House of Commons, 2003). There are many areas of commercial interest to learn. For example, public sector managers must be knowledgeable and conversant with risk assessment and management and be able to negotiate fallback positions and contingency plans into future contract bids against non-performance or failure of contractors to secure equity capital. There are negotiations in sharing refinancing profits and securing bid prices that do not remove the incentive to perform or tie up future options in renegotiating contract prices to meet changing needs of their trusts. Managers need to understand contract arrangements and project management through effective relationship management in order to continue realising value for money from creative designs. But they are learning and PFI schemes offer them the opportunity to learn commercial discipline within appropriate governance mechanisms. Thus, the public sector benefits from PFI schemes as services managers continue to learn through knowledge transfer from their commercial counterparts.

Information systems (IS)

Information systems and the accompanying telecommunication technology are important sources of power in global competition (Eccles, 1991; Starbuck, 1992; Quinn et al., 1996). They can also improve electronic monitoring and security of facilities like hospitals. They are used by organisations like FM providers to integrate all systems, store data from financial and non-financial performance measurements to market share, human resource and innovative project details (Eccles, 1991). They are also used to monitor or track client needs and objectives, technology in use and service delivery in order to improve customer satisfaction through total cost reduction or added value (Nelson, 2004; Williams, 2002). Consequently, information systems are the intelligence of the organisation, a repository of information and monitoring device that helps FM providers add value to client offerings or be a least cost provider and improve their own profitability for competitive advantage. At County and Theresa hospitals, the information systems have improved the central monitoring of systems and reduced the time taken for security staff to deal with bogus fire alarms and hence improve patient and staff safety especially at night. Furthermore, information systems aid management decision-making through scenario planning to generate alternative options for better forecasting in any situation or challenge and for tracking the performance of the workforce whose incentives are aligned to performance measures (Eccles, 1991:133).

For FM providers in particular, information systems help them maintain strict budgetary controls over projects like healthcare facilities, by cutting out unnecessary and wasteful duplication of practices and eliminating needless tasks that add no value to the performance of client operations (Atkin and Brooks, 2000; Williams, 2002; Payne, 2000). Information systems also aid competitive procurement of goods for services delivery. They help monitor supply chain, supplier movements (Nelson, 2004), benchmarked least price payable for goods and the efficient use of the workforce for effective service delivery (Williams, 2002). Consequently, information systems and technology are vital resources for FM providers and indeed form part of the total FM as shown in figure 2.6 above.

The main benefits of information systems to FM providers is in storing, analysing and tracking information or data on their operations, record keeping, integrating all projects and systems in order to maximize profits through a more cost effective and efficient operation that avoids wastage or duplication (Alexander et al., 2004; Williams, 2002). However the centralisation of such vital information and records of any organisation in the possession of their services providers can become a source of power and control over the client, making NHS trusts involved in total FM dependent on their services providers. For example, the FM providers in total FM like Theresa and County hospitals, will own, manage and maintain their healthcare facilities for the next thirty-five years. They have the power to allocate status symbols like office location and parking spaces. They can lock or unlock doors at will and impose security checks on all members of staff, as is the case in this study. All the information on staff movement and all the systems in the facilities are centrally monitored and records kept and owned by the FM providers. This gives the erstwhile "underdogs of support services" power and control over NHS trust workers, their movements and security for thirty-five years hence (Zukin, 1991)!

These are broadly the perceived advantages and unintended consequences of FM services provision from multinationals to outsourced NHS trusts.
This thesis now explores how NHS trusts can efficiently and effectively deploy financial and human resources to improve organisational outcomes and realise their outsourcing objectives.

Chapter 3 Literature Review: Resource acquisition through outsourcing and relationship management

3.1 Introduction

Increasing global competition and changing technology including information technology combined have shifted organisational goal from simply economising to adding value (Pettigrew and Fenton, 2000; Power et al., 2004). Multicultural customers now demand added value in products and services not just cheaper prices while organisations struggle to achieve or maintain competitive advantage (Campbell, 1995; Khong, 2005; Power et al., 2007). Outsourcing can enable firms tap into new ideas, knowledge and creativity through access to services' providers resources like skills, experience, specialised equipment and investments to provide services of better quality, at lower costs than in-house departments (Campbell, 1995; Sveiby, 1997; Power et al., 2007). Outsourcing can also enable workers seize the opportunity for career development and advancement to sharpen and upgrade their skills to professional standards and so liberate themselves from manual workers to professionals (Leavy, 2004; Sveiby, 1997). Consequently, organisations outsource peripheral functions to benefit from its cost reduction or value for money and added value.

The business interaction between hotel services managers and their services providers, Government agencies, charitable organisations and the private healthcare sector involves relationships. The decision to outsource services was made for them. Adding value to firm activities underlies the literature on outsourcing, the resource-based view of the firm and strategic alliances, centred on inter-firm relationships or partnerships (Pettigrew and Fenton, 2000; Eriksson and Laan, 2007). Observers note that business is about relationships that provide the context of interaction, cooperation and collaboration for the successful coordination of economic activity (Webb and Laborde, 2005). Others comment that businesses can be transformed through relationships that enable firms gain access to more efficient specialist skills, best practice and investments to respond to business needs (Linder et al., 2002). Such businesses can become profitable and effective through better focus on core functions, social support and input of new ideas (Elmuti and Kathawala, 2000). Thus business relationships are at the core of successful resource acquisition and utilisation for creating value through innovation and learning for competitive advantage.

The literature on inter-firm relationships is reviewed below. Also reviewed are resource dependence theory, transaction cost economics and interaction model, concerned with resource acquisition, governance frameworks and contractual relationship management.

3.2 Outsourcing: Accessing resources through contracts

Some organisations choose contractual arrangements like outsourcing to access scarce resources in order to reduce costs or build capabilities and competence for competitive advantage (Das and Teng, 2000; Leavy, 2004). The literature treats outsourcing differently from strategic alliances probably because outsourcing of non-critical functions is usually concerned with enhancing specialisation and organisational focus on core activities to build capabilities for competitive advantage (Gadde and Snehota, 2000; Prahalad and Hamel, 1990). The motives for strategic alliances (section 3.6) on the other hand, range from co-option of potential competitors and learning to internalisation of knowledge for creating value (Doz and Hamel, 1998). However, both are contractual in nature, involve hybrid structures and are concerned with collaborative arrangements with external others.

Researchers proffer many reasons why organisations choose to outsource semi-critical or non-critical functions (Cross, 1995; Fill and Visser, 2000; Jennings, 2002; Lacity et al., 1995; Peisch, 1995). Outsourcing refers to "subcontracting custom-made articles, products or services, construction components or sub-assemblies to another company" (Fill and Visser, 2000). Outsourcing is essentially 'contracting for results' not collegiate obligations or assets (Peisch, 1995:32). For services, outsourcing is seen as a solution to the quest for a continuous, reliable and uninterrupted service (Cross, 1995; Fill and Visser, 2000). Outsourcing may be total, as in design, build and deliver arrangements, or selective as in payroll and information technology or in-betweens (Davis, 2004; Fill and Visser, 2000).

Why study outsourcing in line with other studies?

Many studies used participants' perceptions to document the benefits of outsourcing. But none of them specifically involved support services outsourcing in the NHS. For example, some studies analysed the effects, advantages and impact of outsourcing (Elmuti and Kathawala, 2000; Heide and John, 1990; Khong, 2005; Webb and Laborde, 2005). Others investigated public sector organisations (Lacity and Willcocks, 1997; Lim et al., 2007) and facilities management in the health service (Okoroh et al., 2002; Rodney and Gallimore, 2002). Others studied customer services (Khong, 2005) and logistics (Power et al., 2007), to document the benefits of outsourcing as in this study. From these studies, the perceived benefits of outsourcing range from access to provider resources, cost reduction to value for money. To these benefits, this study adds learning, innovation, career development and advancement for the liberation of workers as added value. Thus the value-adding benefits of outsourcing are worth examining.

3.2.1 Cost reduction

Organisations outsource non-critical functions or services in order to reduce in-house cost of production (Jennings, 2002) or acquire skilled personnel (Joshua-Amadi, 2002, 2003; Lacity et al., 1995; Peisch, 1995). Some firms outsource troublesome functions to focus on core competence or enhance resources (Cross, 1995; Dyer, 1997; Peters and Waterman, 1982), while others maximize flexibility and control for competition (Fill and Visser, 2000; Lacity et al., 1995). For example, Cross (1995:102), noted that British Petroleum (BP) outsourced their information technology to effectively focus on 'finding and producing hydrocarbons' while Microsoft and Intel both concentrate on research and development, outsourcing all other functions like administration, security, production and marketing of their products (Davis, 2004). Similarly, Apple computer focused on creating a user-friendly design and appearance of its hardware and software while outsourcing the rest of its functions (Quinn et al., 1990), while Honda used its exclusive engineering skills to become a world leader in small engine production, outsourcing the production of other motor parts (Dyer, 1997). Peisch (1995) posited that the hospital he studied outsourced all its surgical services for skilled personnel to leverage surgical competence from experts. Consequently researchers believe that some organisations can become more productive and competent using managerial time and effort to deliver added value to customers by concentrating on their core competence and outsourcing peripheral functions to external experts.

3.2.2 Access to skill and knowledge for adding value

Organisations can access skills, experience and expertise through outsourcing to build capabilities (Grimshaw and Miozzo, 2006; Rock, 1999) or add value to customer offerings (Grossberg, 2004; Huber, 1993; Leavy, 2004; Linder et al., 2002). For example: services outsourcing enabled ServiceMaster to build its unique capability in maintenance services to become an important market innovator and repository of market knowledge and expertise (Quinn et al., 1990). Continental bank caused a stir in 1991 by being the first bank to outsource its "crown jewels" of information technology in order to concentrate on customer relationships that form the core of the bank's business (Huber, 1993). Similarly, supermarkets now offer mortgages and loans through banks and building societies, to process these services and share in their risks and rewards while adding value to their customer offerings (Rock, 1999). Building contractors have become more versatile in their service offerings through outsourcing to become industry giants in facilities management and so earn higher streams of revenues and profits (Jones, 2000c; Ralph, 2003).

Some organisations have used outsourcing to enter new markets (Grinshaw and Miozzo, 2006; Grossberg, 2004) while others used it to enable them reap rewards of innovation using the resources of their vendors (Leavy, 2004; Linder et al., 2002; Quinn, 2000). Other organisations have become more flexible and in control of their operations freed from distractions and troublesome functions thereby cutting investments in these areas to build unique capabilities in other areas (Davis, 2004; Huber, 1993; Quinn et al., 1990).

Some have transformed their organisations through resource acquisition and overcome the resistance to change (Linder et al., 2002) or become a learning organisation through outsourcing (Jamali et al., 2006; Senge, 1990; Quinn, 1999). Some workers used the outsourcing opportunity to upgrade their skills, improve their image, employability and self-esteem and liberated themselves from manual workers to professionals (Sveiby, 1997; Khong, 2005). Others saved on the cost of risky investments till such services became established and successful or outsourced manual tasks to save costs through the scale economies of external experts (Huber, 1993; Rock, 1999). For example: Barclays Bank teamed up with British Telecom to establish Internet banking while outsourcing its help desk telephone service involving manual repetitive tasks, to improve service quality to users and save costs. Thus outsourcing can benefit organisations in different ways.

But for many organisations, efficiency gains are the main reasons for outsourcing (Cross, 1995; Elmuti, 2003; Fill and Visser, 2000; Knight, 2004), or mimicking the Shamroch organisation (Handy, 1996) by outsourcing peripheral activities such as payroll, legal, information technology, hotel services and peripheral personnel to contractors to reduce total costs (Elmuti and Kathawala, 2000). Some firms streamlined or reduced staffing levels to save on salaries, pensions and benefits (Cross, 1995; IPD, 1995; Peisch, 1995).

Outsourcing can also provide cost efficiency for capital projects, through outsourcing dormant or non-critical functions to outside specialist who have access to superior cost drivers like low cost locations, expertise, learning and scale economies to reduce unit costs (Davis, 2004; Jennings, 2002; Peisch, 1995). Similarly, dormant resources like office space can be redeployed to earn revenue streams for other projects or increase corporate profitability (Lacity et al., 1995; Khong, 2005; Peisch, 1995). Some firms used outsourcing to reduce inventory and possibility of obsolescence or restructured their budgets thereby turning fixed into variable costs (Huber, 1993; Lacity and Hirscheim, 1999).

3.2.3 Un-materialised cost savings

While many organisations (68%) enjoy savings in time and money (Labour Research, 2005a; Rock, 1999), for others, the perception of cost savings may not always materialise leaving them disappointed and frustrated (Currie et al., 1999; Fill and Visser, 2000; Lacity et al., 1995; Labour Research, 2005d; Peisch, 1995; Rock, 1999;). Reasons for this range from hidden costs such as irrecoverable value-added tax (VAT), start up costs that can only be recovered through the lifetime of the contract and different assessment of cost drivers, to changes in need and expectations (Lacity and Hirchheim, 1999; Rock, 1999). For example, clients assume vendors' costs must be lower due to scale economies and specialisation but vendors must generate fair profit for shareholders while in-house operations only need to recover cost (Lacity and Hirchheim, 1999; Power et al., 2004). Furthermore, according to traditional Transaction Cost Economics, in-house operations can minimize their total transaction cost due to efficient system of reward and punishment that can discourage employee opportunism while outsourcing involves initial search and contract negotiation costs and later, coordinating, performance monitoring and contract enforcement costs to mitigate opportunism of vendors (Williamson, 1975, 1981, 1991).

Also when there are few vendors with enough financial backup facilities to engage in total outsourcing, they can take advantage of their captive customers through hidden costs (Barthélemy, 2001; Barthélemy and Quélin, 2006). Thus, contracts without built-in cost flexibility to accommodate changes in client expectation and need, (internal uncertainty), will always be froth with disappointment, frustrations and unrealised expectations.

But the initial assessment of potential cost savings is problematic (Power et al., 2004). Proponents of cost-efficiency note that such expectations may be illusionary due to what Lacity et al., (1995), call 'hidden agendas and divergent interests'. Thus, total costs may escalate beyond expectations. For example, misunderstood contract details, reduced performance standards or expected quality unrealised, may all reduce the total anticipated cost savings (Cross, 1995; Davis, 2004; Peisch, 1995). Williamson (1975) admits that costs are difficult to assess. He notes that costs depend on the frequency of transactions and the threat of opportunism or Williamson's (1996: 215) "self-interest seeking with guile". Thus, Williamson (1996) advises buyers, to assess monitoring and coordination costs against in-house production. Consequently, observers have advised outsourcers to decompose their cost drivers (table 3.1) and evaluate where outsourcing can save them money (Davis, 2004; Leavy, 2004; Power et al., 2004). Total transaction costs can be

controlled and reduced by reducing excessive and frivolous demands and tying service usage to costs (Huber, 1993; Lacity and Hirchheim, 1999; Rock, 1999). Furthermore clients should weigh other intangible benefits that accrue from outsourcing to compensate them. These are the elimination of troublesome functions, saving in management time and effort, turning fixed into variable costs, reduced uncertainty in services provision, the improvements in service delivery and innovation (Anderson and Goodman, 2002; Davis, 2004; Currie and Galliers, 1999; Labour Research, 2005d; Storey and Salaman, 2005).

Table 3.1 Suggested areas to outsource (Davis 2004)

KEEP IN-HOUSE	OUTSOURCE
All core functions	All peripheral functions
All profitable functions	All overused functions seen as internal cost Troublesome functions seen as headache, distraction or frustrations
Non-transferable Critical resource	Functions that maximise flexibility (staffing)

3.2.4 Political imperative

Organisations are political entities (Hall, 1991; Handy, 2000; Hatch, 1997). Outsourcing decisions may be more influenced by organisational politics and needs of the dominant coalition than economic or stakeholder considerations. Thus there are many reasons why organisations outsource within the political imperative. These range from credibility enhancement, where directors outsource their kingdoms to show that they are corporate players. Many jump on the bandwagon of others' success and media reports without detailed analysis of their cost drivers or with hazy expectations only to be disappointed and be forced to rebuild their in-house operations at extra costs (Lacity and Hirchheim, 1999; DiMaggio and Powell, 1983; IPD, 1998). Others may outsource their services to prove that in-house team need more funding to provide the same level of services as outside contractors (Bruce, 1998; Power et al., 2004; Rodney and Gallimore, 2002; Teisberg et al., 1994). Some are constrained by the efficiency drives to streamline staffing levels or dump the efficiency initiatives on services contractors whom they blame for failure to make their outsourced operations more efficient (Rock, 1999; IPD, 1998). But observers note that managerial practices like consolidating data centres, centralisation of information for common usage and the tightening of controls can aid efficiency gains more than vendors' scale economies or specialisation (Lacity and Hirchheim, 1999; IPD, 1998).

3.2.5 Outsourcing process (IPD manual, 1998; Table 3.2 below)

Outsourcing involves a complex process of coordinating activities between networks of other organisations for maximum effectiveness (Bruce, 1998; Davis, 2004; Rock, 1999). The process begins with a decision to solve an organisational problem followed by an analysis of organisational strengths and weakness in terms of resources and capabilities to be matched with external opportunities and threats from competitors (Coulter, 2005). In the case of public sector organisations, there are regulators, political policies and diverse stakeholders' interests to consider (Jones, 2000; Lin et al., 2007). Outsourcing of services ends with managing the contractual relationships with providers to achieve the expected outcomes (Davis, 2004; Huber, 1993). The inability to properly manage this relationship is a source of most outsourcing failures (Elmuti and Kathawala, 2000; Webb and Laborde, 2005). Observers note that top management involvement and commitment in outsourcing is needed for a successful outcome (Linder et al., 2002; Khong, 2005; Power et al., 2004). Executives must take the lead in assessing what is to be outsourced, redirect resources needed, overcome obstacles and resistance to change and help to minimize the effects of outsourcing such as job losses, redeployment and loss of morale in those who are left. Where chief executives took the lead, outsourcing enabled the organisation to transform itself, as seen in Sainsbury supermarket (Linder et al., 2002). The reverse is also true.

3.2.6 Situation analysis

Fundamental to the belief of outsourcing is that organisations focus their time and effort on their core, profitable and unique businesses and outsource the rest (Davis, 2004; Rock, 1999). Thus, a thorough analysis of the present position must be made (Coulter, 2005). This will indicate how outsourcing can help organisations concentrate effort on chosen businesses through access to skills, technology and knowledge, eliminate troublesome functions and enter new markets or new businesses.

Situation analysis generates a clear reason to outsource for which a strategy is crafted based on internal resources and capabilities against external opportunities and threats (Coulter, 2005; IPD, 1998). Strategy is defined as a goal-directed decision and action in which a firm's capabilities and resources are matched with opportunities and threats in its environment (Coulter, 2005:5). It is the duty of management to build consensus through open, honest and credible communication to prepare those concerned with envisaged major changes and obtain ownership of the strategy crafted (Huber, 1993; Leavy, 2004).

The failure of some organisations to adequately analyse their situation, craft a suitable strategy, communicate meaningfully and timely with affected staff to gain ownership of changes that affect their lives may result in outsourcing failure.

3.2.7 Implementing the plan

A detailed study of the feasibility of outsourcing is needed not only to analyse the risks involved but plans to minimize them and avoid later dissatisfaction and frustrations (Huber, 1993; IPD, 1998; Rock 1999). Vendor selection is simplified by the array of experienced consultants who now undertake helping organisations analyse, screen and negotiate contract agreements that work over the long term (Davis, 2004, Huber, 1993; IPD, 1998; Rock, 1999). Vendors are selected based on their skill, experience, expertise, reputation, performance record, financial viability and ability to provide backup or disaster recovery for un-interrupted service (IPD, 1998; Linder et al., 2002; Rock, 1999). Outsourcing firms are advised to always balance vendors' experience, ability, reputation and quality or value they can add to organisational effectiveness with their contract price to avoid the choice of cheapest supplier that may result in unrealised objectives (Khong, 2005; Moore, 2007). Having selected an appropriate vendor, contract details are hammered out through due diligence in important areas of legal, specifications, personnel, service levels, security and joint working agreements to avoid later disagreements, conflict and penalties or arbitration. Thus time spent under due diligence in working out details will save disappointments later.

For the health service, NHS Procurement acts as their outsourcing consultant to ensure uniformity of properly structured contracts that meet with European Union policies (Cabinet Office, 1998). However, senior management are advised to pay particular attention to personnel and union issues that conform to European Union (EU) regulations (IPD, 1998; Rock, 1999) or face legal consequences of non-conformity with European Acquired Rights Directives of Transfer Undertakings Protection of Employees Regulation (TUPE, 1981).

3.2.8 Transfer of Undertakings for the Protection of Employees Regulation (1981)

The growing interdependence of economies and job mobility of workers resulting from globalisation and outsourcing prompted a need for the uniformity and harmonisation of Human Resource practices in the European Union (Ohmae, 1995; Lansbury and Baird, 2004; Sumetzberger, 2004). This is known as Transfer of Undertakings for the Protection of Employees (TUPE) Regulation. The aim of the regulation is to protect workers' rights in

employment relations as they are transferred from one employer to another across boarders within the European Union (EU) and to ensure the continuity of employment. However TUPE provides only limited protection for such workers due to many reasons. Firstly, the regulation is complex and contains legal loopholes open to alternative interpretations and local meaning. Secondly, the regulation does not and cannot cover all aspects of employment relations and work reorganisations. Thirdly, most employment contracts are incomplete and workers lose track of their original contract details over time.

Table 3.2 Outsourcing process (IPD, 1998)

Make or buy decision	Senior management to decide after situation analysis
Reasons for outsourcing	Be clear of objective, scope and focus of main goal to attain
What to outsource	All peripheral functions, non core, non-profitable or unique
Gain consensus and ownership	Communicate strategy to all concerned, union and staff, to maintain productivity, staff morale and alley fears fed by gossip. Compromise
Vendor selection	Get specialist consultants' help to analyse, screen vendors and negotiate binding contracts based on measurable service parameters or engage skilled and experienced contract managers to hammer out mutually beneficial but flexible terms. Know limits of contractor remit. Allow due diligence procedure to verify or change data/specifications Draft in arbitration, termination clauses and controls for change
Relationship management	Senior management involvement, support and commitment needed. Partnership of mutual respect, open communication and problem solving more successful than adversarial confrontation and blame
Transition period (90 days)	Reality dawns. Culture clashes, redundancies, teething problems. Define roles and authorize responsibilities. Reduce resistance to changing roles. Post implementation and quality reviews needed. Open dialogue and counsel for concerned staff to find new jobs
Progress	Regular reviews of whole service to identify and solve problems. Search for service improvements. Regular reporting for corrections. Manage relationship with mutual respect and cultural awareness. Communicate. Manage change, uncertainties and share benefits

Fourthly, most workers base their relationship with employers on the "psychological contract" of mutual expectations rather than formal employment contracts (Argyris, 1962; Cooke et al., 2004). Lastly although new employers under TUPE assume all powers, rights, obligations, duties and liabilities of the transferred workers, they are only obligated to consider salaries, holidays and sickness pay but not pensions. Furthermore, new employers can streamline their workforce under the guidelines offered by TUPE for economic, technical or organisational (ETO) reasons. Thus, employers can repackage and offer revised employment relations that are either favourable or detrimental to transferred workers. The UK Government offered guidelines to those involved in outsourcing (market testing), where workers are transferred in 1993 and ratified it in 1996 (Cabinet Office, 1996). But the legal loopholes can still favour new employers hence the different research findings between the intended and implemented policies (Khilji and Wang, 2006).

Researchers who studied the effectiveness of TUPE reported a diversity of findings even within the same organisation employing workers at different locations (Cooke at al., 2004; Lansbury and Baird, 2004; Sumetzberger, 2004). For example in their case studies of hotel services and estates facilities under PFI, Cooke et al., (2004) found that the reasons for the transfer of workers from public sector employment to a commercial one were essentially to reduce costs and improve the efficiency of the services. They also found a high level of worker resistance to changes being made by the new commercial employer such as team-working and multi-skilling or generic working. These findings are consistent with the problems found during the transition or due diligence stage of change, as workers transfer from the public to the private sector. In contrast to their study, all the outsourced services in this study have been in place from four to twenty years. Thus the commercial services providers have already streamlined the workforce and found alternative work for those unwilling to accept changes or work in the commercial sector.

3.2.9 Outsourcing relationship management

Senior management must be involved and fully committed to managing the resultant relationship for without their support, observers say that outsourcing goes awry (Blumberg, 2001; House of Commons, 2003; Linder et al., 2002; May and Suckley, 2005; Power et al., 2004). They have the unenviable task of overcoming obstacles and resistance to change, communicating the risks and rewards to be shared and dealing with people issues. They also need to redirect resources and encourage the acquisition of skills (Sheu et al., 2006).

Relationship can be through partnership with suppliers, where partnership is defined as "a collaborative and interactive business relationship between a company and its supplier" (Bruce, 1998:1). In such a relationship, both parties are mutually dependent in terms of inputs, co-production and resultant rewards. Such partnerships entail the management of sensitive relationships on personal, social and business levels, as suppliers help clients meet their business needs while retaining control, and avoid the difficulty of adversarial confrontations some outsourcers experience (Bruce, 1998; Kanter, 1994, Teisberg et al., 1994; Webb and Laborde, 2005). Such long-term relationships are built on teamwork, trust, mutual respect, constant communication and cooperation (Blumberg, 2001) to iron out possible misunderstandings or cultural clashes and so improve service quality through innovation and reduce costs (Barney and Hansen, 1994; Elmuti and Kathawala, 2000). For example, while Ford Motors used to rely on adversarial supplier contracts with resultant bad relationships (Campbell, 1995; Key et al., 1994:28), Marks and Spencer and Benetton worked closely with suppliers to influence their product quality and encourage flexibility to adjust to changes and maintain continuous innovation that helped build capability into routines and reduced total costs (Bruce, 1998; Jennings, 2002). But despite all care outsourcing can still fail due to the reasons listed in table 3.2 above.

Customer relationship management (CRM)

However to reduce the incidence of outsourcing failures, Osarenkhoe and Bennani (2007), list the core requisites of effective customer relationship management (CRM) as follows:

(a) emphasis on quality of products or services provided

(b) effective management of the gap between customer expectation and performance in order to satisfy the needs of customers

(c) investment in the workers (training) and giving them incentives to enable and motivate them to give professional services to customers and increase profits

(d) communication and meaningful dialogue with customers in order to listen and adapt to their individual preferences and so retain their custom and loyalty.

(e) setting realistic targets to monitor and assess performance in order to better understand the elements of customer services offering to expand and meet other needs of the customer for prolonged mutual benefits

In this study, customer relationship management is brought to the fore to enable services providers expand their offerings to meet customer needs beyond outsourcing expectation and so retain their custom and loyalty and increase their profits over longer periods.

3.2.10 Outsourcing controversy

Outsourcing in general is said to have hit a plateau (Caulkin, 2007; Preston, 2004). This is probably because of dissatisfaction with the impact of sourcing decisions on the business, uncompetitive costs, and unrealised objectives. Other reasons range from lock-in effects that preclude flexibility for other business relationships (Preston, 2004; Power et al., 2004) to changing needs and expectation or loss of in-house competence (Power et al., 2007).

Outsourcing in the NHS has not been without controversy (Labour Research, 2004, 2005c, 2005d). Some called outsourcing an emotional process (Webb and Laborde, 2005). For example: support services were outsourced in 1983 to involve the private sector in the NHS but to date it has not been accepted and still arouses fierce passions (Carlise, 2007). The unions call for a freeze in services outsourcing because it means loss of jobs for their members due to the central Government's plan known as "Peter Gershon's efficiency drive" to streamline personnel and save revenue. It also claimed that support services outsourcing meant low wages for union members, paid by contractors who must acquire all support services workers as part of the contract deal (Labour Research, 2005b). Many complain that cost containment promised has not materialised probably due to changing expectation, lack of flexibility in their contracts or lack of focus in services improvements (Key et al., 1994; Labour Research, 2005d; Moore, 2007). Some unions regard services outsourcing as part of "the Government's obsession with market-driven Tory policies" and have cut their Labour party contributions to make their point (Labour Research, 2005a). Some NHS trusts regard services outsourcing and extended choice for patients as needless expansion of capacity when their own facilities lie idle and unutilised (Johnson, 2005). Others complain about hospital cleanliness and link it to outsourcing (Moore, 2007). Furthermore, the issues of leaking confidentiality to vendors and external others, ethical consideration and lack of real benefits has continued to plague the outsourced national healthcare information technology to date (Anderson and Goodman, 2002; Foster, 2005). But despite the controversies, services outsourcing will continue in the NHS, alongside a strong central control and domination and may even increase by 25% to increase capacity and capability of the whole system (Arie, 2005; Bellamy, 2002; Blair, 2005; Crisp, 2005).

Outsourcing is generally plagued by controversies due to the changes it brings (Linder et al., 2002; Webb and Laborde, 2005). People dislike the resultant disruption, loss of job security and uncertainty of outsourcing outcome (Power et al., 2004). Others fear the loss of control over services, the inevitable dependence on vendors, the risk of transferring

people, production and services to outside vendors, hidden cost and the cost of rebuilding services should outsourcing fail (Khong, 2005; Leavy, 2004). There is the risk of losing in-house skill when learning opportunity is ceded to a vendor. For example: General Motors outsourced the production of microwaves to Samsung of Korea only to become involved in a dependency spiral that culminated in the loss of a learning opportunity and dominance of the microwave market by Samsung (Leavy, 2004).

These controversial issues are reflected in this study and are discussed in chapter 5

3.2.11 Public sector organisations

Outsourcing in the public sector is generally regarded as a complex, politically sensitive process involving many stakeholders often with different views, conflicting objectives and agendas (Lin et al., 2007; Harland, Knight and Lamming, 2005). There is pressure on them to function like private commercial firms deemed to be more efficient, even though public sector organisations are not designed to be efficient but to be fair and accountable as constrained by the political timetable for the public good (Lin et al., 2007). Furthermore, public sector organisations are plagued with inefficient and ineffective management practices, that build slack into the system and increase total costs while the commercial sector are motivated by economic considerations (Lin et al., 2007). Public organisations are often required to provide better social services like healthcare but often with reduced budgets although the funding for the NHS has been increased during the present administration (Eaton, 2007). Consequently, some public sector organisations are forced to determine what it means to achieve best value for money locally in place of efficiency.

3.2.12 Why outsourcing fails

Observers note that 30-50% of all outsourcing ventures fail due to lack of well-defined focus or contract management (Davis, 2004; Labour Research, 2005d). Other reasons for failure are said to be the inability of suppliers to deliver projects on time and within costs, failure of purchasers to realise the level of expected savings or dissatisfaction with outcomes (Currie and Galliers, 1999; Labour Research, 2005d; Moore, 2007; Rock, 1999). Outsourcing ventures also fail because parties to interaction may fail to address potential problems early to save time, effort and misunderstanding while some make pre-contractual mistakes and fail to clearly define the scope, objective and focus of outsourcing (IPD, 1998; Lacity and Hirschheim, 1999; Rock, 1999). There may be loss of shared vision and ownership of the whole venture or lack of compromise between parties to interaction (Lacity and Hirschheim, 1999). For some there may be lack of senior management support

and commitment to see it through. For others when expected efficiency and cost savings fail to materialise due to hidden costs, inexperience in contract bidding and process management, lack of understanding of scope of operations and changes in expectation, they lose interest due to unmet expectations (House of Commons, 2003; IPD, 1998; Rock, 1999). People problems can present as cultures or personality clashes, lack of mutual respect or cultural awareness (IPD, 1998; Rock, 1999). Also because most people dislike change and uncertainty that produce a sense of loss, instability and anger from disruption of routines and relationships, they resist outsourcing initiatives and do not make the commitment needed to engage in managing the relationship for mutual benefits (Rock, 1999). Thus managers are advised to carefully weigh the cost of services outsourcing against its benefit before embarking on such ventures.

Other organisations that outsource to weather seasonal downturns or reduce competitive pressures may lose the capacity and competence to take advantage of market changes when there is an upturn in demand (Lacity et al., 1995). Similarly, lean, flexible and core competence focused firms may lose the ability to build tomorrow's capability due to lack of relevant resources or narrow vision. Indeed, such firms may be stuck with obsolete functions or lose competitive advantage due to lack of flexibility (Cross, 1995). Jennings (2002) cites the case of Boeing operating lean supply that resulted in their inability to meet cyclical increase in demands and so lost market position and profitability. Thus outsourcing like alliance formation, to access resources for competitive advantage, can become double-edged (Leonard-Baton, 1992). They shield firms from competitive pressures but when conditions change, they can block the ability of firms to respond due to dulled motivation and competence and distorted perceptions from the inertia of either focusing on core competence or inflexibility of in-house integration to reduce transaction costs.

But despite these failure rates, many organisations report improvements to their services offering due to outsourcing. For example, Citi group claimed to have saved $75m in one year while Prudential Insurance made a 30% saving on total transaction cost and American Express made 50%. Similarly, British Petroleum reduced its staffing from 1400 to 150, a 65% reduction in salaries, pensions and contributions due to outsourcing of its information technology alone (Cross, 1995; Davis, 2004; Lacity and Hirschheim, 1999).

Writers agree that the success of outsourcing depends on the degree of coordination and relationship management. They note that mutual cooperation becomes less costly in

monitoring terms, when suppliers gain expected revenue streams for providing agreed reliable and uninterrupted services (Fill and Visser, 2000; Lacity et al., 1995; Peisch, 1995). Thus, outsourcing benefits depend on good internal assessment of resource need against the potential problems of divergent expectations, contract haggling, performance monitoring and relationship management to meet agreed objectives for mutual benefits.

To reduce the dissatisfaction with outsourcing results, and increase their benefits, organisations are advised to first assess internal needs, clarify purpose, objectives, scope of outsourcing and contextual issues and weigh them against the problems of outsourcing (Cross, 1995; Davis, 2004; Jennings, 2002; Power et al., 2004). Hence, the reputation, integrity, capacity to meet demand and the financial foundation that determines stability, attractiveness and reliability, of the supplier firm are of paramount importance to buying firms (Caulkin, 2007; Leavy, 2004). Then parties to interaction must manage the resultant relationship with trust, mutual respect and consideration of future benefits to reduce the costs of contracts renegotiations, haggling and monitoring (Barthélemy and Quélin, 2006). Thus, outsourcing skills are needed to evaluate providers, establish a clear performance criteria and contingency sanctions against non-performance with monitoring provisions in contracts (House of Commons, 2003). Outsourcing and strategic alliances can be classed as hybrid forms due to their strong incentives to reduce costs, adapt processes efficiently and the inter-dependency created by mutual resource needs (Williamson, 1996).

So what relationship skills do the managers investigated in this study have to make their services outsourcing venture successful and mutually beneficial?

3.3 Resource-based view of organisations

The Resource-based view (RBV) was founded by Edith Penrose in her seminal (1959) book, "The Theory of the Growth of the Firm" and later expanded in Penrose (1996). The framework was built up by Nelson and Winter (1982), re-ignited by Wernerfelt (1984), Barney (1986, 1991), Dierickx and Cool (1989) and Peteraf (1993) and subsequently permeated into general management thinking by ideas from Prahalad and Hamel (1990).

The central premise of Resource-based view of organisations is that, "sustained superior performance is a firm-specific phenomenon deriving from resources and capabilities that produce economic rents by virtue of their value, scarcity, imperfect imitability and rent appropriability" (Powell, 2001:881). The heterogeneity of resources and capabilities is the

cornerstone of resource-based approach (Helfat and Peteraf, 2003; Peteraf and Bergen, 2003; Teece et al., 1997). Valuable resources help organisations attain strategic position through cost reduction or product differentiation (Haberberg and Rieple, 2001). These valuable resources include organisational competences and capabilities, incorporated in learned skills and routines, built over time through tacit knowledge (Dierickx and Cool, 1989; Henry and Mayle, 2002; Knight, 2004; Teece et al., 1997; Winter, 2003:991).

Organisations are large complex social systems consisting of assortments of resources (Anderson et al., 1994), capabilities and competence (Kanter, 1983; Teece et al., 1997). These capabilities and competence built over time, become firm specific assets difficult if not impossible to imitate that can help organisations create wealth and value through more efficient production process or new products and services. Thus, organisations can attain competitive advantage through control and access to resources that enable them develop and build competence and capabilities over time (Collis and Montgomery, 1995; Dierickx and Cool, 1989; Powell, 2001:881; Teece et al., 1997; Williamson, 1991:76; Winter, 2003).

Resource-based view assumes that organisations have different resources or capabilities because of their different histories, experience, culture, competence, assets and skills base (Collis and Montgomery, 1995; Knight 2004; Teece et al., 1997). Thus, competitive advantage lies in how organisations deploy and use their stock of valuable or strategic resources (that must be scarce, inimitable, durable and non-substitutable) to achieve superior performance in a dynamic competitive environment (Barney, 1991, 1997; Hamel et al., 1989; Porter, 1980, 1996; Prahalad and Hamel, 1990; Teece et al., 1997).

Organisational resources, competences and capabilities may be embedded in routines, processes, culture or tacit knowledge that cannot be easily bought or controlled (Argyres, 1996; Grant and Baden-Fuller, 2004; Powell, 2001; Prahalad and Hamel, 1990; Hamel, et al., 1989; Teece et al., 1997). Furthermore no one organisation controls or has access to all the resources for building competence and capabilities (Douglas and Ryman, 2003). Thus, organisations may engage in alliances to access valuable resources and build capabilities for competitive advantage. Indeed, alliances are said to be ways of extending resources to build capabilities in order to develop sustainable competitive advantage (Grant, 1991). Alliances formations and management are dealt with below in (section 3.6).

For example, NHS trusts partners with private financial and charitable organisations to share facilities to save costs or access funds for capital improvement and some are in partnership with other NHS and private hospitals to share facilities and so reduce costs.
The resource-based view of organisations has emerged as a complementary approach to understanding organisational competitive strategy (Das and Teng, 2000; Grant, 1996). Its inward looking approach, contrasts with Porter's (1980) competitive forces model and Carl Shapiro's (1989) strategic conflict approach. Both are said to be outward looking and based on strategy of limiting competition through raised rival costs and entry barriers (Teece, Pisano and Shuen, 1997).
Teece et al., (1997:516) regard the term "resources" as misleading and prefer to call them "firm-specific assets", because resources they say, include trade secrets, specialised engineering and production facilities that also contain tacit knowledge. Trade secrets here refer to "secret formulas or techniques or processes known and used to advantage by a single manufacturer or operator" (Collins, 2003). For example, McDonald's spices are secret formulas used to advantage and can be regarded as trade secrets.
Again focusing on the NHS trusts, their specialised medical knowledge may be regarded as "trade secret" while the experienced personnel of their services providers have tacit knowledge as proposed by (Teece et al., 1997), these can enable their combined forces improve efficiency and effectiveness of their operations, thus gaining competitive advantage to remain viable in the face of financial constraints and cost pressures.

However, the resource-based view has been accused of not explaining the heterogeneity of resources and failing to use a conceptual model to explain how competitive advantage is created (Helfat and Petraf, 2003:997; Makadok, 2001:388). Others point to its inability to explain how organisations meet their resource needs (Barringer and Harrison, 2000). Douglas and Ryman (2003), argue that the resource-based approach fails to combine it with alliance formations that allow the leveraging of resources across organisational boundaries for competitive advantage. However, Williamson (1996:309) comments that "business strategy has a broad mandate" hence a single lens like the resource-based view cannot be expected to inform all the relevant strategy issues. Instead the resource-based view offers a general framework stating that firms can use their resources and capabilities to appropriate economic rent. This idea provides insights to which other theories can add needed structures. For example, the resource-based view, as founded by Edith Penrose (1959), was built up by Nelson and Winter (1982), and Barney (1986, 1991, 1999) but

permeated into management thinking by ideas of collaboration and core competence for competitive advantage by Prahalad and Hamel (1990).

Porter (1991:108) argues that successful organisations are successful because they have unique resources and calls the reasoning of the resource-based view rather circular, inward looking and troubling. This is probably because Porter's (1980) competitive forces are focused more on what Teece et al., (1997) call "strategising" to gain privileged product market position rather than emphasising the "efficiency and effectiveness inherent in developing, accumulating, combining and protecting unique skills and capabilities" that can enable some firms gain enduring competitive advantage (Teece et al., 1997:513).
Again, yes NHS trusts and their services providers have unique resources. Medical expertise is unique and patients travel across the world to be treated by such experts. The international reputation, knowledge and experience of services providers as hoteliers are unique resources. When these firms combine their unique skills and resources they can improve efficiency and effectiveness hence competitive edge of their organisations.

3.4 Resource Dependence Theory (RDT)

While resource-based view is inward looking, the Resource Dependence Theory is more outward looking and recognises that organisations may be resource-deficient hence must interact with the external environment to access and meet their resource needs.
Pfeffer and Salancik (1978), identify the motivation for alliance formation or outsourcing as a response to environmental uncertainty and vulnerability. They note that problems arise not because organisations are dependent on the environment but that the environment is not dependable. This is due to problems of environmental changes and resource scarcity that demand organisational adaptation to change for survival. The theory proposes that the key to organisational survival stems from the ability to acquire resources from external sources. This is because firms may be resource-deficient, therefore organisations interface with their environment (be they other organisations, Governments, suppliers or indeed competitors) in order to acquire, share or access the resources needed to survive.

As a result of organisational resource needs firms become inescapably bound up with the conditions of their environment that constrains them but provides the social context that shapes their activities, structural framework and behaviour (Pfeffer and Salancik, 1978). Consequently, organisations enter into relationships or alliances to achieve a "negotiated" and more predictive environment in which to survive (Nichols, 1993; Thompson, 1967).

The negotiated environment buffets organisations that interact through the process of attention and interpretation of information gathered. Thus, collected and recorded information help to shape organisational decision-making (Pfeffer and Salancik, 1978:13). Furthermore, it is not merely organisational efficiency but the capacity to mobilise scarce resources and effectiveness in preserving itself through local legitimacy that determines competitive survival in the market place (Pfeffer and Salancik, 1978; Schoemaker, 1993). Organisational effectiveness is defined as the "ability to manage demands of stakeholders who provide the needed resources and support" while efficiency refers to "how well an organisation is doing" or a ratio of resources consumed to output produced (Hill and Jones, 1992; Pfeffer and Salancik, 1978:11). Thus, external pressure on organisations demands greater efficiency while organisational effectiveness provides acceptability. The diversity of stakeholder interests and demands present organisations with problem of alignment and manipulation through organisational politics in order to retain support (Hill and Jones, 1992; Schoemaker, 1993). The need for valued resources (hence vulnerability) and stakeholder support (uncertainty), leads firms to build coalitions that may result in network formations (Barringer and Harrison, 2000). Coalition linkages help stabilise the exchange between organisations and the external environment through negotiation and agreement for mutual assurance and predictability of outcome (Zajac and Olsen, 1993). Thus, coalitions help reduce uncertainty and can ensure firm survival, growth and success.

Resource scarcity can create dependence that precipitates power advantage for less dependent organisations and a relative loss of autonomy for dependent firms (Hill and Jones, 1992; Schoemaker, 1993). Pfeffer and Salancik, (1978:51) define dependence as "a product of the importance an organisation attaches to an input or resource and the extent to which that resource is controlled by relatively few organisations". However, management can manipulate the interface between organisations and the environment, by avoiding conditions that demand compliance and so maintain autonomy. When avoidance is not possible, organisations must manage the resultant interdependence to enable them gain mutual benefit to survive and grow (Hill and Jones, 1992; Pfeffer and Salancik, 1978). The main thrust of Resource Dependence Theory is that because organisations may be resource-deficient, they must interact with the environment to obtain or access resources. This interaction with undependable environment precipitates dependence and formation of coalitions for support. To manage diverse interest of coalition members who may also be stakeholders, firms are involved in organisational politics, negotiations and agreements to find consensus and so reduce environmental uncertainty and complexity. Consequently,

organisational decisions become "other directed" or a result of stakeholder consensus (Bergen et al., 1992; Hill and Jones, 1992; Schoemaker, 1993; Zajac and Olsen, 1993).

However, Resource Dependence Theory has been criticised for focusing exclusively on resources that must be obtained from external sources for organisational survival, growth and prosperity (Barringer and Harrison, 2002). It is said to lack specifics on how to obtain, access or share resource or how to develop and build competence and capability for enduring competitive advantage. These issues are left for other theories like Institutional Economics to decide. However, Pfeffer and Salancik (1978:132) note that, "power organises around critical and scarce resources" and whoever controls these resources, controls the organisation! The result of resource dependence, namely effects of power and influence and network formations are dealt with in relationship management (section 3.6).

3.5 Transaction Cost Economics (TCE)

Transaction Cost Economics (TCE) notably of Williamson (1975, 1996) provides a predictive framework for reducing the total cost of resource exchange between organisations and hence is intrinsic to the resource-based view of organisations. Transaction Cost Economics (TCE) framework argues that an organisation's make-or-buy decision centres on minimizing transaction and production costs (Williamson, 1975, 1996). Transaction costs refer to cost of activities associated with resource exchange such as: "bargaining, negotiating, monitoring and enforcement costs necessary to ensure the delivery of contracted goods and services (Hunt and Morgan, 1995:5; Williamson, 1975). Production costs include learning, organising and managing production (Das and Teng, 2000). TCE advices organisations to internalise production through mergers, acquisitions and in-house production when transaction costs are high but utilise market exchange when production costs are high (Williamson, 1975, 1996; Das and Teng, 2000). This predictive advice serves economizing purposes in a world of incomplete contracting, bounded rationality and opportunism (Williamson, 1975, 1996; Zajac and Olsen, 1993).

However, the TCE framework "has been copiously critiqued, built on and in some cases muddied" (Gander and Rieple, 2004:62) for providing firms with predictive guidance on structure and governance decisions in their relationships with other firms, based purely on transaction costs. Williamson, (1996:11) defines governance as "an institutional framework in which the integrity of a transaction or related set of transactions is decided". Integrity is further expounded as "a means in which *order* is accomplished in a relation in which

potential *conflict* threatens to undo or upset opportunities to realise *mutual* gains" (italics in the original). Thus, governance can be stated as 'a framework in which transactions are decided in an orderly fashion, avoiding potential conflict to achieve mutual gains'.

Other writers decry TCE's central focus on efficiency and 'economising on transaction costs' (Hunt and Morgan, 1995) while neglecting the value creating aspects of transaction (Barthélemy and Quélin, 2006; Zajac and Olsen, 1993). This can result in missed opportunities or varied and sub-optimal performance for organisations (Dyer, 1997). Barringer and Harrison (2000) comment that 'people' issues such as culture, trust, reputation and learning are assumed away by TCE. Indeed, Faulkner (1995:187) posits that many managers interviewed about the motivation for alliance formation and choice of alliance partners considered survival in a turbulent and uncertain environment more important than governance structures and the transaction costs involved. Hence flexibility in the face of constant change was more important to them. Hence organisations are advised to "try markets, try hybrids (long-term contractual relations into which security features have been crafted), and resort to firms when all else comparatively fails" (Williamson, 1999:1091).

In this study, of the resource exchange between the NHS and its hotel services providers, the choice was made for them. They have tried hierarchy, market competition (Internal market) and are now forced to try a hybrid arrangement (section 3.6.3 below) with private commercial services providers in search of efficiency in human and financial resource use.

3.5.1 Operational efficiency

Operational efficiency is an umbrella term for reduction in total transaction costs, more efficient and effective use of human and financial resources and the attainment of client satisfaction with services supplied against the prices paid (HMSO, 1970; Klein, 2001:50). Cost reduction is also one of the main reasons for services outsourcing as organisations aim to turn their fixed into variable costs. Thus this study confirms previous outsourcing data that rates cost reduction through automation or more efficient use of resources as a major reason for services outsourcing (Fill and Visser, 2000; Harland, Knight and Lamming, 2005; Jennings, 2002; Jiang et al., 2006; Lacity and Hirscheim, 1999).

In a competitive free market economy the idea of operating more efficiently in order to reduce total costs can help to shape problem definition and colour the arena for debate in order to find solutions to the constant cost pressure to reduce inefficiencies and increase the efficient use of financial and human resources for comparative advantage. Hence

through the engagement of commercial providers of support services by some NHS trusts, operational efficiency can become an attainable objective.

To aid its achievement ancillary workers were sold to services providers, streamlined and staffing levels reduced, machines were automated to standardise products and services offered with the incentive of payment by results (PbR) to boost morale in reducing service inefficiencies. But how does the literature analyse operational efficiency?

3.5.2 Components of efficiency (Figure 3.1)

Efficiency consideration can be a strategic or operational issue (Karlöf, 1993:21). Strategic efficiency focuses on products or services, pricing them to retain long-term competitive advantage in a chosen market while gaining profitability in order to grow. Conversely, operational efficiency is concerned with short-term production costs, effective functionality of machines (hence automation) or personnel and productivity. Thus, NHS trusts, being political organisations in perpetual budget crisis as evidenced by the news media, they seem to focus more on short-term operational efficiency. This re-enforces the choice of this theme to encompass costs savings through automation and streamlining of ancillary personnel to reduce total costs or turn fixed into variable cost by using temporary staff.

From figure 3.1 below, organisations that emphasize efficiency can either focus on productivity and production costs hence doing the right thing or refocus on adding value to their customer offerings through creativity and innovation and so being more effective.

Figure 3.1

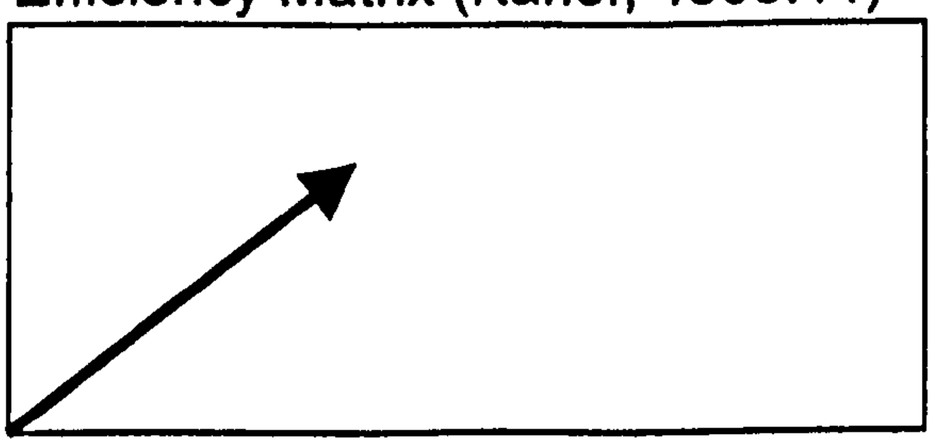
Efficiency Matrix (Karlöf, 1993:11)

Value to customer **High**

-Utility in relation to price

-Doing things right

(Effectiveness) Low



low **Productivity** High

-units of output per unit of input

Doing the right thing (efficiency)

Boyne (2002), paints a grim picture of bureaucratic organisations like NHS trusts. He catalogues the complexity faced by managers in having a diversity of stakeholders with conflicting demands that constrain them. Others also note the short-time horizon based on

political stance and state ownership that leads to instability and confusion (Moore, 1992; Turrill, 1993). The absence of managerial incentives to deal with unprecedented rate and volume of change or to search for alternative sources of funding, the lack of competitive pressures and fear of failure or bankruptcy lead to reduced organisational efficiency and effectiveness. The bureaucratic red tape, low managerial autonomy and policy ambiguities that favour inertia, inflexibility, non-decision making also translate as the inefficient use of scare resources (Boyne, 2002; Enthoven, 2000; Hill and Jones, 1992; Moore, 1992). Thus, it can be assumed that many organisations within the NHS choose alliances to avoid the problems of markets and hierarchies (Barringer and Harrison, 2000; Barthélemy and Quélin, 2006; Blumberg, 2001; Das and Teng, 2000; Tsang, 2000). Authors note that alliances can limit opportunistic behaviour through the development of reciprocal trust over time, commitment to continued association, long-term benefits and expected mutual gains (Dyer, 1996; Faulkner, 1995;Grant and Baden-Fuller, 2004).

3.5.3 Impact of Human Resource Management (HRM) on efficiency drives

For some public sector organisations where Human Resource (HR) departments rule the roost, alliance formations may be frowned upon. The scars of previous change efforts and the enormity of the resultant anxiety, frustration and agitation can force these "custodians of employment contract and protector of workers" to clamour in the opposite direction to outsourcing and change (Pettigrew et al., 1992; Schuler and Huber, 1990; Torrington and Hall, 2002). This avoids repeating painful experiences and erases memory traces as members search for stability, familiar routines and independence (Czarniawska, 1992; Weick, 1995) in what Giddens (1984) calls "ontological security".

Consequently, HR managers provide organisational policies, procedures and practices that guide daily routines, lines of reporting and expected behaviour that reflects the cultural values of the organisation and limits uncertainty, complexity and disruption of daily routines. This can result in fear of outsourcing, risk aversion or bureaucratic control.

Changes in the workplace like technology (automation) and the current ambiguity in the social contract affect the loyalty, motivation and demands of workers (ancillary) based on the perceived job insecurity and inappropriate compensation for time and effort expended. Automation also dictates that less staff is required to do the same work (Sherwell, 2005) while demanding initial investment in machines for the expected increase in productivity (Purcell, 1999). Organisational response to increased competition may be cost pressure that forces some HR managers, to indiscriminately reduce total costs by reducing staffing headcount (Ames and Hlavacek, 1990; Hailey et al., 2004). Furthermore, in times of

unemployment, organisations can pick and choose staffers at very low wages while full employment makes it harder for organisations to recruit skilled and trained staff, already employed by others (Torrington and Hall, 2002).

Thus, the role and focus of HR policies will vary according to these factors. For example, where there is a culture of respect and care for workers, with job security, there will be reduced staff turnover and commitment to organisational goals (Biggs and Swailes, 2006; Dyer, 1994; Gallie et al., 2001; Forde and Slater, 2006). The reverse is also true.

This variety in the role and focus of HR policies in different contexts explains the diversity of research findings between intended and implemented policies (Khilji and Wang, 2006).

3.5.4 Parallels between TCE and Resource-based theories

Parallels can be drown between resource-based theories and Williamson's TCE (1996). Transaction Cost Economics is similar to Resource Dependence Theory in that it views non-market governance as a response to environmental uncertainty (see 3.3.2 above). Uncertainty, in TCE terms, arises due to the behavioural assumptions that pair bounded rationality with opportunistic self-interest (Williamson, 1996:56). Self-interest seeking refers specifically to economic agents being permitted to disclose information in selective or distorted manner, calculated to mislead, disguise or confuse. This is termed moral hazard or agency cost, the mitigation of which can be mutually beneficial in exchange transactions (Williamson, 1996: 56). Opportunism also refers to "deceit-oriented violation of implicit or explicit promises about one's appropriate or required role behaviour" (Hunt and Morgan, 1995:5). These hazards (uncertainties) arise, says Williamson (1996), when incomplete contracting is joined with asset specificity. Asset specificity refers to the degree with which resources (assets) can if required, be redeployed to alternative use without the loss or sacrifice of productive value. Williamson (1996:60) lists the types of assets engendered as site (prime location), human asset (skills and learned competence), physical asset such as dyes for materials, brand names and assets dedicated to specific contract relationships.

3.5.5 Asset specificity

Asset specificity plays an important role in TCE. Williamson, (1996:106) asserts that it increases the total transaction cost in all governance forms. This is probably because transactions costs are made up of the frequency of transactions, the uncertainty of future transactions and the degree of asset specificity involved. Williamson (1996) argues that asset specificity creates bilateral dependency between transacting actors and thus poses added contractual hazards. For example, Williamson (1996:110) asserts that asset

specificity tends to shift the adaptive behaviour of actors in a business relationship towards cooperativeness. Consequently, when disagreements or self-interest bargaining in contract negotiations arise, mal-adaptation costs are incurred raising total transaction costs. Had such assets not been involved, business partners would be free to seek alternatives (if they exist) or adapt more efficiently to reduce costs. Others regard close business relationships involving asset specificity as a disadvantage because it reduces their freedom of choice in developing alternative relationships, alters the power balance within the relationship and involves opportunity costs of foregoing other good partnering opportunities (Brennan and Turnbull, 1999; Schoemaker, 1993; Moschandreas, 2000). Thus, the importance of asset specificity, or sunk costs (irrecoverable costs that cannot be easily transferred to alternative contexts without loss), also lies in its ability to introduce significant asymmetry into future contract bids. The incumbent may gain unfair advantage through investment in such assets to exclude other parties (Gander and Rieple, 2004:64).

3.5.6 Comparison between TCE and Resource-based theories

Both TCE and Resource Dependence Theory deal with uncertainty and dependence. But while TCE bases uncertainty on behavioural integrity of interacting parties namely, self-interest seeking and opportunism and uncertainty of transactions, Resource Dependence Theory bases uncertainty on a non-dependable environment. Such uncertainty stems from the scarcity of resources, lack of knowledge as to how the environment will fluctuate, the availability of exchange partners and the cost of transaction (Faulkner, 1995; Heide, 1994). Secondly, both theories also deal with dependence. Again while Resource-based theories deal with the organisational dependence. While Resource-based theories deal with the organisational dependence on the environment due to resource deficiency, TCE regards dependence as a consequence of asset specificity involved in business transactions that introduce bilateral dependence and maybe mal-adaptive costs. Thirdly, while TCE attempts to identify, explicate and mitigate possible contractual hazards through the prediction of efficient governance structures, Resource Dependence Theory identifies the motivation for inter-firm relationships as performance effectiveness and power influence. Thus, both TCE and Resource-based theories deal with similar problems facing resource-deficient organisations namely dependence and uncertainty but address them in different ways. However, organisations attempt to reduce these uncertainties and dependence while maintaining the autonomy for independent action. Consequently, the Resource-based theories and Transaction Cost Economics are complementary and intrinsic to the present study of NHS resource exchange with its hotel services providers.

Drawing the similarities further to NHS trusts, the TCE view on asset specificity obtains in their cooperative arrangements. Services providers make trust-specific investments like refurbished kitchens and new canteens. These investments make the parties dependent on each other to the extent of increasing their contractual duration to ten years instead of the mandatory five years. This increase may both involve opportunity costs of best alternatives foregone or mal-adaptive costs should the services provider renege on their contractual commitments. Similarly the Resource-based theories are relevant to some trusts in that they chose (or were forced) to outsource non-critical functions to focus on core activity, thus build up competence and capability in order to compete favourably with other trusts. Trusts form coalitions for dealing with environmental uncertainty through business relationships, which may prove to be valuable bridges to as well as buffers from hostile environments and cost pressures. Thus outsourcing and current competitive mode of some trusts may have reduced bureaucratic red tape, made them more cooperative, trusting and outward-looking (Barney and Hansen, 1994; Moore, 1992; Zolkiewski, 1999).

3. 6 Advantages of accessing valuable resources through alliances

As stated above, organisations may collaborate to access, share or leverage resources for developing and building competence and capabilities. Such collaborative arrangements can be in contractual forms like strategic alliances, buyer-supplier partnerships, joint ventures or outsourcing agreements (Faulkner, 1995; Grant and Baden-Fuller, 2004). Strategic alliance is defined as "a particular mode of inter-organisational relationship in which the partners make substantial investment in developing a long-term collaborative effort and common orientation" (Mattsson, 1988). Alliances may involve the commitment of two or more autonomous inter-dependent organisations to exchange, share or co-develop products, services and technologies (Gulati, 1998; Williamson, 1991:271). Indeed joint ventures involve the pooling of resources to create a new business entity (Faulkner, 1995). Alliances have been described as "hybrid" structures between markets and hierarchies (Williamson, 1996). Hierarchy refers to the willingness of participants to submit to control through legitimate authority (Williamson, 1975). Alliances are complex arrangements in which trust, collaboration, cooperation and negotiated roles of responsibility are major features (Bleeke and Ernst, 1991; Faulkner, 1995; Zajac and Olsen, 1993).

Organisations can enter into alliances with mixed motives and objectives. Such motives include internal vulnerability due to resource deficiency or external constraint (Faulkner, 1995; Grant and Baden-Fuller, 2004). Resource deficiency may be in capital, employees,

specialised skills or managerial experience. External constraints range from need for capacity, market turbulence, globalisation, fast technology changes or short product life-cycle among others (Bleeke and Ernst, 1991; Grant and Baden-Fuller, 2004; Makadok, 2001; Stuart, 2000; Zajac and Olsen, 1993). Thus, organisations can access resources to remedy their internal vulnerability or perceived external constraints (uncertainty) through alliance formation and collaborative partnerships.

3.6.1 Wealth and value creation

Accessing resources through alliances can create wealth and result in more efficient production (Zajac and Olsen, 1993). Makadok, (2001) cites the case of Microsoft, who through superior information regarding IBM's resource need (Barney, 1986), enabled him purchase QDOS operating systems for $50.000 in 1980 and sold it to IBM to be used as standard in personal computers (PC). Microsoft has continued to reap the rewards of his alliance with the makers of QDOS while IBM efficiently produced MDOS system for windows. Capability building can also create value through enhancing other resources. Wal-Mart's unique internal "cross-docking logistic system" enhances the productivity of their trucking fleet, workforce and information to create wealth for them (Makadok, 2001). Other studies confirm similar claims (Khong, 2005; Leavy, 2004; Power et al., 2007).

3.6.2 Cost reduction

While alliance formation can help organisations share high fixed costs through expanding production volume, others may share both risk and cost of particular ventures (Dyer, 1996; Okoroh et al., 2002; Rodney and Gallimore, 2002). Indeed Dyer, (1996) found that some Japanese automakers in cooperative arrangements achieved low transaction costs despite their high asset-specific investments. This contrasts with the argument that "asset-specific investments" increase transaction costs of all governance forms (Williamson, 1991:282; 1996:106). Others regard these asset-specific or relationship-specific investments or sunk costs as part of the adaptive behaviour associated with the concepts of power balance and levels of commitment and trust in exchange relationships (Barthélemy and Quélin, 2006; Blumberg, 2001; Brennan and Turnbull, 1999; Morgan and Hunt, 1994).

Indeed, an explanation is offered as to why the Japanese are able to achieve such lower transaction costs in cooperative arrangements. The Japanese Williamson (1996:315) argues, are distinguished by a 'syndrome of attributes'. The life-long employment relations, long-term planning view with their unique cultural, legal and banking systems give them an

edge in contractual relationships. The cultural openness they demand and get from most partners and suppliers helps to build trust and commitment that reduce contract haggling, monitoring and coordination costs and hence total transaction cost and limits opportunistic behaviour (Dyer, 1994; Hundley and Jacobson, 1998; Morita, 1992).

Heide and John (1992:34) contend that the expectation of continuity in supplier-customer relationships for long-term profitability was more important for channel members. Other channel writers view alliances versus in-house production as a trade-off between cost and control (Anderson and Weitz, 1983; Heide, 1994). Indeed Heide (1994:72) comments that while in-house production provide employment opportunities and control advantages, the cost-efficiency of contracting out to specialists may be more advantageous in the long run. This may be because external specialists are able to realise economies of scale and scope by pooling multiple demand curves to reduce unit costs of production (Heide, 1994).

3.6.3 Evolution

Alliance success depends on its ability to evolve over time. But evolution may engender tension and changes from initial objectives, which is the essence of alliance formation (Bleeke and Ernst, 1991). For example, evolution can lead to expansion of both scale and scope of products and services from the initial aims of the partners or lead to new product production, entry into new markets or indeed lead corporations from complacency to competitiveness (Chandler, 1990; Nichols, 1993). Bleeke and Ernst (1991:131) cite two examples from their study of the alliance between General Motors (GM) and Snecma to develop jet engines, which evolved into producing a wider range of engines for other organisations. Similarly, GM—Fanuc alliance to develop robotics for the auto industry evolved into producing robotics for non-automotives users. Similarly, the relationships between services and provider managers have evolved into new products and services.

3.6.4 Learning and knowledge transfer

Inter-organisational alliances often provide learning opportunities for alliance partners (Doz and Hamel, 1998, Grant and Baden-Fuller, 2004; Tsang, 2000). Even competitors can collaborate with each other and win in the market place (Hamel, 1991; Hamel et al., 1989). Through learning, partners can develop more efficient production system, improve skills or find new ways of producing products and services and so create value through alliance formation (Barringer and Harrison, 2000; Doz and Hamel, 1998). Such knowledge-based alliances feature in high-tech, semiconductor and pharmaceutical industries, where speed to market and first-mover advantage is critical (Teece et al., 1997). Indeed, Barringer and

Harrison (2000) cite an example of alliances between biotech and pharmaceutical firms. The biotech industries benefit from investment, distribution channels and reputation while sharing their cutting-edge research and knowledge with the pharmaceutical industry. Such arrangements realised value through innovation and speed to market for their products as well as market position through reputation enhanced by association (Stuart, 2000).
In contrast, (House of Commons, 2003) report comment about the problems of skills and knowledge transfer from the private to public sector managers in the areas of contract and project management. This has led to non-realisation of value from some contracted PFI projects and dissatisfaction with the contract arrangements. However things are improving.

3.6.5 Creating wealth through Innovation

Innovation means different things to different people and different things at different times (Innovation, 2002:42). In short it is difficult to define but seen as the ability to turn creative ideas into commercial reality to meet changing need (Christensen et al., 2004; Innovation, 2002; Seltzer and Bentley, 1999). Innovation is the life blood of development or upgrades (Jolly, 2003:27; Morita, 1992), central to wealth creation, driven by challenges to widen business scope, increase customer choices, meet latent demands or add value to market offerings (Innovation, 2002). Innovation is about profitability, economic growth, gaining competitive advantage and success in the market place (Jolly, 2003; Osborne and Brown, 2005). It is productive change that is discontinuous with the past, said to be 10% inspiration and 90% acquisition, changing values or creating employment (Kanter, 1983). It is also about creating surprise by doing something different or in a different way through the interaction between material, technology and the organisation (Harding, 2005). Thus, organisations are driven differently, to innovate or improve through continuous adaptation.

Innovation, as Joseph Schumpeter noted, creates monopolistic positions and monopoly opens the path to above-average and protected profit margins. But the path to monopoly rent is strewn with other drivers of innovation like unexpected occurrences changes in market, industry, technology or demography, changes in customer perceptions, new knowledge and process needs of organisations (Drucker, 1998). Hence organisations constantly strive to innovate to stay ahead of the competition. Multi-cultural societies now demand new ways of doing business to produce new products and services that meet their needs (Osborne and Brown, 2005). Thus the need to upgrade products and services and sustain competitive advantage or meet changing customer perceptions and lifestyle are forces to continuously innovate and stay ahead to avoid obsolescence, economically

grow to create wealth and profitability (Jolly, 2003; Innovation, 2002; Von Hippel, 1998; Storey and Salaman, 2005). Finally innovative manufacturing is said to be the engine that powers national economy as organisations innovate, grow and become profitable they create wealth that translates into national wealth (Morita, 1992).

Drivers for innovation

Successful innovation depends on tackling opportunities when they arise, having the requisite resources, processes and facilities to innovate and the value system that allows organisations to prioritise the opportunity against other projects competing for resources (Christensen et al., 2005). Kanter (1983:213) states, that the power to innovate is the capacity to mobilise people and resources to get things done. Furthermore the willingness for teamwork that draws on organisational stock of knowledge, recognising and absorbing the same while contributing to integrate new knowledge so created is a pre-requisite for innovation (Cohen and Levinthal, 1990; Huber, 1999). Services providers come with requisite skills, knowledge and resources (Huber, 1999). Consequently, outsourcing and alliances as valuable relationships can facilitate innovation through access to resources like sharing knowledge, learning, co-opting alliance members or provider investments.

Obstacles to innovation

Strict contract specifications without the flexibility for changing needs are obstacles to innovation since they give services providers no incentive for improvement (Eriksson et al., 2007). Bureaucratic division of labour with its fragmentation of specialists, detachment from common goals and blame culture hinder innovation. The lack of knowledge and creativity or the ability to combine them in a conducive environment may encourage continuous improvement but hinder innovation (Huber, 1999). An environment of mistrust and conflict will hamper innovation (Eriksson et al., 2007). Consequently innovation thrives in conducive environments that encourage creativity and change without blame.

3.6.6 Legitimacy

Alliances can improve organisational visibility, image, cross-border or local legitimacy and reputation. These may be doors to accessing or sharing resources and expertise to create unique products (Barringer and Harrison, 2000; DiMaggio and Powell, 1983; Tsang, 2000). Indeed, Barringer and Harrison, (2000:374) cite the case of Wal-Mart alliance with Cifra of Mexico that led to Wal-Mart legitimacy in Mexico and the creation of unique products for the Mexican market. Others consider alliances as aid to building critical mass (Hamel, et

al., 1989; Kanter, 1989; Senge, 1990). Firms may also have other reasons for alliances such as building market power through alliances to neutralise that of competitors or plug a skills' gap (Barringer and Harrison, 2000; Ohmae, 1995) or indeed imitate successful firms in alliances (DiMaggio and Powell, 1983). Others like Mexico's Vitro can transform their organisations from complacent local firms to competitive and aggressive international concerns through alliance formations (Nichols, 1993). Others firms like Sainsbury realised organisational renewal and transformation through change (Linder et al., 2002).

3.6.7 The disadvantages of inter-organisational alliances

Observers agree that about 50% of alliances fail due to difficulties in managing them. These difficulties arise from complexities of managing mixed cultures, divergent motives and objectives, loss of autonomy and resultant dependence, or non-performance (Barringer and Harrison, 2000; Das and Teng, 2000; Jennings, 2002; Tsang, 2000). Besides the objective of cost reduction being elusive and not realised, some writers contend that organisations may lose know-how to alliance partners who use the learned knowledge to compete against them as rivals (Cohen and Levinthal, 1990; Faulkner, 1995; Hamel 1991; Hamel et al., 1989; Khanna, 1995; Khanna et al., 1998; Teece et al., 1997; Stuart, 2000; Zajac and Olsen, 1993).

Indeed, Khanna et al., (1998) comments that organisations fail to consider the dynamics of alliances especially with regards to learning. Khanna et al., (1998) see alliances as quest for learning for innovative purposes. This race to learn from alliance partners provides a forum for both competition and cooperation. For example, partners cooperate and share learning and information for mutual benefit. However, parties may also unilaterally race to learn each other's tacit knowledge for private gain. Thus, alliance partners are advised to learn while the alliance endures to gain future benefits. The ability to learn faster than competitors may become a sustainable competitive edge of the future (Senge, 1990:4).

Although alliances enable firms to access resources and knowledge (as in research and development), or to reduce costs and share risks, alliances may lack the authority-based relationship of a hierarchy needed to embed resources into capabilities (Grant and Baden-Fuller, 2004:68; Gulati, 1998; Stuart, 2000). Alliances can also limit the global future of organisations involved as they may be "locked into" relationships without the flexibility to develop or build their own competence and capabilities for enduring competitive advantage (Barney, 1999; Faulkner, 1995; Gulati, 1998; Hagedoorn and Duysters, 2002).

Furthermore, alliances can lead to loss of proprietary information and autonomy as parties become dependent and may ultimately lead to acquisition (Bleeke and Ernst, 1991). Also, being in one alliance precludes an organisation from partnering with other more beneficial organisations thus alliances can hinder organisational flexibility (Doz and Hamel, 1998; Tsang, 2000). Thus, these seemingly negative aspects of alliances make them complex and rather difficult to manage and maintain for enduring advantages.

However, others note that not all organisations wish to have long-term close collaborative alliances (Ford, 2002; Ganesan, 1994). This is because alliance relationships are costly in terms of managerial time, skills and effort (Reeve and Warren, 2004). Such relationships are complex in the range of services supplied and people involved (Gadde and Snehota, 2000). Alliance relationships are interactive, time-consuming and dynamic engendering levels of complexity, uncertainty, ambiguity, power influence and shifting coalitions organisations would rather avoid (Brennan and Turnbull, 2000; Harland et al., 2005). But, depending on the nature of the business, many organisations use provider/supplier relationships differently for their cost-benefit effects or value creation (Ford, 2002, 2003; Gadde and Snehota, 2000). Hence providers and purchasers may work with a mixture of inter-organisational frameworks from simple marketing to cooperative alliances to reduce their perceived resource deficient vulnerability or external environmental constraints.

3.6.8 Network formations

Networks refer to "constellations of autonomous businesses, loosely connected in collaborative arrangements by the need to exchange, share or access resources" (Barringer and Harrison, 2000:376; Ford et al., 2006). Connected refers to the extent to which "exchange in one relationship is contingent upon exchange or (non-exchange) in another" (Cook and Emerson, 1978). For example, NHS trusts services providers do not make raw materials for food or beverages but purchase these from a network of suppliers. Thus NHS trusts become connected to these external others through their relationships with respective services providers. Furthermore, as firms "seek to avoid dependence and external control in order to shape their own context and retain autonomy for independent action" (Pfeffer and Salancik, 1978) they may form networks. Control refers to 'the ability to initiate or terminate action at one's discretion' (Pugh, 1997:131). The control of critical resources leads to the control of organisations. Hence organisations so controlled, may lose the ability to initiate or terminate action without recourse to their "controllers".

3.6.9 Network context and environment

The network context, is structured by bonds between social actors, the activities they perform in the network and the resources used (Anderson et al., 1994). The position of organisations within the network gives them their network identity, defined as a "perception of how organisations see themselves and how they are seen in the network" (Anderson et al., 1994; Håkansson and Snehota, 1995). Thus, firms become embedded in a business network context that is enveloped by the environment (Anderson et al., 1994) [Figure 3.2]. This 'envelope' formed by a network of firms also limits the administrative and managerial control of the firm thus forming its boundary. This boundary may be arbitrary, or real but it does exist due to the firm/market dichotomy in economic thinking (Penrose, 1996:xvi).

Jarillo, (1988) uses the "hub and wheel" example to describe strategic networks, where the 'hub firm' initiates and maintains the network. Networks can be powerful in aligning stakeholder interests and reducing environmental uncertainty through cooperation and consensus (Barringer and Harrison, 2000). Network members concentrate on their area of business competence while all benefit from specialisation which can reduce transaction costs and curtail opportunistic behaviour through building mutual trust, commitment and willingness to remain in the network (Barringer and Harrison, 2000; Ring and Van De Ven, 1994; Tsang, 2000). Transactions costs are reduced through high volume and repeated transaction over time and the expectation of a long-term exchange relationship (Dyer, 1997; Morita, 1992). Thus, networks are purposeful but voluntary association of social actors driven by the need to access resource, reduce transaction costs and environmental uncertainty. There are many motives for network formations but network contacts help organisations realise objective by acting as a bridge to scarce resources, accessing and sharing of capabilities, knowledge, information or reputation and buffer from a hash, faceless and competitive environment (Araujo et al., 2003; Gulati, 1998; Thompson, 1967).

Network members may belong to trade associations to share valuable and timely advice and information, form a platform for collective lobbying or build market power to neutralise competition (Barringer and Harrison, 2000; Ohnae, 1989). Indeed networks in the auto-industry allow firms to remain small, nimble and flexible, focus on competence while using network of stable component suppliers to accomplish objectives (Dyer and Singh, 1998). Similarly, Benetton uses network of franchises to manage its operations in 110 countries. Other firms in the apparel industry, where timely information is vital depend on network of suppliers to avoid cost of integration and unreliable market transactions (Jennings, 2002).

Organisations in highly specialised knowledge-based fields like oil refinery, high-tech and aircraft use networks of multiple contacts to meet time pressures to accomplish project or to gain first-mover advantage in the market place (Axelsson and Easton, 1992; Cohen and Levinthal, 1990). Others use them to maximize efficiency of learning, knowledge transfer, and innovation to gain advantage (Hagedoom and Duysters, 2002; Kleiner and Roth, 1997). Organisations can use their networks as "brain pool" as in aerospace industry to produce unique innovative products thus gaining competitive advantage and creating value through interdependence (Blois, 2002; Das and Teng, 2000).

3.6.10 Disadvantages of networks

Though network members use self-enforcing norms like reciprocal trust to stabilise relationships, networks are difficult to organise and manage as number of participating firms increase (Barringer and Harrison, 2000; Doz and Hamel, 1998). The large power imbalance and the problems of aligning divergent stakeholder interest may cause attrition between members. Finally, learning and competence of members may wane over time as those of the hub firm and competitors wax (Barringer and Harrison, 2000; Doz and Hamel, 1998). This is probably because the hub firm controls the finished product while all others contribute components. The case of 'Airbus' final assemble in Germany is a case in point. Thus, networks can help firms collaborate to realise business objectives through cost reduction, knowledge sharing or transfer, market power, innovation, flexibility and lean production but can also restrict their flexibility to take advantage of other relationships.

However, to understand networks is to understand the dyadic relationships that comprise them (Ford, 2002; Easton, 1992; Gulati, 1998). These dyadic relationships provide the medium of interaction and resource exchange between actors. They are the context of cooperation and collaboration for the coordination of economic activity (Sheu et al., 2006). This study does not involve the diverse networks of services suppliers and hotel services managers' relationships. But it takes its point of departure here to include Interaction Model as a relationship management framework for successfully using the resources acquired through outsourcing to create value for clients and profits for services suppliers.

3. 7 Relationship Management

3.7.1 Medium of resource exchange

The previous section established the fact that organisations require resources that may reside outside their control for survival and success in a dynamic market place.

Resource exchange is the "basis for business relationships" (Möller and Wilson, 1995). Exchange is defined as "the act of obtaining a desired object from someone by offering something in return" (Kotler, 1980), while a business relationship refers to "a mutually oriented interaction between two reciprocally committed parties" (Ford, 2002:162). Hence business exchange may involve a party offering resources like management skills, experience and investments in return for reputation, cash flow and externalities. A firm's competitive edge lies in its ability to add value to services and product offerings. As many firms add value through relationships, the successful management of dyadic relationships becomes a primary activity for competitive advantage (Pettigrew and Fenton, 2000).

Social exchange theory (Blau, 1964) suggests that personal relationships based on long-term orientation can foster trust, commitment and loyalty that can promote cooperation and discourage opportunism (Pasämaa and Hair, 2007). Similarly, business relationships are often based on personal relationships of people cooperating within and between firms. They engender friendship, loyalty, trust and commitment that limit opportunism, choice of partners and the overt use of power but are beneficial to parties concerned (Gulati, 1995; Morgan and Hunt, 1994; Uzzi, 1997). Thus investing in such relationships and successfully managing them (as customer relationships) become antecedents to benefits like reduced risks and monitoring costs and creating value for clients or profits for providers.

The Industrial Marketing and Purchasing Group (IMP) studies are centred on relational exchange between businesses. The concepts of trust and commitment to mutually agreed rules of conduct, the sharing of risks and rewards are central to their studies, aimed at reducing total transaction costs and safeguarding relationship investments (Ford, 2002; 2003; Håkansson, 1982). Furthermore other studies cited value creation in relational exchanges. For example: in relationship marketing (Gränroos, 1997; Dwyer et al., 1987), working partnerships (Anderson and Narus, 1990; Heide, 1994), contracts (MacNeil, 1980) and business-to-business relationship (Morgan and Hunt,1994; Webb and Laborde, 2005). However neither of these studies was involved in support services or aimed at combining total cost reduction and safeguarding of relationship investment with value creation. Consequently, this study goes beyond the confines of studies on simply creating value through relationships and the focus of IMP Group on safeguarding investments while reducing total transaction costs to advance the interaction model of relational exchange.

The advancement of knowledge for this thesis involves relational exchange that includes learning and knowledge transfer for value creation through innovation in the context of hotel services outsourcing and outside industrial business marketing.

3.7.2 How business relationships relate to Resource-based theories and TCE

Resource-based view established that valuable resources give organisations the edge they need to compete successfully in the market place. Since many organisations are resource-deficient, they may access resources from the environment to develop valuable resources for competitive advantage. This access to needed resources creates inter-dependence, hence organisations form relationships and coalitions through alliances or outsourcing to potentially stabilise supply of resources and reduce their vulnerability.
It has been established that valuable resource cannot be bought in the open markets but must be built as capabilities or competence over time. Thus, dyadic business relationships provide the forum or context of interaction and resource exchange and are intrinsic to the resource-based theories. Similarly, TCE notes the benefits of hybrid mode of exchange as being free from the burden of hierarchy, namely bureaucratic costs, and ability to deal with decreased market efficiency as bilateral dependency increases (Williamson, 1996:110). TCE further notes the benefits of network formations, where information is rapidly and accurately communicated to members thus attenuating the incentive for opportunistic behaviour, integrity and reputation being valuable resources (Williamson, 1996:115). Hence, both Transaction Cost Economics and resource-based theories are involved with relationships through business interaction and organisational collaborations.

3.7.3 The interaction approach

Håkansson (1982), outlined the motivation for developing the interaction approach. Firstly, the realisation that business-marketing literature seemed inadequate for business markets. For example, most business purchases were processes of interaction between companies in the context of a relationship. Secondly, that these business relationships evolve over time, are often long-term, close, complex and enduring. Finally, they realised a need for emphasis on analysing and understanding these complex relationships in order to provide an understanding of their management. The interaction model is presented (figure 3.2).

3.7.4 The Interaction Model (IM)

Håkansson (1982) noted the factors needing careful consideration when investigating industrial markets. These are the fact that both buyers and sellers are active participants in

the market exchange (not active sellers and passive buyers). Secondly, that buyer-seller relationship can become institutionalised. Finally that close links can exist between companies who buy and sell infrequently. Using these factors and the interaction process of industrial markets, Möller and Wilson (1995:112), list elements of the Model as:

1. The interaction process, which contains the actual exchange of business, (economic, technical and social), but which also includes a long-range component in terms of adaptation, contact patterns, etc.

2. The participating actors' resources, e.g., technological and organisational resources available to them. These create both possibilities and limitations and place specific requirements on the information processes

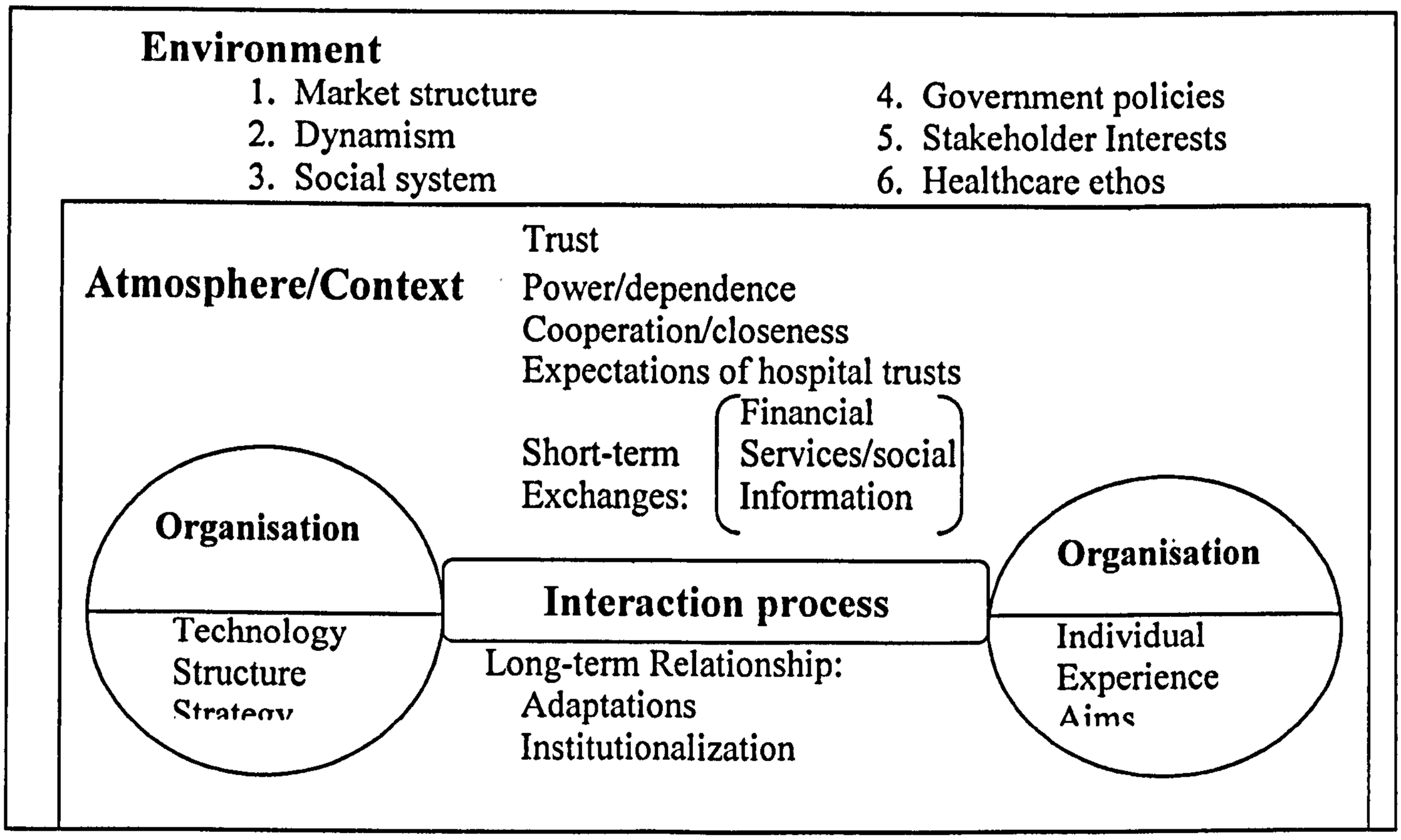
3. The environment in which the interaction takes place, which includes the structure of the actors in the firm's environment. This affects the actual business exchange.

4. The atmosphere in which certain cooperation takes place. This deals with power dependence relations, conflict, cooperation, overlapping proximity or distance and the trust and expectations created on both sides.

3.7.5 Development of business relationships

Ford (1980), states that industrial firms establish buyer-seller relationships, which are often close, complex and frequently long-term. These relationships are motivated by economic benefit and characterised by buyer-seller interdependence. In the establishment and development of relationships over time, Ford (1980), records a five-stage evolutionary process comprising a pre-relationship stage, an early stage, a development stage, a long-term stage and a final stage. As business relationships develop and evolve, Ford (1980) reports changes to a number of variables. For example, the social bonds between the actors become strengthened as they socialise more and come to develop reciprocal trust, which decreases their cultural distance as they interact and learn more about each other's way of 'doing things' and the technology involved in their activities. Senior management decisions may favour a relational posture and commitment towards long-term partnership, which further strengthens their relationship bonds (Håkansson, 1982). In time the relating partners may adapt their procedures, routines and accounting systems as their levels of trust and commitment increase (Hallen et al., 1991). The inherent power in-balance (RDT) can be attenuated by their long-term view of relationship benefits far above costs involved.

Figure. 3.2 The IMP Interaction Model: [adapted from Ford, (2003:29)]



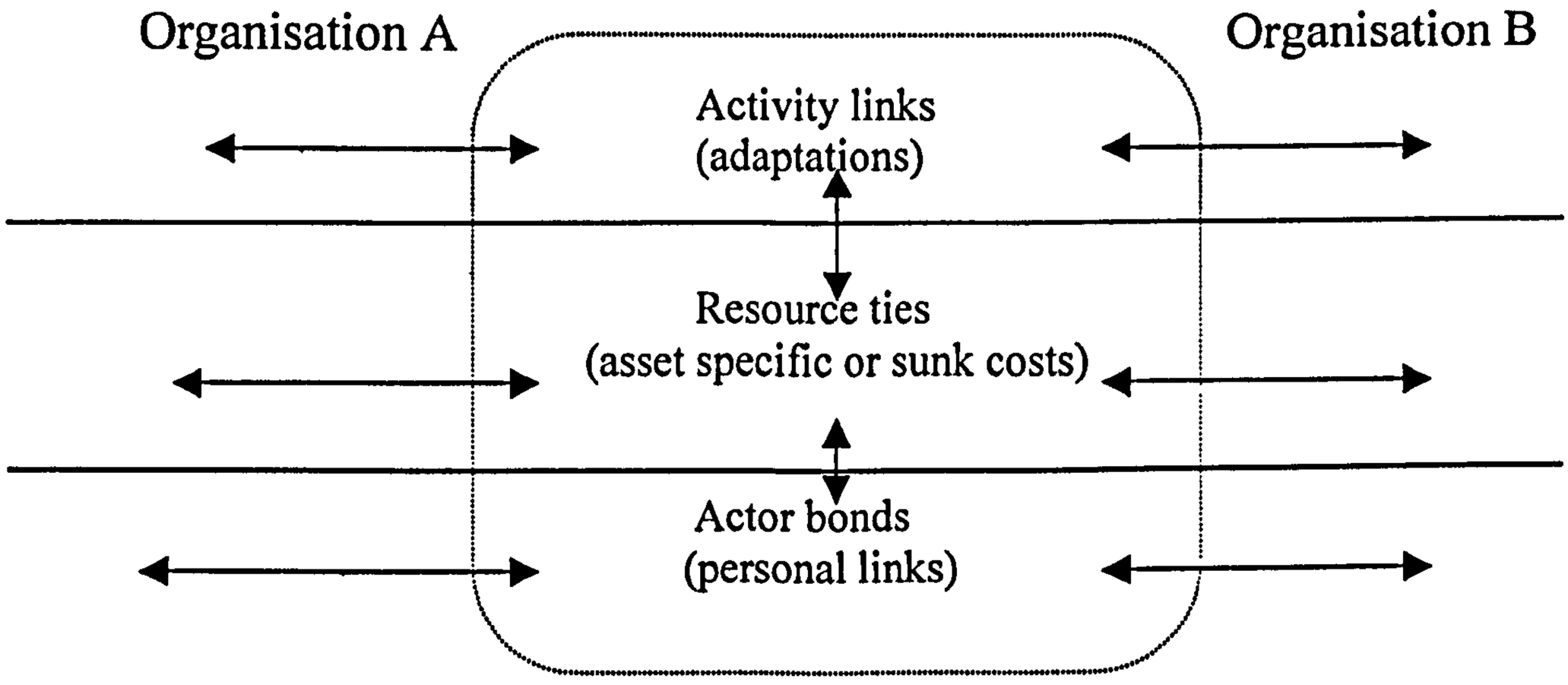
3.7.6 The Interacting parties

As firms access and exchange resources, they become interdependent, develop activity links, resources ties and actors bonds (Håkansson and Snehota, 1995) (see figure 3.3). This interdependence between exchange partners is in line with the resource-based theories. However, these business relationships so formed have liabilities in terms of irretrievable relationship investments or sunk cost (Håkansson and Snehota, 2000). The limiting nature of these investments (resource ties), have already been noted as asset specific investments that burden cooperating partners with opportunity costs. Activity links are mainly the adaptations to routines, processes, planning and procedures as levels of trust and commitment increase. Hallen et al., (1991) found in their study that the failure to make these adaptations resulted in loss of good will and future business. Adaptation can also result from coercion whether explicit or implicit in "if you don't adapt, we will take our business elsewhere". However, most partners did adapt their procedures as a sign of commitment to long-term partnership and expectation of enduring benefits. Thus, collaborative parties are advised (as in TCE) to weigh relationship benefits against the economic cost of relationship development and management (in managerial time, energy, effort and emotional resources).

These relationships are similar to collaborative alliances that precipitate behavioural or social content in terms of commitment, trust and the use of power to influence dependent actors when uncertainty of resources prevails. The resultant interdependence and social factors, prompted Ford (2002:90), to call relationship a "golden cage or an ugly prison". However the successful management of business exchange relationships whether contract or alliance based, can be beneficial to the parties concerned (Halinen, 1997; Tyler, 1996: Tyler and Stanley, 2002). Thus business exchange relationships need not be ugly prisons but can be managed to become golden tunnels to bundles of benefits.

Figure 3.3. Scheme of Analysis of Resource Exchange in a Dyadic Relationship

Reproduced from: Relationship as a dyad [Ford, 2002:177]



Key: ..... delineates medium of resource exchange

3.7.7 Interdependence

As relationships evolve over time, actors learn to cooperate with each other for individual or mutual benefits (Anderson et al., 1994; Svensson, 2002). But such cooperation is tainted by the power imbalance resulting from resource interdependence. Managing this power asymmetry is a "balancing act" organisations must deal with as they interact and exchange resources (Håkansson and Gadde, 1992). This is probably because of the importance of provider relationship, which can account for about 70% of a firm's turnover. The importance of provider relationships may lie in knowledge transfer or sharing, for building capabilities and for innovation (Håkansson and Gadde, 1992; Jolly, 2003). These relationships are dynamic, complex and may involve major investments hence firms that choose to interact with others must manage interdependence as all relationships become

inter-related and inter-dependent hence the network effects (Blumberg, 2001; Gadde and Snehota, 2000; Håkansson and Gadde, 1992; Jolly, 2003; Pfeffer and Salancik, 1978).

3.7.8 Social norms

Fortunately, the exchange parties may belong to the same business network or trade association, where 'social norms' help curb opportunistic tendencies (Heide and John, 1992; Pfeffer and Salancik, 1978:147). Social norms refer to common expectations of behaviour that are shared by decision makers, to which social actors are socialised to behave as prescribed (Heide and John, 1992; Krackhardt and Hanson, 1993; Maitlis, 2004; Ouchi, 1979; Reagans and McEvily, 2003; Westphal and Khanna, 2003).

Norms are developed under conditions of uncertainty to increase relationship predictability hence the stability of organisations for mutual benefits (Pfeffer and Salancik, 1978).
If violated, actors are subject to sanctions through constraints, loss of face or business reputation (Reagans and McEvily, 2003). There are implicit norms of business relationship such as reciprocal trust and commitment to meet expectations and obligations. Here, the expectation of future business interactions makes business norns effective. This reduces total transaction costs through cooperative, self-enforcing arrangements that minimize the cost of searching, bargaining and haggling over legal contracts in what Araujo et al., (2003:1256) call "a world of incomplete contracting and divergent interests". Thus business relationships become what Ford (2002:167) calls "valuable bridges to access resources as well as resources" in connecting organisations and reducing transaction costs.

Organisational interdependence can thrive on interpersonal linkages and social networks that help reduce uncertainty and increase predictability (Blumberg, 2001; Granovetter, 1985; Pfeffer and Salancik, 1978). Social networks and personal linkages provide means of communicating information about each other's activities, costs and pricing, a forum for negotiation and persuasion to obtain needed commitment and support for predictable planning and hence a means of stabilising interdependent relationships (Gadde and Snehota, 2000; Pfeffer and Salancik, 1978). Social networks can also provide legitimacy for organisations. For example, a prestigious stakeholder sitting on the board of a local firm, can provide confirmation of value and worth for the organisation. Similarly, a banker on the board of an ailing firm can become committed to its financial need and mount a timely rescue bid to save the firm (Pfeffer and Salancik, 1978). Thus, interdependence involved in resource exchange presents organisations with a balancing act of power and

dependence to be managed through interpersonal linkages, social networks and norms that promote trust, cooperativeness and commitment to mutual benefits (Ford, 2003).

3.7.9 Trust and commitment

Trust is essentially reciprocal in nature, trust and control being different sides of the same analytical coin in as much as they are both functionally necessary for the generation and maintenance of social order through instituted power relations in legitimate authority structures (Reed, 2001). Thus, trust and power form a communicative medium through which dominant and subordinate groups can coordinate and control their social interaction. Consequently, exchange partners are bound by what Reed (2001) calls 'rule-based trust' and sanction-based power' relations in situations of risk and uncertainty such as resource sharing, acquisition or economic exchange to reduce complexities and achieve stability (Bleeke and Ernst, 1991; Doz and Hamel,1998; Lane and Bachmann, 1996; Tsang, 2000).

Trust and control are linked to the risk and uncertainty of cooperation between exchange partners, for without the uncertainty engendered in exchange relationships trust has no role to play (Das and Teng, 2001; Grey and Garsten, 2001; Reed, 2001) (see figure 3.4). Risk may be relational or performance risk. Relational risk is defined as 'the probability of a partner not cooperating in good faith and performance risk as 'the probability and consequence that alliance objectives are not realised' (Das and Teng, 2001). Furthermore, trust can be goodwill trust or competence trust. Goodwill trust denotes integrity and is defined as "the expectation that some others in the social relationship have the moral obligations and responsibility to demonstrate a special concern for other's interest above their own (Barber, 1983:14). Competence trust refers to the expectation of a technically competent role performance and expertise expected from, say a reputable expert or professional (Das and Teng, 2001). For example, one trusts an airline pilot employed by a reputable organisation to fly safely to a given destination.

Trust can be regarded as a state of mind, which has the capacity to lower perceived risk (Giddens, 1994; Layder, 1997), or a 'leap of faith' tied to risk management mediated through expert power and knowledge (Giddens, 1994). Thus, there is an element of power-dependence or control in all trust-based relationships due to what Layder (1997:64) calls the 'lack of viable alternatives for those who have to trust them'. This trust in expert systems such as justice, law, trade associations, doctors and banking may become institutionalised into 'system trust' that has the ability to moderate the behaviour of

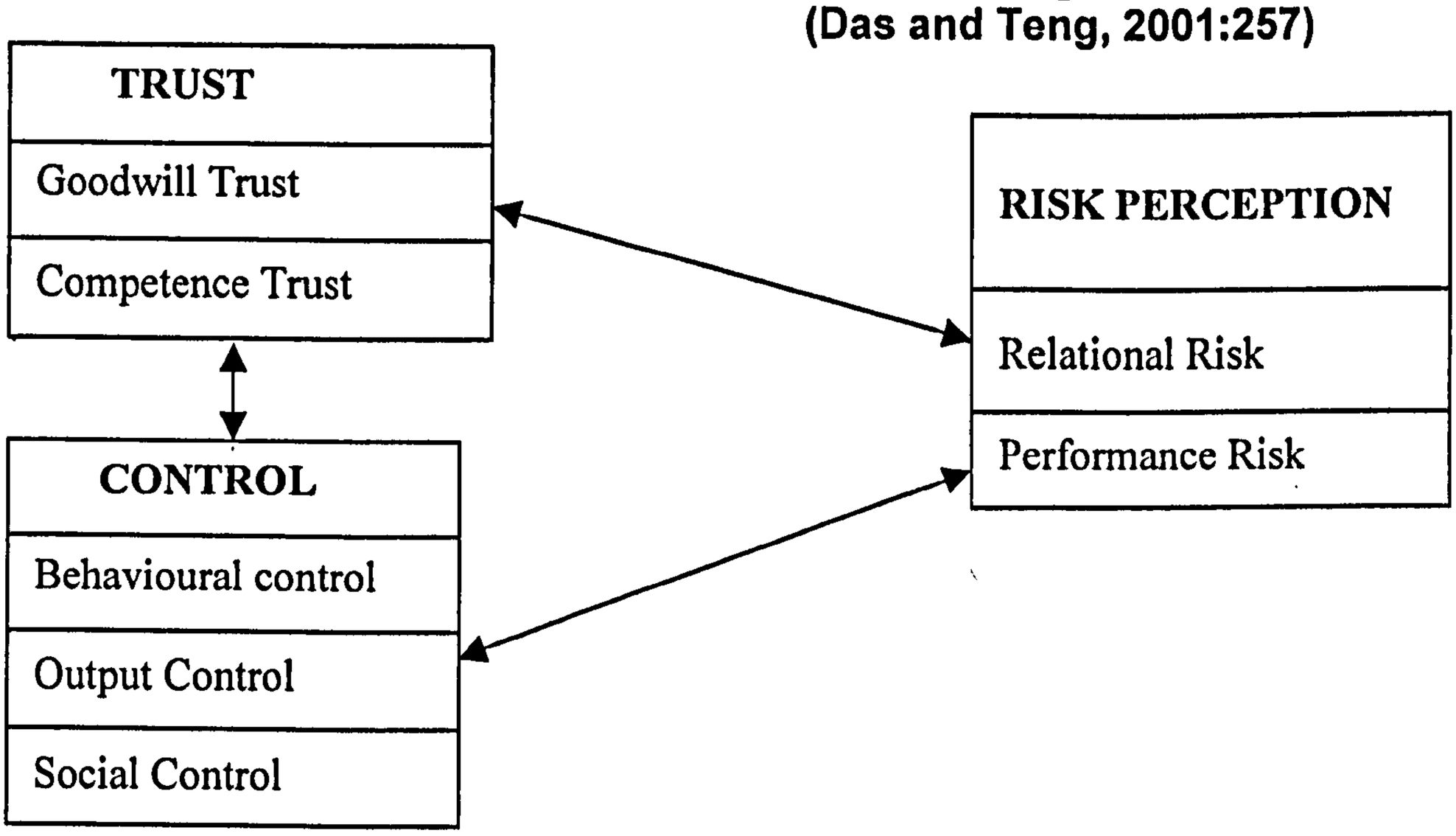
economic actors where goodwill trust and threat of sanctions alone may be inadequate (Bachmann, 2001; Barthélemy and Quélin, 2006; Sheu et al., 2006). Thus, organisations in alliance relationships can use membership to trade associations or network reputations to align the behaviour of exchange partners to meet contractual obligations and reduce total transaction or monitoring and contract enforcement costs.

Inter-firm trust, between actors can also be a source of competitive advantage through the suggestion of good intentions that ameliorate the problems of cooperation and reduce the relational risk of opportunism, thus reducing monitoring costs (Barney and Hanson, 1994). Relational exchange are said to be more effective and productive due to the goodwill of parties to interaction striving to resist short-term attractive alternatives in favour of long term benefits, commitment to preserve investments and shared values that ameliorate decision-making uncertainty and the propensity to exit (Eisingerich and Bell, 2007; Eriksson and Laan, 2007; Morgan and Hunt, 1994; Wilding and Humphries, 2006). Consequently, trust can reduce the risk of opportunism, facilitate the coordination of economic activities and become a source of competitive edge through cost reduction.

The need to maximize organisational acceptability to stakeholders and increase resource and capability base for long-term survival can be the driving force for some forms of trust-building relationships (DiMaggio and Powell, 1991). In such relationships, trust building and commitment to common goals can affect the effectiveness of one actor's control over another and reduce the overt use of power (Das and Teng, 1998; Eriksson and Laan, 2007; Morgan and Hunt, 1994; Wilding and Humphries, 2006). Control can also be 'a process of regulation and monitoring for the achievement of organisational goals'. This is achieved through governance structures, contractual specifications, informal mechanisms and managerial arrangements (Das and Teng, 2001; Maitlis, 2004; Westphal and Khanna, 2003). Thus, trusting relationships and commitment to common goals can minimize the use of control measures and save total transaction costs.

Because commitment of time, energy and resources entails vulnerability for parties to interaction, they will seek trustworthy and competent partners (Morgan and Hunt, 1994). Unfortunately, goodwill and competence trust can be misplaced, but the consequences of misplaced goodwill trust are less dire than that of competence trust (Bachmann, 2001). Lack of trust can result in constant monitoring of preset objectives. This can further erode competence trust and create anxiety (Das and Teng, 2001; Grey and Garsten, 2001).

Figure 3.4 Framework of Trust, Control and Risk in Strategic Alliances (Das and Teng, 2001:257)



Some have questioned the role of managerial orientation towards long-term business relationships in promoting adaptive behaviour hence trust and commitment that can reduce transaction costs through reduced monitoring (Hallen et al., 1991; Morgan and Hunt, 1994). Others found that both managerial posture towards durable relationships and the power asymmetry due to interdependence, led to adaptive behaviour that increased the levels of trust and commitment for mutual benefits (Brennan and Turnbull, 1999). Overall researchers found that trust and commitment over time lead to loyalty and make total customer relationship management mutually beneficial to interacting parties (Eriksson and Laan, 2007; Osarenkhoe and Bennani, 2007; Wilding and Humphries, 2006).

3.7.10 Power and control

Other mechanisms for reducing uncertainty and complexity in the exchange environment are power and direct control. Resource exchange creates interdependence characterised by power asymmetry. It has been stated that the control of critical resources, means controlling the firm (Pfeffer and Salancik, 1978). Power refers to 'the ability to influence others successfully' while authority is regarded as officially recognised power (Hodge and Anthony, 1991). Both power and authority can enable managers to take action on behalf of organisations and achieve goals. For example, financial allocation negotiations during resource scarcity may be won more on the exercise of power than on need, discretion or consensus (Pfeffer, 1994:41).

However, organisations are said to be social instruments of power and energy where people vie for position and control (Pfeffer and Salancik, 1978). Effective power derives

firstly from access to resources, information and support needed to carry out tasks and secondly from the ability to get cooperation in the performance of economic activities (Kanter, 1979). Effective power, notes Kanter (1979) is essentially position power derived from the formal and informal systems in organisations, which help those in authority, coordinate activities. But such authority granted to others through relationships or dependence, can also be withdrawn by those with power (Pfeffer and Salancik, 1978). Therefore, organisations may prefer to share power through social agreements and consensus in order to manage the interdependence involved in exchange relationships. Major sources of power in organisations include ownership, access to, use of, or ability to regulate the allocation of critical resources (Pfeffer, 1981, 1994; Pfeffer and Salancik, 1978). This discretionary power increases with resource scarcity. In ownership situations power influence is exercised through authority position while in cooperative arrangements like alliances, compliance is gained through voluntary behaviour. Hence, organisations use negotiated agreement, persuasion and consensus to align behaviour of business partners and coalition members to stabilise desired outcomes and avoid control (Wrong, 1979).

Furthermore, control of discretionary resource allocation can be used to manage an array of organisations (Pfeffer, 1981, 1994). For example, the 450 NHS trusts in England are managed by this means through the Department of Health (to set the standards) and the Treasury (to allocate allowable funds). Consequently, effective management of alliance relationships that reduces NHS trusts' need for discretionary allocation of funds, can reduce the control of these organisations over the NHS trust involved.

In decisions under uncertainty and complexity, social networks are said to be invaluable (Pfeffer, 1981). These network linkages provide information, experience and knowledge through learning to aid the decision process. Such linkages may be board members drawn from the community who then become committed to organisational goals and help stabilise the organisation with respect to its hostile environment (Pfeffer and Salancik, 1978). Consequently, information can be a source of power in organisations, the manipulation or distortion and withholding of which can affect effectiveness through reduced politicking. Organisations are like Governments and hence fundamentally political entities (Pfeffer, 1994). The interdependence between organisations creates incentives to work together and forge common goals. Consequently, success depends on the ability to coordinate activities through teamwork or mobilise support through trade associations and coalitions to exert political influence on behalf of members (Westphal and Khanna, 2003).

Pfeffer and Salancik (1978), argue that successful organisations engage in minimal power politics, which consumes time, distorts or restricts information and hence may distort perceptions of the state of the environment. However, change in organisations is often a consequence of political processes, using power politics to align organisations with the environment. Thus, power politics and interdependence become "balancing acts" actors must manage in exchange relationships (Ford, 2002, 2003; Håkansson and Gadde, 1992). Organisational politics is the arena for struggles for power (Boulding, 1990; Wrong, 1979). Members must mobilise power to access resources for innovation and to improve services or struggle to countervail the power of others to impose institutionalised routines and policies. Hence those reluctant or unwilling to engage in power politics and conflicts must resign and confine their organisation to gradual developmental change over long period rather than radical change or innovation (Linder et al., 2002; Wrong, 1979:63).

In organisational structures and procedures are located patterns of power and influence in action that recur to establish the 'rules of the game' for effective control (Clegg, 1979; Ronchetto et al., 1989). But such control is never total (Giddens, 1979, 1984) partly due to undercutting and erosion by agency or labour force (Clegg, 1989; Ezzamel et al., 2001; Marx, 1990; Mechanic, 1962) hence negotiation and bargaining power become necessary instruments in successful exchange relationship management (Das and Teng, 2001; Flack, 2002; Lorsch, 1995). This can be achieved through cooptation, which is a less direct method of resisting control through socialisation of hostile elements. The aim is to involve them as participants in board membership, or as advisers to the vulnerable organisation, where they may become committed to the focal organisation's cause and provide needed assistance rather than complaints (Frankforter et al., 2000; Lorsch, 1995; Maitlis, 2004). Indeed one NHS hospital studied used cooptation to invite a complaining community elite as a board member. Through the help and lobbying power of the board, changes were made to the satisfaction of all concerned.

3.7.11 Communication

In relational exchange, of interdependence and commitment to goals, timely, reliable and relevant communication can foster trust through early conflict resolution and the sharing of information to reduce misunderstandings and align perceptions or clarify issues (Anderson and Narus, 1990). Communications refers to the formal or informal sharing of meaningful, timely and relevant information, while conflict is determined by the frequency, intensity and duration of disagreements (Anderson and Narus, 1990). For example the timely receipt of

meaningful, clear information about pricing, competitors activity or resource need to be met allows organisations time to use and benefit from that information. Microsoft sale of QDOS operating systems to IBM is a case in point (see 3.6.1). With long-term view in mind conflicts become functional, most are resolved early and amicably as they provide valuable medium for problem solving rather than disagreements or disputes (Ganesan, 1994). Thus, clarity of communication, loyalty, trust and commitment become important social capital for creating value in business interactions.

Influence patterns can be used to induce desired actions to shape exchange relationships. This may lessen conflict and improve cooperation, communication, trust and commitment that facilitate outcomes for mutual satisfaction (Anderson and Narus, 1990; Maitlis, 2004). Blumberg (2001) argues that communication leads to the development of trust. However, Anderson and Narus (1990) regard the relationship between trust and communication as an iterative process and comment that meaningful communication makes conflict functional as a means of 'clearing the air'. Though their study is predictive and static, it can be adapted for dynamic alliance relationships. Consequently, exchange partners can use communication to reduce conflict, build trust and cooperation as they commit to achieving their set goals for mutual benefits.

In summary, the management of relationship interdependence involves commitment to common goals and building trust over time to reduce the risk and uncertainty of a hostile, undependable environment in the quest for resources. This can reduce cost of monitoring and ultimately transaction costs while building stronger relationship bonds that become valuable resources. Power and politics are essential features of organisations. They can be used to align divergent stakeholder interests and behaviour to achieve organisational goals. Cooptation can make hostile outsiders allies while communication make conflicts functional. Negotiated agreements and consensus work better, than power plays. Common orientation and expectation between exchange partners help regulate their behaviour to prescribed norms, which then maintains the relationship as valuable.

3.8 Where now for NHS trusts studied: Market Mechanism or Hybrid structure?

Having reviewed the literature on some of the theoretical schools of thought that underpin this study, what does it suggest about the NHS trusts investigated?

Are they operating a market mechanism?

Clearly the trusts are not operating in a classical free market, where buyers and sellers are able to judge the real transaction costs and value of exchanges. The NHS has no buyers and sellers. There are consumers (users), services purchasers and providers under the over-arching control of central Government and designated agencies (Øvretveit, 1995). The information about prices, capacity and quality is not freely available so users cannot judge what services they get (Laing et al., 2002; Levitt, et al., 1995). Furthermore, users do not purchase a service rather it is purchased for them by a third party from the funds they paid (taxation) which acts as an insurance for services when needed. The central Government administers funds and ensures services will be there when needed (DoH, 2002; Øvretveit, 1995). Demand and supply are not price mediated as in markets but are highly regulated by purchasers and the Government. Thus, the NHS cannot be deemed to operate a market mechanism based on price, perfect information, with free entry and exit.

Under the present system, trusts have been mandated to engage in long-term services contracts, retain local autonomy and accountability and are encouraged to become more efficient and reduce total costs and waste (Health Emergency, 2004a; Øvretveit, 1995; Williamson, 1975). But there is always the assurance of a bailout and the fact that trusts cannot go bankrupt may encourage slack in the system and reduce incentive for efficiency (Øvretveit, 1995). NHS trusts can only contract with vetted providers whose capacity, prices and quality of service are known (Government agencies vet and approve service providers that trusts can engage) (PASA, 1998). Furthermore, the bilateral dependency created by services outsourcing demands that contracts include contractual safeguards like information disclosure, methods of dispute settlement and equitable sharing of risks and benefits, thus avoiding the type of moral hazard envisaged by economic governance frameworks (Williamson, 1975). Contract details are pre-worded by Government agencies and local trusts can choose between a standard few for their need (PASA, 1998). Perhaps the closest organisational model is, as Williamson suggests, the franchise. NHS trusts appear to act like franchises, having quasi-local autonomy but under greater surveillance, added rules and are highly regulated (Williamson, 1996:107).

Although Williamson (1996) states that the local autonomy of franchises may impede global (or national) adjustments, the Government already uses agencies to impose national adjustments on NHS trusts in spite of their quasi-autonomy (PASA, 1998). Similarly, TCE argues that the added restraint on franchises to use only franchisor materials, to prevent abuse may prohibit utilising local opportunity for cost effective

procurement. This is similar to what obtains in the NHS where trusts must use agency-vetted suppliers for products above £300.000 (PASA, 1998). Thus, the NHS seems to approximate to TCE views based on commercial organisations while modifying some aspects of the framework.

Furthermore, the Government acts as a holding firm, absorbing all cash flow variance to shore up ailing parts, shielding trusts from the effects of financial adversity through bailouts and handouts and policing internal efficiency matters through numerous agencies (Øvretveit, 1995; Williamson, 1975). The Government also exposes trusts to competition by assigning cash flows to high yield users (via payment by results), which is deemed a fundamental attribute of a holding firm or Williamson's M-form (1975:148). The Centre for Research in Strategic Purchasing and Supply (CRiSPS) at the University of Bath, United Kingdom came to the same conclusion (Harland, Knight and Lamming, 2005:835). Thus, the whole system becomes synergistically more efficient as the Government favours local goal pursuit and least cost behaviour similar to profit maximization while retaining the concepts of divisionalisation with centralised internal control and strategic decision-making (Williamson, 1975). Thus the Central Government is shielded from local partisan politics while planning, appraising, controlling and allocating funds to its divisions (NHS trusts).

Based on the foregoing analysis, these trusts, with respect to their resource exchange, appear to be oscillating between a market mode and a hybrid mode with an over-arching Government constraint that makes it a special hybrid type or Williamson's M-form of hybrid, a product of Chandler's (1962) multi-divisional universal form.

NHS trusts do not operate purely on a market mechanism but are subject to political constraints and financial bailouts. However the present trajectory of NHS trusts for autonomy and self-determination as foundation trusts, calls for them to embrace the competitive ethos in order to survive in a competitive market. But some see no profit to be gained as reward, hence no incentive to be motivated to strive for more. Thus some NHS trusts focus on efficiency (value for money) and economising on total transaction costs by in-house production and perhaps to limit the ubiquitous opportunism of economic agents (Williamson, 1981:1550).

Observers note that organisations are unique and different in time and space (Barney, 1991; Giddens, 1984). This is due to their varied history, location, processes, competence,

skill base, attitude to risk, power political orientations, people, culture and capabilities that support their strategic choices (Child, 1997; Hunt and Morgan, 1995; Weick, 1995). Based on these factors, organisations make decisions or non-decisions (Bachrach and Baratz, 1962) and take varied actions to deploy their human and financial resources, skills and competences into uncertain future (Porter, 1991; Powell, 2001:886; Weick, 1979). What most researchers then observe and catalogue are the consequences of past performance and creation struggles, which are the outcomes of where organisations have been. Thus many factors determine the variety of organisations like NHS trusts, their choices as outsourced or in-house concerns and their present state as either autonomous or state dependent or indeed successful or still struggling to survive and compete.

Coase (1937) notes that firms will avoid contract negotiation costs by producing their own inputs till the marginal cost of in-house production equals the market price of the input. But if NHS trusts have no obligation or legal mandate to market-test prices, how will they know when the price of input produced in-house equals that of the market? Thus the fear of opportunistic behaviour of economic agents, deemed guilty by axiom, may prevent some NHS trusts from outsourcing or engaging in competitive market endeavour preferring to cooperate with other in-house low cost operators for stability, predictability or mediocrity.

Besides managers are reluctant to abolish their own jobs by outsourcing to contractors (Williamson,1975). Consequently they retain in-house supply even when external supply by commercial contractors may be lower than viable cost of internal production or supply. What is more, by favouring procurement managers, with in-house operations, other departmental managers make room for trade-offs and reciprocity between departments for future use. Thus procurement decisions are distorted in favour of internal supply and benchmarked against other in-house operators.

Secondly, internal arrangements economise on informative communication devoid of meaningless symbols, using instead their unique occupational and cultural jargons for efficiency. Outsourcing involves external others and a cost in relationship management. Consequently, NHS trusts economise on total transaction costs through favourable internal arrangements (Williamson, 1975).

Thirdly, internal arrangements promote convergent expectations and attenuate uncertainty of interdependent parties making independent decisions with respect to private motives and agendas or changing market conditions, contract details or prices (Williamson, 1975).

Fourthly, internal arrangements and cooperation with similar NHS trusts permit parties to deal with uncertainty in adaptive sequential manner without the same hazards that market contracting can pose. Consequently, in-house managers economise on their bounded rationality (Simon, 1991; March and Simon, 1958) by working on approximations rather than on certainty and by waiting till events unfold to deal with them. Sixthly the sunk cost of existing processes and facilities insulate them against replacement with new or preferred projects, hence favouring in-house continuance.

Furthermore, by abandoning their present facilities to choose alternatives like outsourcing, current committed administration will have to admit failure of internal procurement and management hence the persistence of in-house persists and it becomes rather difficult to separate the inappropriate and inefficient from meritorious performance in such NHS trusts (Moore, 1992; Williamson, 1975). Thus in large complex organisations, where cross subsidisation glosses over inefficiency, market testing is rarely undertaken (no legal reason to do so), so managers focus on cost containment and cooperation while avoiding market mechanisms that will bring accountability, relationship management and more open communication to the fore.

But the NHS trusts that embrace the competitive ethos to aim for foundation status can struggle and strive now to learn and make the financial stability grade that will enable them to attain self-determination and the ability to define or configure their own services with a more efficient and cost effective view in mind. Some have already gained comparative advantage from medical research and expertise and with competition to spur them on many more will attain the foundation status and be freed from Government dictates and domination (Timmins, 2007a), to add value to healthcare services that meet the needs of local community. Thus the variety of NHS trusts will enable patients have more hospital choices with a diversity of hotel support services, while workers and some managers will liberate themselves from the mundane to the professionals, able to hold their own in organisations of diverse professionals.

Clearly the third way (Giddens, 2000), presents NHS trusts with different options and choices for the future. The purpose of this study is to understand and document the perceptions and interpretations put upon these choices by those directly involved in support services outsourcing with private commercial services providers.

Chapter 4 Methodology and Methods

4.1 Introduction

The choice of structuration theory, reflects the nature of the research question, the data gathered from a somewhat unique context and my intention to understand and explain the outcome of complex and dynamic interactive process like hotel services outsourcing on a group of people directly involved in the process. It is difficult to position this study in either of the prevailing polar ends of the philosophical divide of determinism or voluntarism. Determinism deals with the reproduction of social relations as causal mechanical outcomes devoid of any active process involving human agency. Similarly, voluntarism is said to treat only problems of "production", where agency produces reality through meaning (Bryant and Jary, 1991:7). But structuration theory seems to offer another way of examining the situation by suggesting social structures as both the medium and outcome of social interaction. It incorporates the action of knowledgeable human agents with meaning, subjectivity, reflexivity and power, facilitating and constraining agents through the dialectic of control. The support services workers and their managers have been trained and developed from ancillary workers to professionals through services provider investments. This accords them the privilege of knowledgeable and skilled agents able to use available resources to make a difference to their roles, departments and NHS trusts. Similarly, the contractual relationship between services providers and their clients in the outsourced support services engenders autonomy/dependence power positions hence a constant balancing act for their relationship to continue for mutual benefit. Structuration theory deals with the concept of power in social interaction like contractual relationships. Consequently, structuration theory (Giddens, 1979, 1984) provides a powerful but flexible philosophical framework with which to study and explain the evolving social and economic changes resulting from hotel services outsourcing in the National Health Service (NHS).

4. 2 Structuration theory

Structuration theory (Giddens, 1979, 1984) is deemed a metatheory of action, relevant to all social sciences and suitable for the study of patterns of change through interaction or economic consequences (Bryant and Jary, 1991:14,102). It is an ontological framework for studying human social activities (interaction) in social institutions like the health service in advanced or capitalist societies (Giddens, 1984). Structuration theory is dedicated to examining how knowledgeable actors as agents, differentially endowed with access to needed resources like finance, knowledge, managerial experience and a loyal workforce

can make a difference in pre-existing state of affairs that affects their roles, and attain organisational transformation, community renewal and social change. By giving weight to the actors' meanings and actions, the theory helps to show how social structures like culture or reputation are both constituted by human agency and yet are the medium of this constitution.

Structuration theory focuses on understanding of human agency and social institutions, where institutions, like the health service and the monarchy, are regarded as the more enduring features of social life (Giddens, 1984:24). Structuration theory regards all social life as generated in and through praxis; where social praxis includes the nature, conditions and consequences of historical activities and interactions produced through the agency of social actors in time and space (Cohen, 1989:2). Because the rationality of agents is bounded the activities they perform have intended and unintended consequences (Cassell, 1993; Giddens, 1979:215). Thus, actors (by intention) are creators of social life but the resultant social life created is not of their creation due to unacknowledged or unintended conditions of action (unforeseen outcome). For example, diverse intentional acts aimed at improving urban sprawl through housing policies and the need of ethnic groups to maintain cohesion via common language, customs and social events, may result in ethnic segregation as an unintended consequence (Giddens, 1984).

The theory of structuration (Giddens, 1979, 1984) skilfully straddles the great philosophical chasm of objectivism and subjectivism in what is called ontology of social life in sociology while claiming an epistemological middle ground (Bryant and Jary, 1991; Cassell, 1993; Cohen, 1989). Structuration theory is not alone in rejecting this philosophical polarisation described by Burrell and Morgan (1979). Critical theory of Bhaskar (1978) also abandons this restrictive dichotomy for a different focused framework for investigating complex organisations. Both structuration and critical theories deal with concepts of power, control, domination and change in novel ways that transcend description and attempt to explain what is observed in complex dynamic relationships like support services outsourcing in the NHS (Reed, 1996, 1997; Riley, 1983; Stones, 2005; Whittington, 1992; Willmott, 1987).

Structuration theory is eclectic in supporting the synthesis of assumptions and favouring pluralism. This is expressed through its ability to borrow concepts from other disciplines as well as divergent schools of thought (Bryant and Jary, 1991; Cassell, 1993; Cohen, 1989).

For example, from the objective world of structuralism (Levi Strauss) and functionalism (Comte) the ideas of constraining quality is emphasised in the duality of structure where structures are rules and resources that both enable and constrain actors in their daily activities and interaction. Similarly, the social whole is given pre-eminence over individuals although individual agents are acknowledged to be knowledgeable and able to intervene in events to make a difference when they have access to resources (Bryant and Jary, 1991; Cassell, 1993). From the subjective world, the concepts of subjectivity, action, meaning and communication are related to notions of structure and constraint used to explain human conduct. For example, human agency is rooted in the capability of doing things. The motive for action is prompted by want while the reason provides the ground for action (Giddens, 1984). The knowledgeability and subjective experience of human agents entails the ability to meaningfully communicate, explain and elaborate on the reasons for actions engaged in. The rules of social conduct provide a mutual platform for understanding and monitoring the resources (hence structure) drawn upon during interaction in co-presence. Thus human agents can be held accountable and responsible for their actions.

The production and reproduction of social systems[1] involve the communication of meaning through language, exercise of power and the evaluation of conduct through reflexive monitoring of action by actors (Bryant and Jary, 1991:8). For example, the informal use of language as humour, irony or sarcasm to communicate hidden meaning can display the basis for actions or coping mechanisms for those in subordinate positions more than structured interviews. Structured interview formats fail to incorporate local ironies or hidden cultural meanings of those interviewed. Furthermore, the perception and exercise of power and control by providers of vital scarce resources and how they reflexively monitor and evaluate their conduct to maintain custom, reputation and legitimacy can be studied using the framework offered by structuration theory. Thus, structuration theory (Giddens, 1979, 1984) is an appropriate tool for studying the role and consequences of hotel services outsourcing to commercial services providers, who are also investors in capital projects and stakeholders in some NHS trusts.

Structuration theory also rejects the dualism of agency and structure in favour of duality of structure; where structures are rules and resources used in interaction. These rules and resources are both the medium and the outcome of interaction. As a medium, rules and resources provide the structures individuals draw upon to interact meaningfully and as

[1] Social systems relate to the patterning of social relations across space and time (Giddens, 1984:376)

outcome, they exist only through being applied and acknowledged in interaction. Rules and resources do not exist in time and space except in the constitution of social systems, where systems are regularized relations in interaction (Giddens, 1979:65). Thus, structuration theory can be used to study ways in which social systems are produced and reproduced in interaction via the application of generative rules and resources in the context of intended or unintended outcomes (Cassell, 1993; Cohen, 1989; Stones, 2005).

Basically, the ontology of structuration theory, emphasises the self-direction of the individuals as agents and focuses on which conditions of action will maximize the capacity of knowledgeable actors to make a difference in society when they are differentially and socially endowed with access to vital resources (Bryant and Jary, 1991:19). Hence it is concerned with the uniqueness of historical views or perceptions of human action and human societies and the reproduction of social systems (figure 4.1 below). It limits the role of causal laws, defies generalisation (Bryant and Jary, 1991: 18) and excludes all universal laws, which according to Giddens (1990:310), do not exist in human social activities.

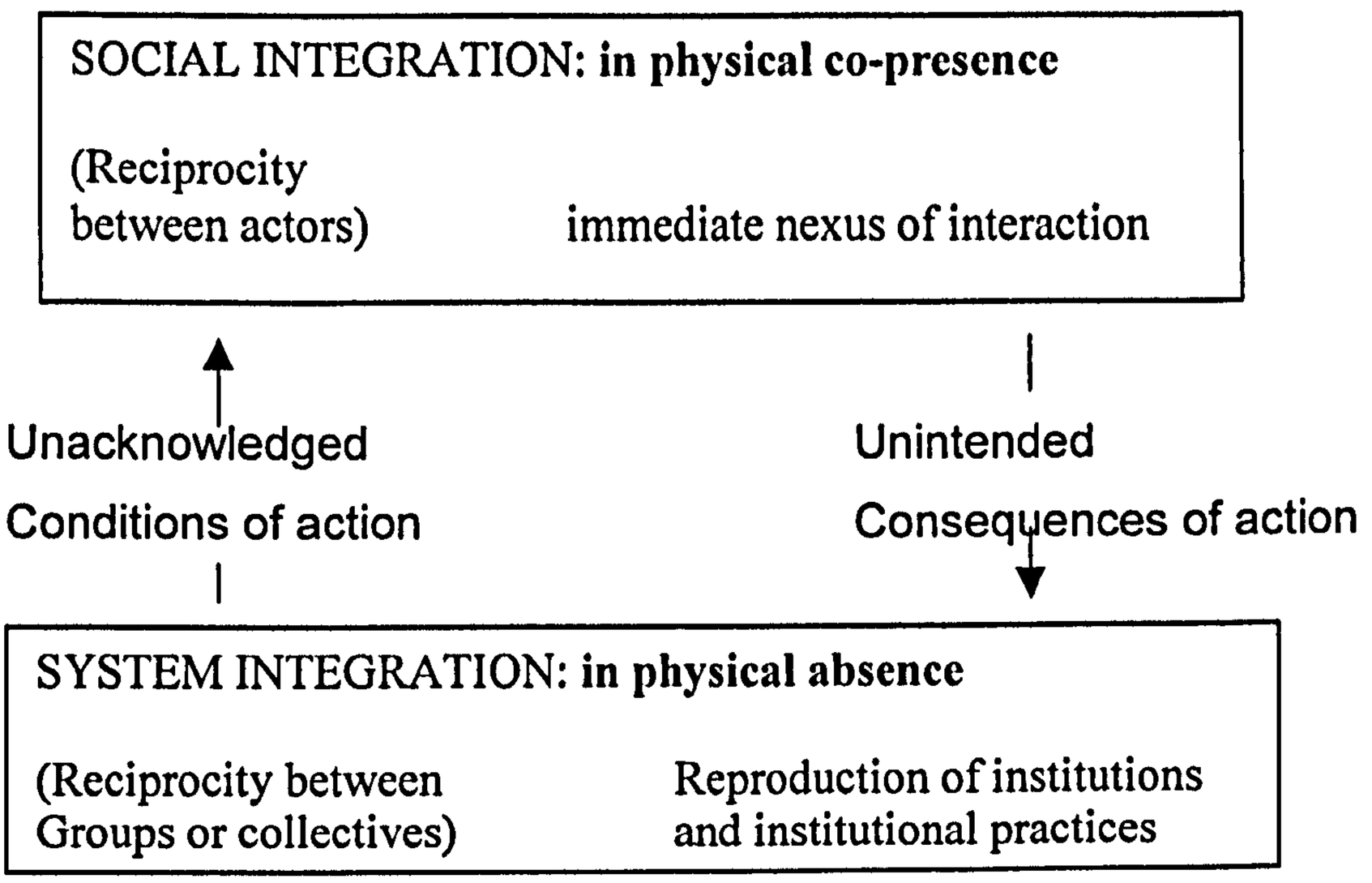
Structuration theory regards social science as neither natural science nor non-science but science with a different character. Hence the open-ended guidelines for investigating social institutions like the health services. There are three stipulations for using structuration theory (Giddens, 1976:6). These are firstly researchers must be sensitive to the complex skills of agents in day-to-day activities. Secondly, they must be aware of the critical discipline in sociology, which seems to undermine ideology or capabilities by making the sectional interests of dominant groups appear as universal ones. Thirdly, research must be in a specific context, with findings communicated in appropriate literary style, having ethnographic or anthropological aspects to them (Bryant and Jary, 1991:24).

The main issues in structuration theory are: Social praxis[2], power as transformative capacity of agents to make a difference, the fact that all historical practices (healthcare delivery) and circumstances (support services) are subject to change, the duality of structure, the broad use of language to communicate meaning, the time-space distanciation, the dialectic of control, where autonomy and dependence are reciprocally related and control is never absolute and de-centring of individual in favour of society.

[2] Social praxis are the nature, conditions and consequences of historical activities (Giddens, 1984)

Figure 4.1 Reproduction of social systems through interaction

(adapted from Giddens, 1979:27-28: Bryant and Jary, 1991:123)



4.3 The nature of reality

In framing his ontology of social life, Anthony Giddens claims that he was inspired by post-empiricist doctrines associated with positivist ideas but chose a middle ground from which to "fire critical salvos (guns, applause or questions) into reality" (Giddens, 1982:72). Hence he regards his world-view as lying between two houses—a factual house and a moral or critical one, neither of which is safe (Giddens, 1982:74). Consequently structuration theory can also be critiqued from any theoretical angle or established schools of thought, as many have done, and Giddens accepts that there is room for other world-views, even in capitalist societies. However, Giddens (1981:184), has been reticent in rebutting his critics and regards such areas of endeavour as contested terrain to be avoided. He maintains that no single theory can be expected to provide the frameworks needed in conducting social research as evidenced in the multiple theories intrinsic to this thesis. Williamson (1996:309) adopts the same view and favours multiple intrinsic theories.

Some writers have been critical of structuration theory. For example, Bhaskar (1986:84) considers structuration theory as too voluntaristic. Stones (2005), makes the same comment arguing that structuration theory overestimates the knowledgeability and power of agents. Others complain that agency may dominate the stage in structuration theory but the issue of dualism has only been refocused not resolved (De Cork and Rickards, 1995). Others argue that such criticisms are epistemological issues on which Giddens has been silent and is reluctant to specify (Barley and Tolbert, 1997; Bryant and Jary, 1991:25).

4.4 Knowledge-ability of agents

Barbalet, (1987:11) argues that there is little credible evidence that the knowledgeable agents of structuration theory know about their institutions as much as they are supposed to. Giddens (1979:255) replies that to be a competent member of society, every individual must know a great deal about the workings of that society. Besides agents are not "cultural dopes" but highly skilled and knowledgeable with both unconscious cognition and stocks of tacit knowledge (experience) on which to draw in the constitution of social activity. Agents also reproduce structures (expertise through learning) as medium and outcome of their interaction and in so doing can reproduce, renew, change or transform their institutions and subsequently society (Giddens, 1979:71). However, Pleasants (1999:55), comments that agents are knowledgeable by virtue of what they can do not what they can theorise. Hence their stock of know-how is more important than their theoretical knowledge. For example in problem-solving, where action not knowledge is needed to avoid conflict.

Whittington (1992:704), also posits that it is by the active exploitation of tensions between divergent structural principles (as principles of organisations or institutional alignment) that managers gain their agency. For example the internal ambiguity and plurality of rules and their subsequent interpretations give agents the leverage to reduce such rules to local contexts, apply them creatively or dispense with them altogether as inappropriate for them. Similarly alien rules introduced through relationships or external control mechanisms are also subject to contestation or interpretation to suit local contexts as seen in the rules governing corporate subsidiaries which agents interpret to suit them and thus avoid central control (Child et al., 2000; Ferner et al., 2004; Grimshaw and Miozzo, 2006). Others argue that change is made through the struggles for autonomy (Craib, 1992; Kaspersen, 2000).

On resources, structuration theory credits knowledgeable agents with the capacity to make a difference when they have access to resources. However, others argue that perhaps access or indeed possession of scarce but vital resources alone does not guarantee their effective usage without requisite skills (Burns and Stalker, 1961; Pettigrew, 1973). Thus the skills agents bring to bear on using resources and their ability to mobilise support for their claims or sectional interest may be more important than access or possession alone.

Stones (2005), had the last word by commenting that structuration theory is meant to be used as a sensitising device and not a detailed guideline for research procedures. Other theories should provide the frame of reference or context for research while structuration

theory deals with the interplay and interdependence between agency and structure. For example, family structure is tied to the job market but Government structures and employment policies provide the context of employment for family members. Thus through the interplay of employment policies and structures, family members maintain their roles.

Despite these arguments, observers contend that structuration theory remains a most promising analytical and explanatory framework, than multiple paradigms, for conducting in-depth analysis of the interplay between structure and agency as they shape and reproduce organisational forms (Bryant and Jary, 1991; De Cork and Rickards, 1995; Reed, 1997; Stones, 2005; Weaver and Gioia, 1994; Whittington, 1992; Willmott, 1981).

4.5 Users of structuration theory

Many researchers have used structuration theory to study aspects of organisations and society. For example:

Whittington (1992) used it to investigate how class structuration and the capitalist division of labour can be influenced by gender, ethnicity, knowledge and state and how conflicts and contradiction between private appropriation of surplus value and socialised production can open up space for agency to transform their organisations through the dialectic of control. The active exploitation of these tensions enables workers to exercise the privilege of defiance in contradiction to capitalist rules of obedience, loyalty, compliance and commitment aimed at employee control and domination at the workplace. Consequently, using structuration theory extends managerial agency beyond the confines of corporate buildings into the communities where managers and workers (employees) are parents, leaders and members of ethnic groups whose rules of conduct and engagement differ from those of the capitalists. Thus employees have a plethora of choices within diverse systems from which to draw on rules and resources in order to make a difference without recourse to capitalist or institutional structures alone.

Willmott (1987) argues that managerial work in social institutions in capitalist societies like support services in the NHS can be influenced and conditioned by the requirements of capitalist labour process because the rules and resources agents draw upon to perform managerial work in these institutions are already accepted, legitimised and sustained by the politico-economic relations of power in capitalists society. Hence managers draw on capitalist structures (rules and resources) within and outside institutions as the medium and outcome of their interaction to enable them accomplish their tasks. Agency is

therefore through the imperfect and multiple confusing roles which managers play, as career managers, agents of capitalist system and employees of corporations with powers to allocate rewards or apportion sanction to which they are also subject. Thus in institutional analysis, managerial work becomes a continuous search for consensus in the conflict of personal and sectional self-interest between power holders and non-clique members within the "dialectic of control".

In the realm of change, Pettigrew (1985), documents how external economic recession triggered change and was used by corporate leaders, as agents of change, to mobilise managerial action in the context of Imperial Chemical Industry (ICI) to transform that organisation. This study resonates with the consequences of hotel services outsourcing in the health services. The trigger for services outsourcing was the inflation or economic recession of the time needing a reduction in Government healthcare expenditure in order to fund competing areas like education. The subsequent mobilisation of forces by managers, as agents in their trusts, has seen trusts like Theresa hospital attain foundation status and become liberated from central control. Others trusts studied are poised to gain the same through the enabling action of services providers as capital projects investors and major stakeholders that streamlined activities, instituted innovation, commercial ventures and ancillary staff training in many trusts with outsourced services.

Still on change, Chanal (2004), used structuration theory to study how project teams in an industrial setting can draw on organisational rules and resources (structures) and through interaction produce new knowledge that resulted in change through innovation in design.

Huber (1999) also used structuration theory to study how an organisation outsourced its design features to access skill, knowledge and expertise. The in-house team and their vendor, through interaction and drawing on organisational rules and resources were able to produce new knowledge to redesign features that effectively impacted the client firm.

Similarly, Ranson et al., (1980) used structuration theory in the context of organisational structure as informal patterned regularity of interaction combined with structure as framework of the organisation to show how organisations change over time through interaction. Here Ranson et al., (1980), acknowledged the separate notions of structure as a medium of control and domination through hierarchical positions or social

relationships (interaction). Both involve political processes to enable agents to access, allocate and to administer scarce resources or mobilise forces to achieve desired outcomes for change or renewal.

Akgűn et al., (2007), used structuration theory to understand organisational intelligence as an interplay between individual and corporate intelligence, which through interaction of workers as agents, is combined into a comprehensive form of organisational intelligence.

Others used structuration theory to study the interaction between information systems and agents who receive, interpret and use or resist using them to improve the effectiveness of their delivery services in logistics (Lewis and Suchan, 2003).

On cultural issues, Patricia Riley (1983) used structuration theory to investigate culture as organisational politics rife with patterns of symbolic discourses and subcultures (as what an organisation is and not what organisations have). In her institutional analysis, she compared political symbols from two professional bodies, which were subsidiaries of the same organisation to elicit features of control, power play and domination. One sample was routinised (public) and the other non-routinised (private). Her aim was to identify structures that govern the political nature of organisational culture and to elicit structures of domination through resource allocation and budgetary decisions.

Although her data collection was hampered by the refusal of some people to be interviewed, the transfer of employees, resignations, vague responses to interview questions and attrition, she achieved 20/50 scheduled interviews in the end. Such data collection problems were also seen and experienced in this study (so I am not alone). In her analysis, using structuration theory schema, (figure 4.2), she also found it difficult to discern actions generated through domination and hence relied on respondents' views at interviews on what was important to them through repetition or voice modulation. However she managed to arrive at a plausible conclusion that organisations are rife with informal cultures or subcultures not officially espoused by all members but through the dialectic of control, the official culture predominates. This is the same conclusion arrived at in this study.

Figure 4.2 **Analytical elements using the process of structuration**

(adapted from Giddens, 1984:29)

STRUCTURE	**SIGNIFICATION** (semantic rules)	**DOMINATION** (resources)	**LEGITIMATION** (moral rules to evaluate conduct)
MODALITY (mediation of interaction in process of production and reproduction)	**Interpretative scheme** (stocks of knowledge and capabilities)	**Facility**	**Norm** (Accountability)
INTERACTION	Communication	Power	Morality /sanction

Although structuration theory has been criticised as a meta-theory of action, many researchers have successfully used aspects of it (as intended by Giddens) in social studies involving change, power through culture, organisational intelligence, innovation in design and logistics, but none of these studies involved a large public organisation like the NHS or support services outsourcing.

However, Lawrence et al., (1997), used structuration theory to investigate the ability of agents to mobilise forces during crisis situation prompted by economic recession to effect change, survival and transformation of their organisation. Although the context of the study was a large public hospital in New Zealand, the research was in the accounting section. There are similarities with the research presented here. For example, the context of study and the stimulus for change through operational efficiency are the same but again it does not deal with either support services or services outsourcing as in this study.

4.6 Research Methods

Introduction

This section defines the data collection methods, ethical, validity and reliability issues. The decision to use a resource-based approach for this study, evolved during the pilot study of NHS trusts. The relevant theoretical frameworks that underpin the study namely Resource Dependence Theory (RDT), Resource-based View (RBV), Institutional Transaction Cost Economics (TCE) and Interaction Model (IM) emerged as "lenses" to guide the study, select people interviewed and raise important questions and issues to examine (Cresswell,

2003:131). Subsequently, structuration theory (Giddens, 1979, 1984) also emerged as a unifying lens with which to understand the perceptions of particular individuals in specific contexts of NHS trusts and how these people create meaning in their roles as procurement managers, services provider (FM) managers, stakeholders or members of the workforce. These theoretical underpinnings have been reviewed and discussed. Their combined assumptions provide a rich broad framework amenable to the study of complex and dynamic phenomena like the perceptions of key personnel involved in hotel services outsourcing and the consequences of their business relationships with commercial services providers in the eight NHS trusts studied.

Others have used multiple theories to investigate business relationships. For example, Heide and John (1988) used TCE and power theory to study inter-firm relationships while Anderson and Narus (1984 and 1990) combined intimate relations theory and power theory in their study of working partnership relationships. Furthermore, Transaction Cost Economics and Resource Dependence Theory have also been used to provide models that were empirically tested (Anderson and Narus, 1984, 1990; Weitz, 1981). Recently, Chanal (2004), used structuration theory (Giddens, 1984), communities of practice theory and the discursive view of organisations to investigate how innovation in a firm contributes to organisational learning. Also Grimshaw and Miozzo (2006), used contract law (Barley and Kunda, 2001) and varieties of capitalism (Hall and Soskice, 2001) in their comparative studies of institutional effects (context) on IT outsourcing. These multiple theories aid better understanding and explanation of the subject under study by moderating their individual distinctiveness (Easton, 1995). Consequently, the five intrinsic theories used in this study also complement and moderate each other for similar effects.

Because so much is new, complex and interwoven in these outsourcing relationships, coupled with the evolving process of interaction exchange, the research is based on the subjective views (perceptions) of managers on both sides of the relationships. These views embody the constructed meanings of these actors or agents from their experiences, jobs, routines and the paradoxical political climate and diverse stakeholder interests that govern, influence and constrain their work and exchange relationships. Hence an inductive stance allows for a richer understanding of the evolving change processes, the dynamic nature of these relationships and their outcomes (Easton, 1995). Induction may also play a powerful role in knowledge development through the discovery of theories in use and their

applicability in the design, management and structural outcomes of inter-firm outsourcing relationships (Berger and Luckman, 1966; Dwyer et al., 1987; Easterby-Smith et al., 2002).

Qualitative research is referred to as "an umbrella term covering an array of interpretative techniques that seek to describe, decode, translate and come to terms with the meaning, not frequency, of certain naturally occurring phenomena in the social world" (Van Maanen, 1983:9). Flick (2002:9), further defines qualitative research as "a process of constructing versions of reality in time and place". However he bounded it by stating its relevance to social relations, not the formulation of general laws or measuring to quantify phenomena (Flick, 2002:2). This may be because a hypo-deductive approach is deemed static and unable to capture the complexity and dynamism of inter-firm exchange process. Qualitative methodology lends itself to the study of complex inter-organisational functions such as business relationships through outsourcing and provides powerful tools in management studies (Easterby-Smith et al., 2002; Flick, 2002; Gummesson, 1991; Miles and Huberman, 1994; Mintzberg, 1973, 1990). Hence, this study has a descriptive and explanatory purpose.

This thesis endeavours to add to the body of knowledge by aiding the understanding of the process of hotel services outsourcing in the unique context of the health service and the hopeful production of knowledge for managers and stakeholders to better understand their resources and how others have creatively used theirs for comparative advantage through hotel services outsourcing in the healthcare arena.

4.6.1 Research aim

The aim of this thesis is two fold. Firstly it should contribute to and develop knowledge of outsourcing process in the NHS context. Secondly it should allow academics and both NHS and FM managers to gain understanding of the structural outcome and impact of hotel services outsourcing in these eight selected NHS trusts, in order to perhaps apply it to improve their outsourcing outcome or gain advantage in the competition for healthcare.

4.6.2 Research objectives

The objective of this thesis is to investigate the perceptions of managers, workers and stakeholders most closely involved in the contractual business relationships between eight selected NHS trusts and their providers of hotel services. It does not seek to quantify the resultant benefits or extend these benefits to third party network interests. Rather the study

seeks to explain the commonalities, differences and contradictions between perceptions of these respondents directly involved in hotel services outsourcing in their different trusts.

4.6.3 Research focus

This research focuses mainly on the contractual relationships between hotel services providers and their clients with reference to the resources involved and the structural outcome of these relationships. Many previous studies (as shown in the literature review) have used the Resourced-based approach to study the benefits of business relationships. For example in using inter-organisational relationships (alliances) to create value through resource combination or knowledge sharing (Barringer and Harrison, 2000; Das and Teng, 2001) or to transform their organisation (Jamali and Sahyoun, 2006). Some used alliances to gain access to foreign markets, increase the speed to market as in high-tech firms (Doz and Hamel, 1998; Faulkner, 1995), while others, through alliances, built capabilities for competitive advantage (Barney, 1999; Grant and Baden-Fuller, 2004; Powell, 2001).

Other researchers used outsourcing of Information Technology to enable them focus on finding and producing hydrocarbons (Cross, 1995), to improve manpower needs (Peisch, 1995) or to investigate its impact in the public sector (Jiang and Qureshi, 2006; Lin et al., 2007). But none of them investigated support services outsourcing in the NHS. However, the focus of this study is on how trusts use outsourcing of their non-core activities namely, hotel services to access skills and know-how that enable them focus on their core activity of medical research and practice and so compete with other NHS trusts. Resources acquired, as investments, also enable some trusts to build capabilities or facilities to improve working environments and human capital to enhance their performance. Some services managers used such investments to upgrade their skills to professional standards and so liberated themselves and their workforce from manual workers to professionals.

4.6.4 Access

Access is referred to as the researcher's main problem (Easterby-Smith et al., 2002; Gummesson, 1991; Phillips and Pugh, 2002). This problem is magnified in management and business studies, where managers are unwilling to be interviewed (Mintzberg, 1973). This may be because research is deemed a disturbance that disrupts business routines and has no immediate pay off for the managers or institutions involved (Flick, 2002:56). Besides busy managers count the cost of their time and decline to give interviews that may become prolonged and interfere with paid business schedules (Easterby-Smith et al.,

2002). Hence some managers may have genuine reasons to avoid being interviewed. Thus, access becomes an exercise in securing their willingness to be involved. Many well-conceived studies are aborted for lack of access to organisations and to people with relevant information (Easterby-Smith et al., 2002:72; Faulkner, 1995). Indeed restricted access to research environment in management research leads to superficial knowledge that is misleading at best or worthless (Gummesson, 1991).

Many managers feel threatened by disclosing information. They fear that such information might be of use to competitors, or used out of context to threaten their jobs or position. Without an open working relationship based on trust, experience or knowledge of issues involved in organisations, researchers fail to gain insight into organisational dynamics. Thus access involves the credibility of researchers, gaining the trust and cooperation of informants with useful information, their transparency and the willingness of managers to give up their paid or free time for lengthy interviews.

However, after decades of my working in and managing hospitals, access was obtained to many NHS health centres. The mental access of understanding what is going on in NHS trusts was also accessible to me. But my knowledge and experience should neither block innovative thinking nor prevent collected data speaking to be heard (Glaser and Strauss, 1967). My naivety in research terms is hopefully balanced by my knowledge and familiarity with NHS trusts and the ability to confirm issues with others within trusts. The problems of politics and power in organisations are inherent in organizational research. Acknowledging and dealing with these issues without the loss or distortion of data is the essence of social or management studies. Avoidable problems of bias were identified and avoided.

4.6.5 Bias in management studies

I am aware of the problems of bias arising from researching an organisation in which one also works. Indeed Dalton (1959), investigated an organisation in which he also worked, while Faulkner, (1995:ix) investigated organisations that were also his clients.

Forms of bias identified are:

1. Observer bias due to prolonged association with the organisations.
2. Participant bias due to participating in a different area of the organisations, that is being researched—the problems of "going native" in an NHS context
3. Semantic bias as different respondents may use words differently.
4. Power and political bias inherent in researching support services sections of large complex NHS organisations

5. Behavioural bias in interpreting non-verbal behaviour (body language).
6. Bias in interpretation during interviews and also in transcription.
7. The interpretation of silences during interviews and on transcription tapes.
8. Cultural and professional bias between researcher and respondents.
9. My personal beliefs and values may intrude into the research process.
10. Personal experience of NHS trusts may influence interpretation of data.

However, it should be noted that my work is in the medical and clinical areas of NHS trusts, which are entirely different from the areas of study. This study is on managerial, purchasing and support services areas. However there were occasions of participant observation when worked and shadowed frontline nurses in their daily routines and helped out hotel services workers in order to gain first hand knowledge of what their work entails.

4.6.6 Validity

This thesis makes no claim to universal validity. However the thesis presents a plausible account of the outsourcing process in the NHS context and their structural outcomes through multiple access to the perceptions and experiences of those directly involved to aid understanding for academics, procurement and support services (FM) managers and NHS stakeholders. Validity in qualitative research is mired in the problems of researchers "accurately interpreting respondents' perceptions and presenting them" (Flick, 2002:222). However, Hammersley (1992:50-52) asserts that firstly, the validity of knowledge cannot be assessed with certainty but assumptions can only be judged by their plausibility and credibility. Secondly, that phenomena exists independent of our claims concerning them hence our assumptions can only approximate to them. Thirdly, that research should aim at presenting reality not reproducing it.

The use of structuration theory in analysing data in this study also precludes justification. Discussions are based on participant's viewpoints and perceptions with those of others to generate the essence of reality in these business relationships. These coupled with my prolonged engagement in the trusts and persistent observation throughout the period of five years should validate this study. Awareness and avoidance of avoidable research bias identified above will also aid validity.

4.6.7 Reliability

Reliability involves showing that the operations of the study such as data collection and analysis can be repeated and the same results obtained (Stake, 1998; Yin, 1994).

Working alone in the chosen hospitals, which are typical of NHS trusts, I have retained the same Interview Protocol (Appendix 1), while allowing for in-depth interview variations between interviewees. These should increase the reliability of response to the same questions. Furthermore the data analysis has been done with due regard to transparency but within the limitations of the study.

4.6.8 Limitations of this Research

It was not possible to catalogue and record all exchanges made by the managers and others interviewed due to time pressures and the unwillingness of some informants to be interviewed on tape or beyond certain limits. Hence it will not be prudent to extrapolate direct research results to hospitals in different economic, geographical or cultural locations. Besides respondents were not chosen at random hence some caution in generalising interview data to other organisations is called for. Also structuration theory posits that knowledge of practices in most organisations is never completely shared by groups, organisations or collectivities. Thus, any information gathered from respondents at each NHS trust support services, their stakeholders and workforce, must only be recognised as containing and attributed to the individuals who create or recreate these structural patterns out of their own lived experiences though they are also members of the larger society. The research is further limited to understanding the vital processes and driving forces for hotel services outsourcing relationships within the support services of the eight NHS trusts. Although outsourcing outcomes have a knock-on effect on the other clinical and non-clinical departments of some of the hospitals investigated it is hoped that this research will contribute to a deeper understanding of hotel services outsourcing and elicit possible benefits as structural outcomes from these complex dynamic exchange relationships.

4.6.9 Ethical Issues

The confidentiality and anonymity of participants is maintained. All the names of people, places, hospitals and organisations in this study are fictitious. Any relationship or similarity to known places or organisations is purely coincidental and non-attributable to anyone. The choice of neutral venues for interviews in some cases did enhance privacy. I am aware of the possibilities of participants either deliberately or unintentionally providing misleading information. These are parts and parcel of social interaction as researchers and participants exchange views to discover meanings and build a holistic picture of emerging experiences, perceptions and choices in all their complexity and contradictions.

But the use of triangulation and my long immersion in the research context have hopefully limited such misleading information.

4.6.10 Triangulation

Triangulation here refers to the use of multiple but independent sources in the study of the same object. The term was borrowed from navigation and surveying where a minimum of three reference points are taken to check an object's location (Easterby-Smith et al., 2002:146). It can also refer to using multiple methods to study the same subject (Denzin, 1989:236). Indeed scholars regard triangulation as an essential part of methodology. Four types of triangulation are described here (Easterby-Smith et al., 2002:146)

a. Data triangulation covering time, space and people involved in the study by using multiple data sources from multiple informants in the same organisation or data collected over different time frames
b. Investigator triangulation, using multiple observers for the same object to collect data which is then compared thus providing different perspectives of the same situation in order to compare, develop and refine studies
c. Theoretical triangulation involves borrowing models from one discipline and using them to explain situations in another discipline. This can reveal insights previously ignored from data.
d. Methodological triangulation involves using both qualitative and quantitative methods of data collection or interviews and questionnaires.

However triangulation should not be an end in itself but premised to balance out individual weaknesses with the strength of others and so maximize the totality of data collected. Consequently, both data and theoretical triangulation were used in this thesis to clarify agents' perceptions in each NHS trust and multiple theories applied in the discussion.

The uses of triangulation

Although the standard use of triangulation is in using different methods to provide different perspectives on what is being studied, that was not the case in this study. For example Hofstede (1991) used a combination of quantitative data processed through qualitative narrative in his classic study of national cultures. Others have used qualitative narrative in attempting to quantify the economic impact of outsourcing. They also used both interviews and questionnaires and gathered quantitative data for their study (Jiang et al., 2006). Thus

these researchers have used methodological triangulation to validate the accuracy of their findings. However in this thesis data triangulation was used.

4.6.11 The use of data triangulation in this thesis

Gathering qualitative data involves actively listening to respondents at interviews, trying to decipher their voice modulation, body language and facial expression and later reading interview transcripts to understand respondents' perceptions as they create their realities and make sense of their lived experiences through narratives. This active listening and the perception of respondents are intangible attributes. Consequently, as Stengel et al., (2003) suggested, the issues involved in such narratives should be looked at from a number of different angles. Hence the same interview questions should be asked in different ways to different people in the same organisation. By so doing the most pressing issues to those interviewed and their relatedness can be identified. Thus by asking different people the same questions in different ways, lapses in organisational memory can be jogged to enable researchers obtain more accurate and holistic information from respondents.

However, my over-arching reason for using data triangulation in this study was to determine the accuracy and authenticity of the evidence gathered. Therefore different members of staff in the same hospital were questioned to check the accuracy of information gathered through interviews and to explore and confirm my own observations in order to eliminate needless observer bias from the findings. Data triangulation also enabled me to understand diverse, multiple realities of those directly involved in support services. Consequently by comparing and contrasting different conversations and varied perspectives of respondents and stakeholders as they tried to make sense of their daily working lives in support services, I was able to seek the underlying meaning of their narratives in order to focus on the main issues or over-arching structures.

To accomplish this, I worked as a part-time agency or bank nurse on night duty at most of the hospitals investigated to enable me observe things for myself and also to dialogue with nurses. In the hospital environment, nurses are the linchpins between the medical and non-medical support staff, of which hotel service is a part. Nurses are at the fulcrum of activity and at the centre of the interaction between patients and other hospital personnel. However agency nurses are always out in the cold, never accepted as members of the team no matter their length of service. This accorded me the emotional detachment and distance needed to maintain my objectivity as a researcher.

Therefore by working as a nurse on numerous occasions over the entire period of this thesis, I was privileged to observe, first hand, how support services workers function in both the outsourced and the in-house operations. During the night shift, it was possible to have quiet conversations with nurses and support services workers be they cleaners or caterers. Issues raised by respondents at interviews were constantly clarified with nurses and cleaners, unaware of my research interest, so had no reason to give me misleading information. Thus through data triangulation and reflection in my journal, I gained a deeper understanding of the working lives of some of the support services workers and was able to appreciate their perspectives and iron out discrepancies and personal bias. For example, at Theresa hospital, where only two people were willing to be interviewed due to the management ban on workers talking to outsiders or giving interviews to reporters, I resorted to getting a job there to enable me talk to other stakeholders. In the process of my working the night shift as a nurse, I encountered and talked with two other managers, (agents C and D) herein called Joanna and Sue. Their valuable contribution enriched the narrative from the two respondents interviewed and enabled me gain a richer perspective of issues like the motives and benefits of services outsourcing at this hospital.

Similarly at Victoria and County hospitals NHS trust, I also worked as a night nurse in order to make first hand observations there. Although three people were interviewed at this hospital, some people who would have contributed to the narrative, declined interviews. Consequently, I talked with nurses, porters, cleaners and caterers, again unaware of my research interest, while working the night shift. Agents P and Q (on the respondents profile) made more meaningful contributions by sharing their experiences as cleaners with me. Their narratives are included as excerpts in the data analysis. Thus my conversation with porters, cleaners, caterers and security men at work and observation gave me a more holistic perspective to augment the interview data and enrich my analysis of this hospital.

Furthermore, I had previously worked at Helina, Karena and Reinhard hospitals as a night nurse during the pilot and preliminary studies and formed relationships with some workers. Subsequently it was not difficult to return and talk to these workers to clarify issues raised at interviews or to observe support services workers at work. Indeed I trained as a nurse at Dickson Memorial hospital before attending medical school at Charlston memorial hospital. Consequently, I was conversant with the layout of both hospitals and remember too well the set up of the kitchens and dining areas. I was most surprised that they have remained the same dull and dingy places I remember despite attempts at refurbishment. Thus, my

knowledge of the different hospitals and work opportunities gave me unlimited access to the people working there either to clarify issues raised at interviews or to observe workers.

The use of data triangulation in this thesis may seem to differ cross-case due to the need to clarify, confirm or verify issues. Because different NHS trusts investigated have different history, operate in different locales and are somewhat unique in their modes of operation, the use of data triangulation was also different or cross-case. Thus data triangulation was used in this thesis as needed to understand the multiple realities of different respondents from different perspectives and so gain a more holistic view of the emergent structures.

4.7 Research Method proper

My interest in NHS hotel services outsourcing started during my MBA project. I noticed that catering, laundry, portering and cleaning services (called hotel or support services) were being outsourced in several NHS trusts. I wondered why and reflected on the benefits thereof. When the decision to engage in doctoral research was made, I was glad to try and find out why and how outsourcing benefited these trusts that engaged in it. Thus a preliminary study was carried out in three NHS trusts in the London area.

4.7.1 Preliminary study

This was firstly to ascertain the do-ability of such research, secondly to gain access to the people involved (the procurement managers and their services provider managers), thirdly to determine the suitability of such a study for a PhD and finally to generate a suitable research proposal. Three London trusts were selected on the strength of previous visits during my MBA project. Three procurement managers of these trusts and their services provider managers were interviewed using a semi-structured interview format to unearth the motives and benefits if any, of their trusts outsourcing hotel services. The study was focused on the NHS networks of suppliers from a services marketing perspective. The results were revealing.

The results of this preliminary study revealed that the research was doable and would be suitable for a PhD. A suitable research proposal was generated but most importantly, that the motive for hotel services outsourcing was mostly due to resource scarcity and not services marketing per se. These motives ranged from lack of space for laundry facilities through lack of managerial experience, knowledge and skills to inability to recruit and retain ancillary (support services) workers. This resource scarcity seemed to hinder and

distract these trusts from competing favourably with other trusts either for Government allocation of funds or in the effective, smooth running of their organisations. Some of these trusts' procurement managers also reported the benefits of outsourcing as value for money and a chance to refocus on medical services on which their reputation and expertise lay. Outsourcing helped some avoid the ugly scenes of ancillary staff demonstrations for more pay since by outsourcing, the ancillary staff were sold to the contractors who then became responsible for their pay, benefits and contributions. Thus this preliminary study helped to redefine my area of interest and research focus and also enabled me to build relationships with services managers and their provider managers for future use.

Further literature search in areas of services outsourcing (Cross, 1995; Huber, 1993) alliance formations (Faulkner, 1995) resources for competitive advantage (Penrose, 1959, 1996; Pfeffer and Salancik, 1978; Prahalad and Hamel, 1990) services business relationship management (Ford, 2002, 2003) and services marketing in the NHS (Laing et al., 2002) revealed gaps between what obtained in the commercial business sector and the experiences of some managers. For example the NHS is a public sector organisation providing a social service in healthcare. Consequently, trusts are not profit oriented and cannot compete with commercial organisations yet can outsource hotel services to these commercial operators and report benefits, cost savings and more reliable services. Thus the stage was set for a pilot study.

4.7.2 Pilot study

This paradox of the health service in partnership with the commercial sector, helped deepen my interest to find out the real motives and benefits of hotel services outsourcing. Subsequently, a pilot study was carried out. The aim of this study was to explore in greater depth, the motives and benefits of hotel services outsourcing in three trusts in the London area and to better understand the management of the dyadic business relationship between the procurement managers and their services providers managers that enable them benefit from hotel services outsourcing. To further buttress the reports of the managers involved, the interviews were extended to stakeholders and support services workforce. Again a semi-structured interview format was used in order to enable the managers, stakeholders and workforce tell their stories from their lived experiences and not just tick sections of a questionnaire without explanations, motives or reasons.

The results of this pilot study confirmed those of the preliminary study. The motives for outsourcing were mainly due to scarcity of resources in personnel experience, skills and knowledge, finance for improvement of support services like kitchens, canteens and cafés and the nurturing of new ventures as reported in some trusts. New venture like the *Diners' Den* at Victoria hospital, was later taken out as commercial a business for the services provider. Thus the pilot study revealed economic benefits for the trusts involved, nurturing of new ventures, infusion of funds by services providers into the refurbishing of kitchen, cafés and canteens and improving cleaning and portering to aid the smooth running of some trusts and patients' journey through them. Outsourcing was also seen to extend to medical supplies, payroll and theatre equipment due to the benefits generated from hotel services. This pilot study also established the uniqueness of each trust investigated and the accomplishment of my transfer from MPhil to PhD.

The pilot study helped me redefine areas for the main study and the subsequent research design. Again further literature search revealed the need to focus on both the motives for outsourcing and the outcomes both intended and unintended. Thus the main research question became the consequences of hotel (support) services outsourcing in selected NHS trusts in the Greater London area. This was changed to the present one following my mock viva to reflect the dominant perceptions of those directly involved in the study.

Twelve NHS trusts were initially chosen for the main study. These were, Dickson memorial hospital, Charlston memorial hospital, both of which engaged in limited outsourcing (10%). Others were Featherstone, Karena, Victoria, Reinhard, Theresa and Helina hospitals. The rest were Blummer, Chapter and Davison hospitals and Freedman mental hospital. These last four hospitals were not included in the final study due to their location, outside the Greater London area, the long distance involved in getting to them for interviews, the lack of willingness of the managers to be further involved in the research process and mainly because the same services provider, Assured, was also the provider in each of the four hospitals. Hence it was felt that including them in the study would not add more in the final analysis but then I could be wrong and should have included them for variety sake. Finally, eight hospitals were chosen on the strength of their location, unlimited access, the variety of hospitals involved and the willingness of the managers, stakeholders and hotel services workforce to engage in a prolonged research endeavour.

4.7.3 Research method used

A total of twenty-six managers and directors of eight NHS trust hospitals (some hospitals like Theresa and Featherstone are based on more than one site as shown below) and their hotel services providers, together with members of the workforce and other stakeholders were interviewed using a semi-structured interview format in a case study inquiry. This enabled the agents tell their stories and generate insight into how these trusts' managers have managed their complex relationships with outsourced services providers in the face of constant cost pressures and the structural consequences of their interaction.

Interviews were chosen over questionnaires to enable me explore, clarify and elicit the perceptions of agents and the multiple meaning of their experiences (Silverman, 2000:35). Interview data provides access to attitudes, perceptions and beliefs, which reveal multiple meaning in such complex phenomena as inter-firm contractual exchange relationships. The explanatory nature of the study and complexity of the social phenomena, called for the flexibility offered by unstructured and later semi-structured interviews that allow the "views of agents to be known" (Easterby-Smith et al., 2002:86). Moreover, health service workers and especially busy managers dislike questionnaires. Questionnaires fail to capture non-verbal communication and personal contact, which may be present in facial expressions and inflection of the voice that help researchers gain valuable clues to meaning (Easterby-Smith et al., 2002:86). Observers suggest that managers comply with what they think some researchers should know about their organisations when completing questionnaires and may avoid extreme responses in either direction creating a discrepancy between the data sought and that obtained from questionnaires (Cresswell, 2003; Eastherby-Smith et al., 2002:41; Gummesson, 1991; Punch, 2002). This may be because managers are unsure of what use the questionnaires will be put to and the possibility of their competitors making use of the information contained. But face-to-face interviews can overcome these problems through trust building and sensitivity towards, what agents deem confidential. Furthermore case study uses a narrative medium crucial to understanding complex organisational behaviour and attitude in natural settings (Van Maanen, 1988) while multiple case studies "provide multiple views of the evidence sought" (Yin, 1989:23). Other observers agree that case study inquiry in management studies can provide varied and comprehensive views of the project (Cresswell, 2003; Easterby-Smith et al., 2002). Furthermore case study may aid in practical applications managers can identify with and probably modify to apply in their situations (Gummesson, 1991; Stake, 1998; Yin, 1994).

In total twenty-six interviews, out of the thirty-one conducted from May 2005 to April 2006, were recorded. The managers interviewed are responsible for hotel services in their respective NHS trusts. Hotel services comprises of catering, cleaning, portering, laundry and in some cases, housekeeping. These seemingly non-critical functions outsourced to contractors by some trusts form part of the total facilities management remit of support services. The perceptions and experiences of these hands-on agents are vital in eliciting what they perceive as the reasons and consequences of outsourcing hotel services under their care.

Some interviews were held at neutral venues within the hospitals to increase confidentiality and ease of agents' disclosures. Overt and covert observations were made (as I already work in the hospitals) to confirm issues raised at interviews or to improve later discussions. The same interview questions were put to each person interviewed but they were allowed to tell their story as they saw fit. This method helped to unearth some information that respondents would not have volunteered and also aided consistency in agents' responses. Some agents were asked follow-up questions to clarify issues while stakeholders and members of the workforce were later questioned formally and informally to collaborate and triangulate most of the stories until June 2007. Consent was sought through internal means, where necessary and sensitivity towards personal or confidential issues was maintained. All data collected are treated as confidential and non-attributable.

Eight NHS trusts were chosen as my sample on the strength of an earlier pilot study, to refine interview questions as well as gain access to people with useful information for the study. These trusts were chosen on the strength of unlimited access, location in the Greater London area, the participants' willingness to be involved in the study and to be interviewed as the need arose and the variety of hospitals (from teaching to general) to provide sustainable intrinsic interest for me as researcher and their level of outsourcing from 10% to 100% as indicated in (table 4.1a and 4.1b) below. Those interviewed in each outsourced category are listed in (Appendix 2). The potential for learning from their differences, similarity and uniqueness increased my interest with a view to generalising modified forms of the results to similar hospitals (Cresswell, 2003; Stake, 1998).

Most managers were willing to be interviewed. But in places like Charlston memorial hospital with six catering managers, one of them was interviewed at her convenience during shift work and in other places some managers volunteered more useful information

than others. However, some managers were reluctant to discuss some "sensitive issues" despite several attempts and different ways of asking the same questions, while others fearing for their jobs, sanctions or just being uninformed about their contexts chose not to contribute (Dyne et al., 2003; Milliken et al., 2003). Perhaps these are the ones sworn to secrecy by management using "gagging clauses" to ensure that they don't give interviews critical of the NHS to anyone (Craft, 1994; Jones, 2000a; Sheard, 1994). Indeed this was confirmed at Theresa hospital, where the managers were vocal but stressed that they had been reprimanded by management for giving interviews of any kind. Consequently, some interviews are shorter than others where agents were willing to talk but felt constrained. However, a point of data saturation was reached when agents' responses were repeated on several occasions in different hospital contexts.

Interviews lasted from sixty to ninety minutes, were taped, transcribed (available for scrutiny on demand), analysed and coded according to the main issues of concern to the managers interviewed (Flick, 2002) and displayed for comparative analysis and discussion (Miles and Huberman, 1994). Relevant documents and Annual Reports of each hospital and those of the services providers were collected and information contained noted.

The underpinning assumption is that different views are found in different social worlds (context) hence their uniqueness. This method of coding for comparison makes for a deeper understanding, flags up negative cases and helps one explain contextual issues. However the coding procedure remains sensitive and open to specific case contexts by preserving their uniqueness while allowing group comparison. Hence the focus is on the analysis of both uniqueness and variety in the distribution (Flick, 2002:189), while the display allows for inferences to be drawn on emergent themes or patterns (Miles and Huberman, 1994). But the procedure is limited by being time consuming.

4.7.4.1 Self critical awareness in conducting qualitative interviews

Qualitative research is said to be specific to the study of social relations, which are replete with inequalities in knowledge, experience, skills and balance of power (Flick, 2002). There are myriads of differences between researchers and interviewees in their beliefs, values, understanding, cultural background and outlook. Furthermore, because these studies involve the subjective meaning that respondents attach to their lived experience and daily job routines and practices the researcher lacks familiarity and knowledge of the field and

subject under study. Consequently, researchers are always negotiating and managing the interview interface with sensitivity and skill to gain insight into the subject of study.

Unlike in quantitative studies where researchers are armed with research questions and hypotheses from theoretical models and go into the field of study to test such hypotheses against empirical evidence, the qualitative researcher is dependent on the information gathered from the field through interviews, narratives, personal observations and reflection on the data and evidence gathered. Thus patience, understanding and perseverance are virtues that can enable researchers, in pursuit of information, to gain insight from interview narratives while mindful of the difficulties and problems of conducting them.

Why I kept a reflection journal

To help me deal with my initial inexperience and lack of much needed skill and sensitivity in conducting face-to-face interviews and gathering data through observation and dialogue with stakeholders, I kept a reflection journal. Even after I thought that I had gained some knowledge, skill and experience in these areas, I continued to reflect in my journal to help me catalogue and analyse difficult or contradictory situations and dialogue I encountered during this study. Through these reflections I was able to unravel some of the underlying meaning between and within data gathered and come to what I perceive to be a plausible meaning of the issues and situations in their varied context. For example I have included in Appendix 1b, a full interview transcript conducted in March 2004 during the early part of this study. I chose to include this particular transcript because it was the most difficult and yet least informative of all the interviews I conducted but it was also the most productive because I learnt a lot from it to help me make future interviews more informative.

In the said interview transcript I used the analogy of pulling out teeth to reflect on my inability to gain the information sought. I was inexperienced at the time and so was the interviewee. It was a case of two inexperienced people trying to accomplish a highly skilled and sensitive feat of managing and conducting a qualitative interview. So how does the dental analogy of tooth extraction fit in with this interview as I reflected on it?

1 Did the tooth need to be extracted?

In other words did I need to gain the information sought from the interviewee? The answer was yes

2. Did I anaesthetise the area adequately to lessen the pain and make the extraction pain free? The answer was no. This was mainly due to lack of the right equipment in the form of skills, sensitivity and experience in conducting such interviews.
To adequately anaesthetise the area is analogous to first building rapport with the interviewee, which would have put him at ease, enabled him to trust me more and would have given him the confidence to be more open and to readily cooperate with me by telling me his story. Instead what transpired was a dry and bland interview with an apprehensive respondent that became laborious for both of us and in the end elicited only superficial data.

However, a tooth (information) was extracted and the experience enabled me to reflect on what went wrong in order to improve on the skills needed for future qualitative interviews. For example after my reflection on this interview, I decided to give future interviewees, where possible, an outline of the questions to be asked, to give them an idea of what to expect. I also learnt to listen beyond what was being said or what interviewees tended to couch in verbosity. Consequently future interviews were more in-depth and revealed more of the meaning behind the issues and situations discussed when applied to their context. For example by November 2004, I conducted other interviews at Charlston memorial hospital NHS trust with the previous encounter still ringing in my ears. An extract of this second interview went thus:

> MJ: some people say they outsource services to reduce cost and wastage. How do you manage to contain both cost and wastage doing things in-house?
> Florence: it all depends on how you manage it. If you have a very good in-house manager, wastage in catering should not be a problem. Basically you bear all the risk. You are not passing it on to outside contractors. With contractors there could be a lot of problems like quality of service and control of the level of service. Every time you want to make a change, it will cost you a lot of money with outside contractors whereas we could be more flexible with in-house services.

In my reflection journal I analysed the answer to the question of wastage and cost containment in this in-house concern as follows:

1. Having very good in-house catering managers will reduce wastage
2. The fact that you bear all the risk whether services are outsourced or in-house
3. Outside contractors could pose a problem with their fixed prices

4. There is more flexibility in making changes with fellow in-house managers than with contractors. Such changes can result in cost savings when made between in-house managers than with contractors.

Explaining my reflection in context of this hospital

Charlston memorial hospital NHS trust has six catering managers poached from the commercial sector. Florence herself, who was the director of operations at the time, has over twenty years experience in support services both within the NHS and the commercial sector. Furthermore, one of the catering managers interviewed claimed to know how contractors cut corners to reduce their costs and so make profits. Consequently when Florence talked about having very good catering managers, who are able to reduce wastage, I was sensitive to her underlying meaning and understood what she meant. Good catering managers meant experienced managers who would know how to cut out wastage, if not for profit, to become more efficient in resource use and so reduce costs.

Secondly the fact that the support services managers still bear all the risk whether services are outsourced or in-house makes outsourcing redundant. To this in-house concern with previous experience of a contractor that went into liquidation, forcing them to rebuild their transport services, there seemed no point in outsourcing services. If they outsource, they still bear all the risk and are forced to deal with possible problems with contractors and manage the resultant relationship they find inflexible and costly in time, energy and money. Consequently, support services have remained in-house, allowing managers to make needed changes while shifting their budgets around to contain costs or save money. The services managers have also become risk averse in order to preserve in-house jobs, maintain control over services and reduce any interference from contractors, all of which manifest as their fear of services outsourcing. Thus the sensitivity and skills that were lacking during my interview with Roland are less evident during later interviews. My skills were augmented and sensitivity to insights on issues discussed heightened by journaling to understand the underlying meaning of respondents' narratives.

Value of reflection journal

By reflecting in this journal I was able to critically analyse the words respondents used within the context of their operations, my own observations and experience of the NHS trust concerned and my dialogue with other stakeholders on the same issues. This critical analysis enabled me to compare and contrast the catalogue of issues, thoughts, ideas,

feelings, impressions, hunches, contradictions and my own prejudices in order to clarify them and find the underlying meaning hidden in respondents narratives and conversations as they endeavoured to create their own realities and make sense of the situations around them. There is always a potential problem of misinterpreting what respondents mean or say at interviews due to the differences in language, culture, values and beliefs but far from the interview sites, issues can be dissected in the reflection journal to elicit problems or indeed find solutions to problems that arose during interviews. Thus by journaling in my reflection book, as part of the research process, I became more critically aware of the emotional problems faced by both researchers and respondents during interviews and the difficulties encountered by researchers who conduct qualitative interviews in social studies.

This self-awareness helped to heighten my sensitivity to non-verbal communication be they voice modulations, facial expression or silence during interviews. Consequently, the work done in the journal enabled me to handle future interviews with more confidence and sensitivity and hence probe deeper into issues under discussion. For example at another interview, this time with the domestic manager, Linda, at the same hospital, the dialogue went thus:

MJ: Can you tell me what you do here and why you choose to do it in-house?

Linda: In this department we employ all the cleaners that clean the whole hospital. As an in-house concern, I have mixed views about whether it is a good or a bad thing having worked for a contractor before I came here. I think being an in-house concern has benefits to the service and to the trust but not necessarily to the staff. But a hospital served by contractors has more benefits than one cleaned in-house. In my experience, having been on both sides, when domestic staff and I worked for contractors, they (staff) were more flexible and more manageable. Most of the staff did expect to do what was a reasonable day's work whereas here I have staff, who tell me that they have been here for thirty years and they don't work on the wards because they don't like sick people. I mean this is a hospital!!

Background to the analysis in my journal

This hospital was under pressure to reduce costs and wastage. As a teaching research hospital, with all the government allowances it collected, it should have been preparing for foundation status. Instead the hospital seemed to be under-performing having gained only two stars instead of three. Most of the managers were under pressure and felt it. The staff were said to be "dead wood pillars" of the establishment whom no one could shift because

the Human Resources managers (HR), as custodians of the workers, shielded them from discipline. Consequently, they worked to rule, avoided work as they pleased and voted with their feet through constant absenteeism or sick leave. Thus the domestic manager felt pressure from her superiors and from her own staff whom she found difficult to manage.

Furthermore her experience with contract work was being stifled. In a contract job where contractors must perform to earn their fees, anyone will do what is needed to get the job done. That was her idea of flexible and manageable staff. For example, if a ward has an emergency where a sink or toilet was overflowing with water, any cleaner available will get there quickly to get it cleaned up to prevent business failure or ward closure. But in the in-house services, the domestic staff may not be available to do the cleaning. Even those available will first ascertain whose duty it is to clean that area and why the nurses cannot deal with it. The in-house staff members have no incentive to do more. They have tenure and see no reason to do more than their basic duty. Consequently, this commercially experienced domestic manager finds her in-house staff inflexible and difficult to manage. But for personal reasons, she prefers to work in the NHS for now and so must endure the inflexible and difficult to manage staff and the pressure transferred from her superiors.

The main issue again is flexibility in services, this time with domestic staff but the reasons are different due to the context in which the word is used and by whom. Thus journaling enabled me to jot down all the relevant facts around the words respondents used and play around with them to find their underlying meaning in their entire context and usage. I hope journaling will enable me to conduct future interviews with more confidence and skill as a researcher!

4.7.4 **Interview transcripts** (A full interview transcript is attached - Appendix 1b)

Selection of sections from interview transcripts was based on their recurrence during interviews and their perceived importance to the agents interviewed due to either the emphasis laid on them or the ways they discussed other issues around them. Hence the presented excerpts represent the perceptions of interviewees, borne out of their jobs or lived experiences in the different context of operation or locales. Obviously there is a lot of overlap between examples in different categories of outsourcing and structures but in the main all respondents' answers remain relevant (chapter five). From outsourcing outcomes evolved structures that are grouped as structural categories and discussed in chapter five.

This study fits in with previous research on the NHS "internal market" operations where qualitative methods were used (Klein, 2001; Zolkiewski, 1999). Healthcare trusts and support services managers will now have a comprehensive research evidence to better manage their scarce resources through cooperative arrangements and look inwards to find and utilise their respective valuable resources for enduring comparative advantage.

The profile of NHS trusts investigated is depicted below in (figures 4.1a, 4.1b).

4.7.5 Data analysis method

It may have been possible to use one of the current software in the market for my data analysis as tools to facilitate and aid the management of large volumes of data generated. There is a non-numerical unstructured data indexing, searching and theorizing software (NUDIST) and its in-vivo counterpart, Nvivo (Fisher, 1997; Gibbs 2002). However, some researchers who have used them admit that they can be technically demanding and intellectually arduous especially if one comes to use them after data collection to help keep afloat from drowning in mountains of data (Fisher, 1997; Gibbs 2002). These researchers also comment that some universities and computing facilities do not generally support the use of these software. Consequently, researchers are not exposed to them, cannot test-drive the different types to assess their suitability before or after data collection. Hence some software may be incompatible with generated data files or incomprehensible when original codes are re-entered between software. However, computer assisted qualitative data analysis software are said to be easier, more accurate, reliable and transparent in managing, coding and retrieving bulk of data than manual cutting and pasting chunks of text (Cassell and Symon, 1994; Fisher, 1997; Gibbs 2002). They also have perfect memory to facilitate data storage and retrieval.

Discourse analysis was also considered. This focuses on language as used by respondents in the social context of their daily work. Others have used it to analyse organisational processes and outcomes in attempts to understand the meaning of workers' experiences at work (Cassell and Symon, 1994). Although language is a medium with which we express ideas and understand the world, discourse analysis, is mainly used to classify and categorize individuals and groups. For example, it is used in psychology to classify personality traits into extroverts and introverts. Also it can be used to examine individual differences to see how and why variations occur and what purposes they serve as in job satisfaction or insecurity over time (Cassell and Symon, 1994).

Consequently, it was not deemed entirely appropriate to my analysis of the perceptions of individuals involved in the complex and dynamic consequences of support services outsourcing in eight unique NHS trusts with all the attendant political imperatives involved. Content analysis was ruled out for similar reasons although Riley (1983) used it successfully in combination with structuration theory to analyse organisational culture using political symbols and language that embody political intent.

However using software can reduce creativity and sensitivity bordering on loss of control with collected data or inability to understand and interpret respondents' perception and experience beyond data because software cannot understand the meaning of texts like humans (Cassell and Symon, 1994; Fisher, 1997; Gibbs 2002). Consequently, it was decided not to attempt to use either of the available software in my data analysis.

My choice of data analysis method was somewhat limited by the decision to use a case study inquiry method since all the trusts studied were unique in their outsourcing needs, motives, history, clientele and location. The flexibility offered by structuration theory enabled me to accord stakeholders, hotel services managers and their workforce the status of knowledgeable agents, able to mobilise resources needed for action to shape the internal environment of their departments or liberate themselves and their workers from manual work to professionals. The aim of this study is to understand and explain the particular, unique features of hotel services outsourcing relationships and their outcomes and use their unique differences to fashion commonalities applicable on a wider basis. For example, where the motive for services outsourcing was to access resources like managerial experience or ancillary workforce they lacked and resulted in a favourable outcome, other NHS trusts can use the information presented here to craft their own outsourcing need and expect similar outcomes.
Consequently, to unravel the uniqueness of the trusts' outsourcing relationships, it was necessary to explore unfolding processes against their contextual backgrounds and allow the agents or participants to introduce terms and concepts unique to their situation.

Through a dialectic process, important themes emerged from key issues that were important to the respondents. These were collected into patterns of relationships. These are then discussed in the light of extant theories and relevant studies in order to explain their particular meanings, problems, situations or contradictions and in some cases find common themes like innovation, organisational change or efficiency (value for money).

Thus my understanding of the conditions for action in unique NHS trusts' contexts can enable others specify conditions under which such actions can be expected to recur. Others have used similar data analysis methods to unravel mountains of data and elicit participants' meaning by allowing data speak and letting simple themes evolve from key issues (Eisenhardt, 1989; Lawrence et al., 1997; Nordin, 2006).

Table 4.1 (a) Profile of NHS trust's (Hotel services) investigated

Hospitals	Helina Hospital (HH) NHS trust	Theresa Hospital (TH) NHS trust [8 locations]	Karena Hospital (KH) NHS trust [2 locations]	Victoria Hospital (VH) NHS trust [2 locations]
% Outsourced	100	100	75	75
Speciality	General and Blood disorders	Specialist Teaching Transplant Reputation	Specialist Teaching Renal Reputation	General and Blood disorders
Total beds	500	820	550	800
Total staff	2000	6000	3500	4500
Ancillary staff	200	400	500	440
% Ancillary to total staff	10	6.6	14.3	9.7
Meals served per day	800	1900-2000	1200-1500	1500-2000
Star-rating	2,2, 2	3,3, 3	3,3, 3	2,2, 2
PFI	Yes [Access to capital]	Yes [Access to capital]	Yes [Access to capital]	Yes [Access to capital]
Foundation status	Not yet qualified	Yes and operational	Applied for	Not yet qualified
Hotel Service provider	Assured (Premier Group)	Kingsland	Mediserve International	Areno

Key to profile of hospitals investigated (Table 4.1a and 4.1b)

-Speciality: represents areas of interest or global renown

- % outsourcing: shows the level of hotel services outsourced

- Total beds: is the hospital capacity

- Ancillary staff is the total number of hotel services staff employed

- % Ancillary to total staff: is the percentage of hotel services staff to total staff (in most cases also represents the level of investment into hotel services)

-Star-rating (1-3): represents level of government allocation secondary to performance

-PFI: represents Private Finance Initiative or private sector capital project investment

Table 4.1 (b) Profile of NHS trust's (Hotel services) investigated

Hospitals	Featherstone Hospital (FH) NHS trust [4 locations]	Reinhard Hospital (RH) NHS trust	Charlston Memorial Hospital (CMH) NHS trust [3 locations]	Dickson Memorial Hospital (DMH) NHS trust [3 locations]
Speciality	Specialist Teaching Research Reputation	Specialist Teaching Orthopaedics Reputation	Specialist Teaching Transplant Reputation	General Blood Disorders and Diabetes
% Outsourcing	50	50	10	10
Total beds	560	245	1100	575
Total staff	6034	906	4727	2068
Ancillary staff	400	170	500	133
% ancillary to total staff	6.6	18.7	10.5	6.4
Meals served per day	800-1200	450-500	2600	800-1000
Star-rating	3,3, 3	3,3, 3	2, 2,0	2,2, 2
PFI	Will not rule out	Yes	Not preferred route to capital	Yes [as access to capital]
Foundation status	Applied for	Not sought	Not yet qualified	Not yet qualified
Hotel Services Provider	Assured (Premier Group)	Assured (Premier Group)	In-house	In-house

Chapter 5 Data Analysis

5.1 Introduction

From the central Government's point of view the reasons for outsourcing hotel services to private commercial contractors were to reduce bureaucratic waste (Williamson, 1996:311) deemed prevalent in the health service, contain the escalating cost of providing healthcare from taxation alone and eliminate labour unrest that has plagued many public sector organisations (Klein, 2001; NHS Plan, 2000; Thornton, 1999). The services providers were motivated by "making money" through "doing business together" (Kay et al., 1994) and as commercial firms, increasing their area of interest with time (Jacoby and Rodriguez, 2007). It was hoped that through collaborative contractual arrangements and interdependence, with commercial service providers, hotel services managers would become commercially oriented to see and operate services as a business. They would save on operating costs, generate revenue, improve their performance effectiveness and become more efficient in their use of human and financial resources (Laing et al., 2002; Levitt et al., 1995).

My own interest for this study was stimulated by the scarcity of studies in support services outsourcing in healthcare in particular and a dearth of literature on outsourcing in general (Cross, 1995; Fill and Visser, 2000; Jennings, 2002; Lacity and Hirscheim, 1999; Nordin, 2006). I wanted to discover the views of those directly involved in the process as to why they thought their in-house services were outsourced to private firms and what benefits, if any accrue to them as a result of outsourcing. The perceptions of those interviewed are quite revealing. Many have used the opportunity accorded by outsourcing to improve their roles and positions and the image of their departments, profession and NHS trusts. Table 5.10 below shows the combined motives for outsourcing and their outcomes.

Furthermore, the results of this study suggest that some NHS trusts (Featherstone and Theresa hospitals) seem to have strongly imbibed the commercial ethos. Through their cooperation with commercial services providers, they have both strengthened and stabilised their financial standing enough to attain Foundation status (Theresa hospital or are poised to do so (Featherstone hospital). Thus the political imperative to outsource support services, the internal need of the NHS trusts to access resources they lacked and the external environment (services providers), have combined to shape hotel services towards perceptions of favourable outcomes.

5.2 Data analysis method

In this study, I did not have optimum control over the interview questions due to the political nature of the NHS trusts and some respondents' wish to steer clear of political issues and stay out of media attention. Consequently most of them were reluctant to discuss certain issues like their budgets, economic impact of outsourcing or private finance of their department except by asking other leading questions in some lateral ways to elicit some of the required response. Thus respondents were allowed to talk freely and in their own colloquial ways and to tell their stories as they saw fit and in the process, many questions were answered and issues inadvertently raised were discussed.

Final choice of analytical method

Basically I have adapted structuration theory 3X3 analytical schema (Giddens 1984) to Miles and Huberman's (1994) data analysis method to come up with a simple method of data reduction and selection of relevant texts based on key issues respondents were concerned with in their respective departments or trusts. This method, to my mind, allows me to incorporate the perceptions of respondents in their particular context with my prolonged observation and knowledge of the areas discussed in an attempt to understand the meaning beyond their expressed views, opinions and language in use. It can be argued that what is presented is my understanding of participants' perceptions, views and opinions. However one of the tenets of qualitative study is to represent constructed meaning from the diversity of respondents' perceptions, ideas or opinions as accurately as possible in order to reflect a holistic view of their particular departments like support services in the wider NHS trusts' overall context and the researcher's observations and reflections (Cassell and Symon, 1994; Creswell, 1998). Thus, I have endeavoured to present relevant verbatim transcripts to enable readers to make their own assessment regarding the fit of key themes as elicited and discussed with the theories in use.

Structuration theory analytical schema

Structuration theory provides a 3X3 analytical schema as shown on figure 5.1 below. Structuration theory is concerned with the conditions that govern the transformation or reproduction of structures. These structures are the rules and resources agents draw upon at interaction. They are also the medium and outcome of interaction. From the schema below the main institutional structuring mechanisms of signification, domination and legitimation are depicted against modality for interaction. All these structures are inter-related and have transformative capacity. Their analytical value lies in eliciting how

these structures come into being from the perceptions of respondents, how they are sustained, the conditions that allow them to continue despite alternatives and how they become reproduced or facilitate change and alter power relations over time.

Figure 5.1 **Analytical elements using the process of structuration**

(adapted from Giddens, 1984:29)

STRUCTURE	**SIGNIFICATION** (semantic rules)	**DOMINATION** (resources)	**LEGITIMATION** (moral rules to evaluate conduct)
MODALITY (mediation of interaction in process of production and reproduction)	**Interpretative scheme** (stocks of knowledge and capabilities)	**Facility**	**Norm** (Accountability)
INTERACTION	Communication	Power	Morality /sanction

Signification

This is language in use, important codes or verbal themes of how respondents as agents perceive their roles or departments as a whole, trappings of power, prestige and status like office locations and the stories they tell about working conditions or the tedium of daily work.

Domination

Structures of domination depict the ability to mobilise, authorize and control resources for administrative or economic decision-making and allocation, as in budgets. Controllers of resources (budgetary allocations, project funding or expertise) can dominate others.

Legitimation

This depicts the interplay between value standards and sectional interest that favour dominant groups. For example legitimate decision to outsource services must embody rights and obligation that favour dominant groups to have a binding force to be actualised. Hence legitimation involves rights and obligations as well as sanctions both overt and covert. Hence deeper structures may not be overt as themes but can be inferred.

5.3 Presentation of this analysis

Since each NHS trust studied had a different motive for outsourcing hotel services based on local needs, first a short history of each NHS trust is presented to provide readers with background to judge respondents' perceptions and opinions based on their transcription excerpts. These are presented and findings discussed. One NHS trust in each category is analysed using structuration theory (Giddens, 1984) analytical framework to elicit resultant themes. These common themes are discussed in the light of extant theories. The motive and outcomes for outsourcing from each outsourced category (10%-100%) is tabulated in (Tables 5.1-5.8 below). A comparative summary of all outsourcing motives is shown in Table 5.10. The research question of how respondents directly involved in hotel services outsourcing structure their experiences is answered. Thus the consequences of support services outsourcing are presented as themes and discussed and compared with regards to my prolonged observation, knowledge and triangulation with stakeholders aiming to iron out discrepancies or lapses in organisational memory. Respondents' profile is tabled (inserted at the end) for easy identification of the speakers of selected excerpts.

5.3.1 **Theresa hospital (TH)** 100% outsourced

This is the nations flagship hospital. Located in the centre of town and of world renown. Presently, it is the only hospital in my study that has attained the foundation status of autonomy and self-determination as an NHS trust. There are eight specialist teaching hospitals that form the trust. These focus on dental, obstetrics, heart, tropical diseases, children and adolescent, neurology, homeopathic and bone marrow transplant. Therefore it is well funded as a specialist, teaching and research institution. The hospital started as a charitable organisation in 1826 and had medical students attached to it in 1834. Another nearby hospital founded in 1755 also applied for teaching hospital status and got it about the same time. Theresa hospital is credited with a lot of firsts. For example, Robert Liston performed the first surgical operation under anaesthesia at here on 21 December 1846. Betty Anderson opened the first hospital for women in Harrington place near Theresa hospital in 1890 and when she died in 1917, the hospital was renamed after her. This association with Betty Anderson hospital is of historical importance because she was the first female British medical doctor but was trained in France.

Theresa hospital merged with the School of Hygiene in Gordon Street in 1924. Following the reorganisations of the NHS in 1974 and 1982, six of the eight hospitals that make up the group were joined together under the Bloomingdale Health Authority. The hospitals became a trust in 1994 and were joined by other hospitals in 1996. Theresa hospital

boasts of sponsorship from fifty pharmaceutical firms, medical devices and research organisations that have enabled it reach the present enviable position of autonomy and self-determination.

The trust employs six thousand staff, four hundred of which are ancillary staff (6.6%), placing it on the lower end of ancillary/staff ratio in this study. The trust has retained three stars for three consecutive years, which is an achievement in itself hence the foundation status that it has enjoyed since July 2004. Kingsland is the services and project provider. Kingsland specialises in design, build, refurbish and operate global investments that set it apart as a leader in centralised facilities management processes. The contractor believes in driving change through continuous productivity improvements that enable clients businesses run more effectively, while adding value to their operations. For example, Kingsland is the sole provider of capital investment and facilities management at this trust. The contractor has contracted with the trust to pay one fixed price for all services and loans over a 38 years period. Thus the trust can plan ahead focused on improving its medical and research expertise without threats of any seasonal of inflationary variations. Kingsland is noted for innovation in operational efficiency saving clients time and money and enhancing the quality of the services they provide to clients. Thus the partnership of this trust with Kingsland, as a complete services provider and financier of capital project has enabled the trust evolve and is now able to determine its own capacity, areas of operation, how to manage its performance and choice of NHS clientele.

The trust moved into its state of the art £422 million building in central London on 19 April 2005. This new fourteen-story building (seven below and seven above ground level) is the most prestigious of any NHS trust hospital. The aim was to bring services together for a more pleasant patient journey (patient-focused), operational efficiency and effective team working. The trust covers a diverse community from the deprived and homeless in the centre of town to those in affluent areas of London with its migrant population as well as the surrounding areas. Consequently, the trust faces and deals with diverse inner city health problems. The trust attracts and commands the services of eminent doctors and influential non-executive board member like an editor-in-chief of a medical journal, a local councillor, a director of Chinese community and members of commerce, industry and international banking, who help maintain its legitimacy with the local community and worldwide renown.

Theresa Hospital (TH) outsourcing—excerpts

Four people were interviewed at this trust (Agents A, B, C and D) and their views triangulated and collaboration with those of other workers for accuracy and consistency.

5.3.1.1 Motives for outsourcing:

We outsourced our support services under the PFI. It was not tendered, as is the case these days. We chose the contractor (Kingsland), on the strength of previous services, their reputation and financial standing and of course recommendation. There are eight different specialist hospitals in this hospital group and our aim was to bring them under one roof and so reduce our expenses in transporting patients from one hospital to another either for tests or treatment (Agent C).

We outsourced our support services and hospital project to our contractors because we think that they have enough clout to help us achieve our aim of housing all our services in one place. This will reduce the chaos of running eight hospitals. You cannot imagine the confusion that creates sometimes. There is also the cost of conveying patients and staff from one hospital to another. It can be a nightmare (Agent D)

We believe that contract services provide the trust with value for money. Cost savings are imperative. We contractors can do a better job with the same if not more resources than in-house services (Agent B)

Staff training:

In this trust you have trained staff. Before services outsourcing the commitment of the trust for training ancillary staff was very low. But now we have more trained staff and we (contractors) give more training than the trust ever did. We train them especially in food and personal hygiene, which have direct effects not only for the members of staff who eat here but also for the patients (Agent A).

Yes we were sold to the contractors. There was no freedom. If we did not wish to join the private company we would have made ourselves unemployed. I did not want to become an employee of the company but we had no choice. All our pensions and contributions were frozen because under the pension scheme, they said they could not transfer a pension so we lost out (Agent A).

But we have a happy and committed workforce, we give the trust continuity of service and because the staff are happy, they work better and the performance level of the trust has increased (Agent A)

Our staff members eat free here, it is their duty deal and there is also a staff discount of 20% for all those who eat here (Agent A)

Investments:

We run the vending machines and canteens for the trust to generate funds for them. The trust owns all the machines and all the proceeds from the canteens. We don't provide money to the trust, our investments are in providing the services they want and at the higher standards they demand (Agent A)

There are eighty different service level agreements (SLA) the trust wants us to meet. Everything they want is done at a different standard than before. The trust blames the Government for the new higher standards of performance and the extra work put on services providers to meet these new levels of performance. We have no choice we meet all the standards. We serve the trust well. They source nothing for us (Agent A).

The hospital trust is broken into three different contract caterers. When they move into the new building, we will be in charge of all catering, maintenance and management. We will be the major contractor, in control of the whole project. It is a brand new building for a foundation trust and we are helping the (consortium of) builders to build it. We give our time and experience to the trust (Agent A).

We are international and on the Stock Exchange. We have financial backing from banks and building societies. Our shareholders are our stakeholders. The company is so diversified, we can be working on building projects in Malta or oil rigs in China. We also work for the ministry of defence (MoD) and do school and hospital catering and support services (Agent A).

While we are running the new hospital, we will do all the maintenance work—plumbing, carpentry, the lot but if the trust people damage anything, they will get a bill for it and if we do the damage, we pay for it, it works both ways (Agent B).

Contractor investment in facilities prompted stakeholders to say:

This is what a hospital should look like, clean, airy, roomy and with much needed privacy for patients and staff, we can now work better and not step on each other's toe all the time. The changing rooms are the best in the bargain, no more having to change into uniforms in cars, toilets, linen cupboards, broom cupboards and patient's bathrooms, we have our own place to change in and you can let your hair down without disturbing anyone, very good and very thoughtful of the trust, but it must have cost a lot (Agent C).

Relationship and Communication:

We use PASA approved suppliers to ensure that our products are of the highest quality. We have good relations with all our suppliers but they also know that there is more than one greengrocer approved by PASA that we can use. For catering alone there are twenty suppliers on this section of the trust (about a third). But when we move all the suppliers will be amalgamated too so they will be fewer (Agent A)

We belong to the same social club with the trust members and we meet everyday to discuss operational matters. The official catering meetings happen every two weeks but we also meet every month with dieticians, facilities people, nursing staff and all the rest of them. We communicate daily (Agent B)

Impact of outsourcing:

The biggest impact of this new arrangement (outsourcing) is this magnificent building. Now I can come to work with a spring in my step, not the former "Oh Lord not that horrible place again", all day long (Agent D).

Because of the investment we (contractors) made, the trust has more freedom. They don't have to employ accountants to pay wages and salaries to 400 ancillary staff (sold to contractors). They have no worries on pensions or contributions. They don't have to deal with personnel disputes, discipline, conflict or people management. They can concentrate on their prime business of healthcare while we concentrate on our expertise of providing them with superior support services and value for money (Agents A).
They would not have extended our level of service if they were not satisfied with our services (Agent B).

We have been in this basement for thirty-one years and with the contractors for four. But when we move into the new building, fit for the 21st Century, things will be different. There will be new changes and challenges. As the changes evolve we have to motivate workers and support them through the change process. A cook cannot be told on the first day that he cannot cook because the trust has decided to use cook-chill meals so he must go and become a cleaner. It is not possible. He was contracted to cook and not to clean so we have to support him till he gets sorted out. The challenges will be in finding our way round the new place and all the expansion of duties—there will be duty managers, patient services managers and facilities managers, the lot and working in a brand new place where everything is a challenge (Agent A)

I think the trust is running more smoothly and efficiently than before (the staff are trained to be more efficient and they have more support), the whole place operates in a more user-friendly way with less conflict than before and the place is cleaner. The new building will be a brand new place with everything under one roof. It is a flagship for the trust and the Government. What is the point of having such a brand new hospital if you are not going to call it a flagship? (Agent A)

Furthermore, it was observed that the facilities managers here, through their relationship with commercial contractors gained advice or insight into disposing a property on prime site previously left to weeds and squirrels. This was the property in Edgware road that previously housed few elderly psychiatric patients. Thus they raised funds to augment their bank balance in preparation for foundation status. Without the aid of their contractor, those patients will still be there rather than at Chertsey with other inmates and no new flats will be built on that site. Consequently, this trust has become adept at disposing dormant functions to raise funds and reduce its total costs.

Innovation:

There is no innovation here because we are moving into a brand new building but under the interim service level agreements (ISLA) we continue to operate services from these old buildings till the trust decides to move into the new one. The length of time we will stay open depends on the trust because once they move in, they start paying so they will delay moving until they are ready (Agent B).

5.3.1.2 Discussion (TH)

The contractors at this trust have been there for four years, during which the trust gained foundation status, built its new state of the art facility and moved in. The motive for outsourcing was realised (eight specialist hospitals moved to one site). The contractors are perceived to have added value to client offerings. The added value is in the form of a

new facility liberating workers from eight different aging hospital facilities and managers from life in the basement (for 31 years) into better work environment and changing rooms, training of the ancillary staff to professional standards with incentives to give professional service to make the hospital environment more user-friendly and so attract more clients.

The support services managers here chose a relational exchange with the contractors as opposed to market mechanism or in-house authority control. Although managers can use authoritative orders to control and coordinate activities, in exchanges with high investment or asset specificity, as in this case, authority control becomes an ineffective governance mechanism due to power struggles and the inability of authority to control professionals involved in such exchanges (Eriksson and Laan, 2007; Williamson, 1996). This power imbalance distorts information exchange, limits knowledge sharing and transfer through learning thus limiting value adding through investments and innovation (Eriksson, 2006). Consequently authority becomes an efficient but ineffective governance mechanism.

Similarly, market mechanism of supply and demand based on prices encourages multiple sourcing with resultant competition and conflicting goals. These restrict the sharing of confidential information and investments hence learning and innovation that can add value to offering (Wilding and Humphries, 2006). Consequently, in relational exchanges, involving high levels of asset specificity, parties to interaction, as seen here, believe that without the exercise of authority, or markets they can get what they want without fearing opportunism or divergent goals (Eriksson and Laan, 2007; Wilding and Humphries, 2006).

Specific investments generate mutual dependence that forces interacting parties to commit to long-term collaboration and cooperation to achieve common goals for mutual benefits (Wilding and Humphries, 2006; Williamson, 1996). The problem of incomplete contracts and expert professionals involved in relational exchange, as in support services, makes control through soft parameters more effective and efficient as a governance mechanism. These soft parameters are social norms, professional ethics and membership to common business networks that impose self control to limit self-interest seeking and provides the incentive to perform and add more value (Das and Teng, 2001; Williamson, 1996). Thus the emphasis on professional self-control, reputation and informal communication that can foster trust and commitment to common goals is enhanced in relational exchange. The outcome is seen here as satisfied client, cost reduction through reduced personnel issues, reduced costly contract haggling, monitoring, and coordination costs, revenue generation

through disposing dormant functions in prime sites and long-term valuable relationship as bridge or buffer to the external environment to reduce the uncertainty of services provision. This confirms the findings of the interaction model framework (IMP) on the effectiveness of relational exchange to safeguard specific investments. Furthermore the results of services outsourcing by this trust goes beyond this framework to impact the services managers and workers by liberating them from the dungeons of the basement and unsuitable work environment into more suitable facilities that has also transformed the local community.

5.3.2 **Helina Hospital (HH),** 100 % outsourced

This is a community general hospital in Barnley with buildings dating from 1906 and crumbling. The hospital evolved from the Poor Law Amendment Act of 1834 when the Local Union became guardians of the poor who could not afford medical treatment. The hospital continued to house both the sick and the poor till 25 July 1906 when those with small pox, typhus and cholera were housed separately from the poor. It served as a military hospital from 1915 and became Helina Hospital after the first World War in 1920. The workhouse for the poor was closed in 1938, inmates transferred to Chaseville and the whole institution used as a hospital. Thus the hospital has several buildings, built at different stages hence crumbling at different rates or needing attention. For example, the accident and emergency was built in 1955, the out patients department in 1960, the pathology department in 1982, theatres in 1991 and walk-in centre in 2000.

The trusts' catchment's area is a mobile community of "doubtful ethnic mix" mainly in Barnley, Chaseville and surrounding areas. The hospital became a trust in December 1990 and was named a university training hospital in July 2001. Its main focus is on HIV and blood diseases but has a thriving and active children and youth health centre affiliated with other children's hospital in keeping with a university status. There are local community centres like a dental access centre and a Learn-Direct. The trust has pooled together a lot of managerial experience and commercial know-how through World Agents to build a "commercially aggressive team" to help it save money and provide commercial support to the facilities manager in tendering and revenue generation.

HH outsourcing—excerpts

Four people were interviewed at this trust (Agents E, F, G and H) and their views collaborated and triangulated with those of their workers for accuracy and clarity.

5.3.2.1 Motives for outsourcing:

We are a commercially aggressive team and we are here to save the trust money, that's the bottom line. We have also pooled together, a lot of experience as a team of very experienced purchasing managers from different walks of life. So the trust benefits from our experience and world-wide contacts (Agent G)

When we tendered for the business, we looked at costs and expertise and other areas that can benefit the trust in a competitive way so that the hospital gets value for money. The trust is currently looking into a PFI scheme and having one primary contractor as a part of the consortium to maintain all our existing contracts. That will help the contractor to tailor our services and to provide a more personal service (Agent F)

Companies are in business to make money so they have to be as efficient as possible to make profit. But one of the reasons for choosing the present contractor is their management structure. It is to the advantage of the trust to get better value for money, when contractors invest in senior management personnel. A team of qualified and experienced managers who care for their customers are able to project a better company image to make the business more successful. So firms that invest in management personnel invest for the long-term benefits not short-term profits. It is important to see that people are properly trained to serve the needs of the customers and so make the company more effective and successful (Agent F).

World agents provide commercial support to the facilities manager in tendering and other areas of contracting. Our patient turnover is very high with all the day cases we treat. That increases our overall expenditure. We also have old buildings from 1906 that are very difficult to keep clean. So we hope the PFI will enable the trust to maintain and improve standards in newer facilities (Agent F)

The trust would outsource services if there are operational and economic advantages. For example if we need to recruit more staff on the NHS scale (as in support services) it will be better for the trust to outsource the service. That way we save the trust the problems of personnel and their management costs (Agent F)

It does not really matter whether services are outsourced or in-house, as long as the services are provided. What is important is the management of these services so we get what we tendered for. We went for quality not the cheapest supplier but the best services provider and we are satisfied 90% of the time (Agent E)

Services outsourcing takes away the strain and risk and all the extra work involved in catering and providing the services in-house (Agent H)

Risk assessment:

For example, when cleaning contractors bid for the contract, they looked at the square footage of the wards and what needs to be done and decided "what do we need to get this hospital clean". That will decide how many people are needed to run the services—how many supervisors, cleaners and managers are needed to get the job done as specified (by the trust) and then they bid accordingly (Agent G)

Investments in developing managers:

I am aware that a lot of investment has gone into developing purchasing teams of other organisations as professionals to make them more responsive and effective to the needs of their clients (Agent F)

Investment in staff training:

The ancillary staff are better trained by the contractors. The NHS did not train ancillary staff. They were the bottom of the pile and there was no point in training them. Now they are better trained and get better uniforms, look more professional and even their salaries are improved at par with the rest of the NHS. They have better recognition for what they are and the work they do. Sometimes people just blame cleaners, cleaning and contractors as an easy target because they cannot answer back (Agent E)

We (contractors) train some of the staff in food and personal hygiene when they start here and they have refresher courses. They can work anywhere we have contracts if they request for it (Agent H)

We have 10% discount for all the staff that eat here. We have social get-together for the staff to enjoy themselves and forget about the world. No we don't solve problems there but it helps them to relax (Agent H)

My staff are well motivated. They don't need me to control them. Someone else has been doing my job for the four weeks while I have been away. We all need to try and empower ourselves to perform. Everyone is empowered to use initiatives. There are rules and regulations we all have to abide by. We don't need any other formal thing to empower people to do their job. We all need to be alert and work together (Agent E)

Things are done more professionally now. They (ancillary staff) now realise that you cannot have loads of staff hanging around doing nothing while you are paying them for it (Agent E)

Relationships and support

It is not a bad relationship with the trust members but it could be better. We are always regarded as the contractors. Well they are satisfied with our services or they would not have renewed the contract if they were not. We have been here for twenty years now (Agent H)
We use Premier nominated suppliers, vetted for hygiene purposes to ensure that the products we use are safe. We have a good relationship (network relationship) with them (Agent H)

We (contractors) network with other trusts and dialogue with them to learn best practice and get to know what others are actually doing and who is who in purchasing (Agent F)

We serve hundreds of other hospitals around and we support each other. Premier is the biggest catering company in the world and Assured is the hospital branch of it. We've been here for twenty years (Agent H)

We (NHS managers) have no support from neighbouring hospitals. There are no NHS formal support networks to my knowledge. But I have informal contacts if I need them (Agent E)

Communication:

We meet often with the trust on commercial matters especially best practice and tell the trust when matters of commercial interest arise (Agent F).

Things are done more professionally now and that may have added a layer of communication (Agent E)

We meet every day informally but fortnightly we have formal meetings with managers from catering, cleaning, security, health and safety and things like that to discuss things. It is important to maintain the same standard of output (Agent E)

Externalities:

If the contractors do well, they can use this contract as a springboard to provide other services here or elsewhere. It is also an incentive for contractors to continue performing well (Agent F).

Learning:

There is a lot of learning between the trust and the contractors. When a new contractor is engaged, it is important for the contractor to quickly understand what is required. For example a new pest control contractor needs to know the layout and sites where pests can become involved. They need to learn quickly to prevent any misunderstandings and avoid under-performing. The trust also learns from them (Agent F).

Innovation:

Assured has its own branded cappuccino and all the rest of them and we have Nevitto, as a commercial venture in most petrol stations all over the country (Agent H).

Power and control (Reciprocity)

You manage individual relationships. I don't control the contractors I deal with them on personal basis and expect them to do the same. There is no difference whether they are contractors or on the NHS (Agent E).

Trust plays an essential role in our relationship with contractors, without trust, there is no contract (Agent F). Sitting contractors may have advantages at contract renewal but can also have disadvantages. You get to know their faults and weaknesses as well as their strengths and on balance it can work against them, resulting in a change of contractors. The important thing is having an open and fair competition at tendering. Using the same contractor time and time again may be anti-competitive and may result in having a "cosy relationship", where personal interests may become more important than business ones (Agent F).

These excerpts from Helina Hospital (HH) are analysed below in Table 5.1

Table 5.1 (HH) Using structuration theory (Giddens, 1984) analytical methods

Structures	Signification	Domination	Legitimation
Efficiency	-Commercially aggressive team here to save the trust money -We looked at costs when we tendered so trust gets better value for money	World agents provide Commercial support to facilities manager for economic advantages	-Avoid budget deficits and overspend -Maintain standard of output
Investments	-World agents give commercial support and advice to benefit the trust -Services risk capped and transferred to contractors -Old buildings difficult to keep clean hence PFI	-Contractors enable the trust obtain operational advantages through commercial support -Investment in management structure	-Avoid service disruptions or contract termination -Give personalised service
Staff training	Ancillary staff better trained by contractors to professional standards -Purchasing teams now developed to be more responsive and effective to client needs	Contractors own and train all ancillary staff -Incentive to train other purchasing teams	Give better professional service
Managerial experience	-We have pooled a lot of experienced managers from different walks of life	The trust benefits from our experience and network connections	-Avoid conflicts -Improve skills of managers for better services
Relationships	-Network with other trusts to learn best practice -Contractors have other networks for support or help with equipments	-There is a lot of learning between the trust and contractors -We manage individual relationships not control managers	Client is satisfied with services so renews contract
Innovation	-Branded Nevitto -Improved food and services -Contractors' wider input	We work with all our contractors as a team in partnership	Avoid problems and complaints from patients

5.3.2.2 Discussion of 100% outsourced services at HH

The contractors at Helina hospital (HH) have been there for twenty years, during which the hospital has become a university training centre. However the motive for outsourcing was for operational and economic reasons. The operational reason was the lack of experienced and skilled managerial resource with the professional knowledge to give personalised support service to the trust, to improve its image and effectiveness. With their commercial aggression and extended networks, World agents provide the trust with value for money and claim to have enabled it become more economical, in efficiency savings. This is

achieved through effective client relationship management and investment in their management structure that enables them to provide personalised hotel services.

Customer relationship management (CRM) emerged in the 1990's aimed at obtaining and storing customer preference data in order to secure a one-to-one relationship and create long term relationships with loyal customers (Osarenkhoe and Bennani, 2007). This was a shift from transaction-based marketing. The aim was to lower the cost of acquiring new customers by keeping the old ones as seen at HH for twenty years. Serving a smaller number (or segment) of customers individually also attracts premium prices as those customers become loyal and indifferent to other competitive offers (Eriksson and Laan, 2007). These satisfied customers help to promote the products and services of their providers by word of mouth as seen in the externalities reported at HH. Over time the services provider build a trusting relationship with their clients and both become confident that their relationship will not be harmed or put at risk by either party's action (Das and Teng, 2001; Morgan and Hunt, 1994). This confident trust generates commitment to long-term relationship of mutual benefit that further reduces cost of formal monitoring and threat of opportunism, thus promoting the concepts of relational exchange to reduce total costs.

Furthermore trust and commitment in relationships here allow for confidential information exchange, meaningful communication and learning. Through learning and knowledge sharing, ideas for innovation are realised to build capabilities or nurture new products like Nevitto. Thus the effective customer relationships management at HH seems to have enabled the parties to interaction realise long-term benefits as profits for services providers and added value for clients. This is shown in the training and equipping of ancillary staff with skills to liberate them from manual workers to professionals and the proposed PFI project to improve facility, work environment and image of the hospital as a result of client satisfaction with the services providers, thus extending the remit of services providers. The moderating influence of trust and commitment to mutual goals in their relationship is shown in the lack of control and exercise of power. Rather personal ties come to the fore in their association to push their commitment and loyalty further towards a common goal. Their professional ethics promote informal social control to guard their reputation and frown at having cosy relationships that can tarnish their image. Thus trust and commitment reduce the exercise of power or authority in interdependent relationships of mutual benefit.

Finally the requirements of customer relationship management (CRM) of Osarenkhoe and Bennani (2007) were met at HH. They went for quality services, not the cheapest. The skill, expertise, experience and professionalism of the managers guaranteed personalised service and customer satisfaction. The services providers invested in training the staff to equip them with skills and knowledge and turn them into professionals with incentives in the form of free meals, to motivate them to give professional service. There is investment in management structure to equip them with skills and knowledge to give personalised professional services to the trust and liberate it from a community hospital to a university training centre over time. Constant communication and meaningful dialogue enabled the provider and client to avoid misunderstandings and resolve issues before they turn into conflicts. Thus the services providers at this hospital engaged in effective customer relationship management to retain their clients over time and increase their profitability while adding value to support services offering.

The combined summary of 100% outsourcing results is shown in table 5.2 below

Table 5.2 Summary of outsourcing in the 100% outsourced NHS trusts

NHS trust	Motives for outsourcing	Excerpt themes elicited	Theories in use
Theresa Hospital (TH)	-To concentrate effort and resources on one site -Gain value for money from best hotel services provider	Value for money Investment Staff training Relationships Learning	RBV (acquire resource) TCE (economise costs) IM (safeguard investment)
Helina Hospital (HH)	-Lack experienced and skilled services managers -Value for money (through competitive tendering and providers' relationship networks in purchasing)	Best provider Investments Staff training Relationships Learning Innovation	RBV (acquire resource) TCE (economise costs) IM (safeguard investment) CRM (manage client for profit and add value)

5.3.3 Karena Hospital (KH) 75% outsourced

This trust is a specialist, teaching hospital in central London. It is associated with royalty and renowned for being the birthplace of penicillin, in the days of Alexander Fleming (1928). It specialises in kidney, liver and bone transplants for which it has become world famous. The trust took over the management of the charitable and eye hospitals both in Queensland road. This trust is 75% outsourced with Mediserve as its services provider. The trust has also applied for foundation status and has a contentious PFI scheme in

progress, all during this research period. The trust has a mixture of very old and new buildings and was thinking about merging with other nationally renowned hospitals to become a consortium of clinical excellence, hence the contentious PFI arrangement. This arrangement has now been shelved in favour of a more viable relationship with Featherstone hospital. The trust also maintains good relationships with Colleges of research, and local universities for training nurses and doctors.

The trust gets donations from pharmaceutical and commercial organisations with whom it collaborates in research. Furthermore, the trust boasts of eminent non-executive board members chosen for their community standing and the work they did in the past or are currently doing. For example, the chairman of the board is a peer and former conservative member of a London borough. Other board members are currently serving as a global investment banker, a chartered accountant, an experienced commerce and industry member, a managing director of a financial institution, a private personnel recruitment consultant and a professor of medicine well versed in research, development and treatment of HIV disease. Consequently, these eminent board members help the trust smoothen out its environmental threats while seizing commercial and business opportunities as they arise to help the trust to evolve.

Karena Hospital outsourcing—excerpts

Four people were interviewed at this hospital (agent I, J, K and L) and their views collaborated and triangulated with those of their workforce for clarity and accuracy.

5.3.3.1 Motives for outsourcing

We outsourced our support services for two reasons—cost savings and staff retention. Even though contractors pay their staff at lower rates than in the NHS, they always manage to hold onto them probably because their staff can work anywhere within their organisation and also in any of their other contracts around the world but NHS staff employed in this trust will be confined to this trust alone or work in different departments. I think that their staff value the variety contract work gives them (Agent I)

We transferred a lot of risks to the contractors and capped all our support services and they met all the needs of the trust. They procure all our services within one contract price and we pay a set price (Agent I)

First it was a Government directive that all hospitals outsource catering, cleaning and laundry but since then there is a marked difference in price, we know. Also they (contractors) relieve us of the cost in time and money of recruiting and managing people. Managing people is costly because it consumes time. Now they recruit and manage their own staff. That's a huge load off my back (Agent K)

We give the hospital a good service so that they get the right food in a good clean environment (Agent L)

Staff training:

The contractors recruit and train their own staff. They operate services all over the country and can get staff and retain them. Our staff vacancy rates and turnover are greatly reduced (Agent I)

They (contractors) provide employment for their staff. They took over all the ancillary staff here and now train and manage them better if you will and so relieve us of the burden of personnel management and all that goes with it (Agent I)

The contractors recruit and train their own staff and some of them have trained to do other jobs in the trust. One of the catering staff is now a nurse in the private wing (Agent J)

Investment

We are always short of money but as an organisation we cannot borrow money. The contractors are private organisations with wider networks and they can borrow money. With new buildings, they can get money from the Government but we cannot, that's just the ways things are, (we are a public organisation so we cannot). But we need money to maintain these old buildings and to finance the work we do here. The contractors have access to national resources and they can borrow money and make it available to the trust. This last time they invested so much money and we are paying back gradually over time. They invest for interest. There is nothing wrong with making interest. We don't get the money for nothing. We pay for the privilege of having the money we need to function so we pay back with interest over time (Agent I)

They (contractors) bring a lot of skills, knowledge and experience and they are professionals in their chosen fields. We learn a lot from them (Agent I)
The contractors have invested lots of money here in equipment and personnel (Agent K and J)

We built this trust a new restaurant, because they needed one and refurbished the kitchen (because it needed refurbishing) and we run the canteens and cafés to raise money for them to reduce costs (Agent L)

They (contractors) refurbished the kitchen and changed it completely from conventional cooking to cook-chill because we could never get staff to work in the kitchens. The fast food houses and restaurants around here are the reasons. The chefs prefer to work in those places with better pay and conditions than what the NHS could offer to attract them to provide continuous services. Because we cannot retain them we changed our kitchen services to cook-chill and the contractors enabled us to achieve that (Agent I).

Relationship and communication

The key to a good contract is a good contract manager. If you have a good contract manager, you will work well and quickly with them otherwise you will have conflicts and problems and things become difficult.
So we work with the contractors in a relationship as a team. If you work with them as a team you will achieve goals and if you don't, you won't achieve your goals. It is that simple (Agent I)
We work in partnership with the trust. We don't have different views we have the same objectives (Agent L)

Good teamwork is all about relationship and how you work well with people not discipline (Agent I) The domestics and hostesses who help to service the meals are part of the ward teams. The ward managers use them as they see fit (Agent I).

We maintain a good business relationship with them (contractors) it is important that we maintain good relations with all our contractors, because we depend on them for services to continue. We are satisfied with their work. They are professionals and they have their pride so they do a good job (Agent K)

Contractors have changed in the thirty years I have been in this hole called an office but the present one is good. They are doing very well. We are satisfied. I retire soon but someone else will be here (Agent K)

As a teaching hospital we work in alliance with local research colleges to provide the standards and the flow of patient services (Agent I)

We relate with PASA because they save us a lot of money. And with NHS Logistics that help us buy in bulk so we save money because they help us with storage, re-distribution and transportation (Agent K)

We meet regularly, informally say weekly but we communicate daily. We meet formally monthly to review important issues and we have annual reviews with their managing directors, executive and non-executive board members so they can all be a part of what we are trying to do here (Agent I)

We meet regularly. Informally we meet daily with the facilities manager and the contractors but the monthly meetings are with the directors to discuss performance and other issues (Agent K)

We communicate every day by phone or e-mail or face-to-face and if there is a problem we rectify it immediately. We have a set of procedures to follow and we learn from each other everyday (Agent L)

The contractors know what to do and the consequences of under-performing. There is no conflict we trust and interact with them as professionals and they do a professional job (Agent K)

They are our clients and we trust them. We give them good quality services as they specified (their set standard is the quality they require) and they are happy and the patients are happy. What is a dodgy client? I have never met one my company will not get involved with what you call a dodgy client (Agent L)

We use company procedure books to resolve conflicts and disputes so everyone knows it is fair (Agent L)

Power relationships:

We have the power to penalise them by taking money away from them. They know all that from the start. We don't have penalty clauses in our contracts because they can be fiddled and they get in the way of good teamwork but if we can show that the contractor has not done the work as required, we can take money away from them provided you are fair and can provide evidence that they have not performed (Agent I).

The contracts are set for a definite period of time, the maximum period is seven years but we limit it to five years with an extension period of two years to see how they are doing. At the end of the contract, we can either extend it or revoke it. This gives them the incentive to perform well (Agent I)

We monitor them. We use monthly patient and customer surveys to see how they are doing. We have had our traumas with contractors but the present one is doing a good job. We have a good service now (Agent I)

The contractors are professional and they do a very good job here but we manage them because sometimes we get complaints (Agent K)
Hospitals depend on contractors for support on patients' services to continue or the hospitals will grind to a halt. Support services are crucial for smooth healthcare delivery (Agent K)

The contractors have managed to let the public know how important the support services are. Hospitals are usually thought of as doctors and nurses, but without the support services, hospitals could not function (Agent I)

Innovation:

We may know what we need as an organisation but the contractors have visions and views of how they can provide more services and do it better. They also have wider input and more sources of supply so they can procure materials cheaply. They come up with ideas to help us achieve our goals and objectives (Agent I)

Our staff dining services and new canteens are based on commercial ventures to provide us with income which we roll back to offset some of our costs. Our coffee shop for visitors is also a commercial venture to provide income to the trust (Agent I)

Impact of outsourcing:

The biggest impact of outsourcing here is innovation in food and services. We may know what we need but the contractors have visions and views of how they can provide more services and do it better. They also have wider input and more sources of supply. They help us with ideas to achieve our goals (Agent I).

Image of support services raised

The contractors have also managed to let the public know how important the support services are. Hospitals are usually thought of as doctors and nurses, but without the support services, hospitals could not function. The support services are critical to this trust. Because the support service workers have a better profile, image, work uniforms and improved training than before, they stick with the contractors (Agent I)

Other benefits of outsourcing:

We capped all our services and transferred a lot of risks to them and they met all the needs of the trust. They bring a lot of skills, knowledge and experience and they are professionals in their chosen fields. They have access to national resources and they can borrow money and make it available to the trust and we repay it over time with interest. They have invested so much money here this last time and we are

paying back gradually over time. They have completely changed our kitchen services from conventional cooking to cook-chill and refurbished the kitchen and built new canteens based on commercial ventures to provide us with income. They procure all our services within one contract price so we pay a set price. They operate services all over the country and can get staff and retain them. Our staff vacancy rates and turnover are greatly reduced. They come up with ideas to help us achieve our goals and objectives (Agent I)

There is more patient choice in food, especially on the private wing and the caterers check and monitor themselves and the Government agents monitor them too so we don't have to. The rest rooms and the visitor's areas are also cleaner, we know because there is less complaint coming in to me (Agent K)

They (contractors) provide employment for their staff. They took over all the ancillary staff here and now train and manage them better if you will and so relieve us of the burden of personnel management and all that goes with it (Agent I)

Foundation status and autonomy:

We will never be autonomous. There will always be an aspect of Government in the shadows telling us what we should be doing. But one clear message with foundation status is the ability to borrow money and do all the things we want to do now. Instead of depending on the Government, we can go out and double what they can give us. Also we can look at services from a money generating point of view. We will look at our bread and butter core element of the community we treat differently, in ways that can generate money and not drain the trust of resources. It will enable us see healthcare as a business and give us completely different visions of how that business can be run, if not for making profit, then run successfully (Agent I)

The present state of affairs is that the Government provides us with funds through the Strategic Health Authorities (SHA). They set the direction of all the trusts in their area and decide how much money we can have depending on our performance and all sorts of things. So we have a budget and have to work within that budget. But if we go down the foundation route, we will be able to change all that and function as a business. We will still have and work within our budget but things will be a lot easier and simpler (Agent I)

Tabulated analysis of excerpts from Karena Hospital is shown in Table 5.3 below

5.3.3.2 Discussion:

Karena hospital trust outsourced its hotel services to enable it retain ancillary staff and reduce total transaction costs. They achieved the aims outsourcing and realised more benefits in innovation in food and services and improved image of support services. The services managers realised that a partnership arrangement with the contract managers would facilitate a more trusting relationship of mutual commitment and cooperation to help them achieve their goals. Consequently, rather than exerting their position power in controlling or penalising the contractors, services managers use informal social control.

Social control is defined as building a common organisational culture that encourages self-control and limits opportunism (Das and Teng, 2001). Social control is a more effective form of control in cooperative arrangements where goals to be attained are uncertain and performance monitoring is problematic as in support services outsourcing that adds value over time (Eriksson and Laan, 2007; Power et al., 2007). This is achieved through trust and commitment in business relationships that impose self-control to reduce the fear of opportunism and monitoring costs. Trust and commitment become incentives for services providers to invest more and help the client organisation to achieve more. Consequently the visible hand of authority to control behaviour is replaced by self-control or reciprocal conduct when asset specificity is coupled with inter-dependence. Thus the advantages of cooperative relationships of mutual benefit, governed by social control outweigh the exercise of power to attain goals. This reinforces the tenets of the interaction model (IMP) that parties, to interaction without the exercise of authority or power, can achieve mutual goals through relational means without fearing opportunism, control or domination (Ford, 2002, 2003; Håkansson and Snehota, 1995).

Having secured a working partnership based on trust and commitment, the services provider sets about optimising the client's business processes as seen in the investments made to refurbish the kitchens and build canteens to generate funds because the kitchen needed refurbishing and the trust needed to generate funds to offset their costs. Further investment in equipment, workforce training and motivational incentives equip the staff with skills and knowledge to become professionals and to provide professional services with enhanced commitment and loyalty to the services provider despite lower wages and loss of entitlements like sickness benefits. Consequently, providers' investments enable the staff to make a difference and transform the erstwhile run down image of support services. Thus the outsourcing objectives of this trust were achieved and value added by liberating the workforce from a rundown image of manual workers always waving placards and agitating for a better living wage and improved working conditions.

This reinforces the tenets of structuration theory (Giddens, 1984) with regards to the ontological security perceived by agents. When workers feel cared for by managers they are more committed to daily chores, reduce absenteeism and exit. This is evidenced here as better staff retention and reduction in staff vacancy rate and turnover. Thus the professionalism of the workforce helps to improve the image and profile of support services as added value to the outsourcing goals of cost reduction and staff retention.

Finances invested for profit benefits the services provider and enables the trust function better without budget deficits. Through the investment in managerial time for learning and knowledge sharing, innovation in food and services is realised, commercial ventures are nurtured and run by the services provider to generate funds to offset costs. Learning has also equipped the services managers with knowledge to see healthcare as a business and poised them to qualify for foundation status that would further liberate them from the dictates of the Strategic Health Authority commissioners and perennial budget deficits. Consequently the impact of hotel services outsourcing here goes beyond cost reduction and staff retention to include commercial skills acquisition by services managers through learning and teamwork to liberate the trust from budget deficits and the dictates of commissioners, giving them the freedom of charting their own course as foundation trust.

Issues of power

Although the services managers possess the authoritative power to take money away from non-performing providers, they also realise that these services providers possess allocative power of investing funds to enable them function better by upgrading their processes like kitchens and canteens, to generate funds through vending and coming up with ideas to help them achieve their goals. Consequently the services managers chose not to exercise their punitive power (Foucault, 1977) but to work with services providers through the dialectic of control (Giddens, 1984) to achieve a more favourable outcome. Power is a great motivator that facilitates interaction by constraining or enabling agents to achieve outcomes both intended and unintended (Giddens, 1984). Secondly, the services providers possess the scarce resources the services managers require to function. These are finance for investment, ideas to help them achieve goals, ancillary staff to do the work and professional expertise to supply hotel services. Thus the expert power of services providers enables them to manage and reduce the uncertainty of resource acquisition. This is in keeping with the tenets of IMP relational exchange where the interdependent sharing of knowledge for building capabilities and innovation far outweigh the momentary exercise of authoritative power (Håkansson and Gadde, 1992; Gadde and Snehota, 2000; Jolly, 2003). Consequently, both parties chose to communicate and negotiate to achieve consensus for mutual benefits. This also reinforces the ontology of structuration theory (Giddens, 1984), which emphasises the self-direction of agents in focusing on which conditions of action (interdependent teamwork or punitive power) will maximise the capacity of agents to make a difference. Thus, allocative and authoritative power, combine in a trusting partnership relationship, to make the overt exercise of power

redundant. Cooperative partnerships can reduce misunderstanding, nip conflicts in the bud, eliminate the need to find alternative sources of supplying resources (Smith 2000) and to facilitate needed change better than punitive exercise of authority to discipline erring contractors. Other studies confirm these conclusions (Courpasson, 2000; Eriksson and Laan, 2007; Osarenkhoe and Bennani, 2007; Wilding and Humphries, 2006).

On innovation

The services managers had operational flexibility to achieve innovation. This was in the certainty of investment, through the ability of the providers to mobilise national resources and invest it and their diverse inputs that enable them achieve innovation in food and services (Harding, 1999 and 2005). The contractors provide a stream of stable and cheaper loan to be repaid over time while they generate revenue for the trust to offset such debts (Harding, 1995). Consequently, a major obstacle to innovation (investment) was overcome making it possible for managers to realise the benefit of innovation in food and services.

Innovation is a radical combination or integration of knowledge (Pettigrew and Fenton, 2000; Huber, 1999). Successful innovation requires a conducive and trusting environment that supports creativity and drives to make it flourish (Christensen, et al., 2004). Services providers, acting as change agents, already come with requisite knowledge (Huber, 1999). This is found in contractor expertise, experience and skills, tacit memory or standard operating procedures (SOP), equipments and routines (Nelson and Winters, 1982). Working in a trusting partnership with the client managers, they draw on organisational resources (stock of knowledge) as a medium of their interaction and reproduce the same as innovation in food and services (Giddens, 1984). The services managers are already sensitised with the absorptive capacity (Cohen and Levinthal, 1990) to regard support services in healthcare as a business needing innovation to move beyond its present state. Thus, through their inter-dependent and cooperative working relationship based on common goals and mutual benefit they communicate constantly and openly to share knowledge across disciplines and apply new knowledge to produce something perceived as novel and new in food and services (Okoroh et al., 2002; Osborne and Brown, 2005).

An environment of mistrust and risk aversion hampers creativity and stifles innovation (Eriksson et al., 2007; Jolly, 2003). Agency theory uses the metaphor of contracts to describe principal—agent relationships and assumes that agents are risk-averse due to their inability to diversify their employment, hence preferring a more secure line of action

Table 5.3 (KH) Using structuration theory (Giddens, 1984) analytical methods

Structures	Signification	Domination	Legitimation
Efficiency	-Marked price difference -PASA and logistics save us lots of money -Services procured at one fixed price -We roll back income to offset some of our costs	We depend on contractors for services to continue	Avoid overspend and budget deficits
Innovation	-Contractors come up with ideas to help us achieve our goals and objectives -More patient choices -Creative ways and wider input to do services better	-We work with contractors as a team in partnership -We learn a lot from our contractors	Avoid problems and conflicts or complaints from patients
Investments	-Contractors have invested lots of money here - We capped all service risks and transferred to them. They met all needs -These old buildings crying out for money	-Contractors access national resources and make them available to the trust -They invest for interest and we pay back over time	Avoid service disruptions or contract termination so to retain contract they add value to client offerings
Managerial experience	-Contractors are professionals -Contractors come with lots of skill and knowledge -Key to good contract is a good contract manager	-It is important that we maintain good relations with all our contractors -We work well with contractors to achieve our goals	Avoid conflicts Learn from them
Foundation status	-Autonomy has some clear messages—Ability to borrow money now and do all the things we want -Look at healthcare as a business to generate money not drain us	We look to the contractors to help us achieve our goals -We learn a lot from them (commercial ethos)	Avoid dictates of Strategic Health Commissioners
Community concern or Legitimacy	-Hospital as focal point of local community -National teaching and research centre -HIV and rape centres	We serve the needs of our local community as our bread and butter business	Local relevance to avoid closure

(Bergen et al.,1992). Contrary to this assumption the services managers (principal) state that they transferred a lot of risks to the contractors (agents) and they met all their needs as evidence of their ability and competence to perform and achieve specified details of their outcome-based contracts. The services managers are committed to improving their lot to gain foundation status and liberate themselves from the commissioners, while providers have a need to innovate and create wealth, avoid obsolescence, make profits and sustain their competitive advantage over other suppliers (Von Hippel, 1998; Morita, 1992; Story and Salaman, 2005). Consequently, both engage in meaningful dialogue, having secured investment funds and creative ideas, to drive innovation forward and reap mutual benefits. Thus in relational exchange of mutual benefit, interacting parties can become risk-neutral.

5.3.4 Victoria and County Hospitals trust (VH) 75% outsourced

This is a community hospital group located in two different areas of London that reflect the diversity of its population. One is in a depressed inner London with a varied ethnic mix while the other has its own ethnic community and suburbs. The trust chose to outsource services up to 75% to focus on core activity, save costs and especially guarantee services supply and support. The trust has built a Day Care Surgical Centre (DCSC) and an Emergency Diagnostic Centre (EDC) in their local Industrial estate, using PFI funding to replace the crumbling old hospital building founded in 1946 on an old railway station. The trust is currently undergoing plans to rebuild the Victoria extension, whose land was purchased in 1898 and built in 1970. The two hospitals were amalgamated as the West London NHS trust in1991. It has maintained its two star status for three years and is yet to qualify for foundation trust status for which probably its chief executive was recalled to the Department of health for bringing the name of the trust into disrepute. The trust maintains partnerships with local boroughs, the Olympic committee and its services suppliers, Areno (hotel services) and Builders International (PFI capital projects). Both companies are multinational corporations with headquarters in UK and Paris respectively. Both are actively in the market place armed with commercial ethos to exploit opportunities for profit, market share and growth through innovation and customer satisfaction. Thus, their combined association with this trust has enabled the trust evolve meaningfully as shown below. The trust receives the largest research and development funding for a non-teaching hospital mainly for clinical trials and is associated with specialist hospitals, of international repute, an infectious disease hospital, an eye clinic and a research college. It also has excellent relationships with private healthcare organisations for which it has a centre at its main base at Victoria hospital.

Victoria Hospital outsourcing—excerpts

Five people were interviewed at this trust (Agents M, N, O, P, and Q) and their views were collaborated and triangulated with those of the workforce for accuracy and clarity.

5.3.4.1 Motives for outsourcing:

The objective of the trust as we see it is to provide a quality, timely and reliable service which would fit in with the needs and policies of the trust. We are big enough to meet that need and guarantee the service by providing all the backup and technical support needed to make it a quality service. In short we are a one-stop shop for all their services. At the end of the day it is value for money or perceived as value for money for them because we guarantee a quality service at a fixed price through all seasons (Agent M)

My understanding is that hospitals are in the business of providing healthcare. We are not great at catering or cleaning or business so we get people who are very good at these things and can organise them better and we pay them to do it for us (Agent N)
We (contractors) have contacts and personal links all over the world and can buy stuff cheaper than the trust can source them so they benefit and we do what we are best at. They will never be able to afford to do it themselves because of their enormous overheads (Agent M)

We are a big organisation and we specialise in support services unlike the health service that mainly treats patients. Anyway, we supply ready cooked meals and a lot of choices for patients so the trust saves on raw material, labour and storage costs and they don't pay consultation fees to source anything so there is a lot of savings by letting us provide the services for them. So for my company, the objective was an opportunity to provide services here. That's what we are good at and that's what we do world-wide (Agent O)

Staff training:

We support and train (ancillary) staff in food hygiene, health and safety and infection control. As our own initiative because we are a big company, we project the trust and help them move forward (Agent M)
We recruit and train all ancillary staff in support services. There is staff discount of 25% on purchases (which nearly bankrupts us). There are prizes for staff of the month and other sports events for staff with prizes for winners so we try to keep staff motivated and productive (Agent O)

When I was with the NHS, they (managers) sat in the office and only sent for you when there is a complaint (no visible management). Every time patients complain you go to the office and explain why they complain. How do you know why patients complain? Some people always complain but the supervisors think you make the patients complain which is bad for the hospital. But things are much better now (Agent Q)

When the NHS sold us to the contractors who won the contract, we lost things like London weighting and sick leave allowance other than that it is okay because there are monthly competitions and if you win you get vouchers or paid holidays for two weeks. Also the supervisors and managers are here to help you if you

get stuck and they don't blame you if wards or patients complain they just come and talk to them and afterwards they explain things to you so you work better next time (less blame on contract staff) (Agent Q)

I worked at a mental hospital before my family moved here and this company allowed me to transfer here. Yes they let you transfer if you move house or want to change location. Now I work from 7.30am till 2pm then start again at 5pm till 8pm so I can go home and get the children from school and come back (flexible working). But in the NHS if you moved house you have to travel or find another job. I used to spend two hours on the bus to and from work and it tired me out. This company (contractors) also let us eat free when we work so I save money too and we have better uniforms and equipment to do the work (Agent P)

We all get training from the company before we start work and monthly we go for refresher courses. It is free and we train in work time, which is good for me (Agent Q)

Investments:

In providing support services there is a financial burden to bear. If something happens for whatever reason, the client wants to know that the company is big enough to sustain it and continue with un-interrupted service. When we took the contract we were able to provide £5 million to build a new kitchen in the private wings because the trust could not afford it. We also provide support and training for staff because we are a large company, we help the trust with information and other projects to push the business forward. We have since created two new restaurants at a cost of £4 million over ten years, interest free (Agent M)

The project contractors are aggressively in the market place so able to access national resources and make them available to the trust. There is no way we could have been able to build EDC. The Government was not going to fund it and we did not have the funds so the contractors enabled us to build it (Agent N).

We (contractors) bring a lot of skill, knowledge, experience and expertise to this trust. I am trained, I worked in the army as an electrical and mechanical engineer, then I went and trained to be a chef, worked in many hotels and restaurants within Britain, Austria, France and Italy came back here and got into catering management and from there to facilities management. I am not alone but all my managers are highly trained too. The job demands that we do the best, so we provide quality service. We are experts in what we do whether it is for royalty or the NHS trust, we believe we are the best at providing quality service and we are in the business for value for money, not the cheapest, but value for money (Agent M)

We refurbished the main kitchen and canteens with extensions at our own cost interest free (Agent M)
We also provide support and training for ancillary staff because we are a large company and we keep up with all the technology so they don't have to (Agent M). The trust learns a lot from us. (Agent M)

Innovation:

We have since created two new restaurants at a cost of £4 million over ten years, interest free. We help the trust with information and other projects to push the business forward. And we come up with creative ideas to make them look good so they get better hospital scores and meet their objectives (Agent M)

We built two new restaurants as commercial ventures *Diners' Den* and *Café Locale* and run them together with the vending machines to collect revenue for the trust to offset their massive costs (Agent M)

Relationships and communication:

We have thousands of suppliers in a world-wide (network) who can supply anything anytime from anywhere, no problem (Agent O)

Our relationship with this trust, I think it is a high profile thing to be serving an organisation like the health service, but we do a good job in providing the service they need (Agent O)

We work closely with local partnerships, London Coaches, the Lord Mayor's office and other community leaders we consult on regular basis. They are all involved and support the schemes here, financially and socially, it is their hospital and we serve their community. The Local Government is also involved. They gave their blessings and support so we can move on with the work we do here (Agent N)

I personally meet daily with my opposite number at her office or mine, along the corridor, on the phone or what have you and we discuss any matters of interest from cleaning to catering or patient entertainment, which we provide as extra under due diligence. That way we nip minor issues in the bud before they become major concerns. My managers do the same daily. It is a very informal relationship that I have constructed. The more formal ones happen on a monthly basis when we meet with people from health and safety, patient forum, infection control and directors (Agent M)

I (on behalf of the contractors) meet with all the different departmental managers, client managers and we talk about innovations, how we are performing, what the scores are, standards we are targeted to meet by the trust or by head office, patients' surveys or any downfalls in services we provide. We also keep the trust abreast of what is happening in our company through newsletters, leavers and starters and our levels of services supply, all that sort of thing. We are constantly talking to everyone who needs to know (Agent M)

We maintain long-term relationships and work with the client in partnership to meet their goals, we communicate often and personally (Agent M)

We (contractors) use a network of 36 suppliers here so we can supply most things (Agent M)

We (Contractors) try to promote them (client) socially as our partners (Agent M)

When there is a problem I can react as professionally and swiftly and competently as possible to rectify it because we always make sure that we have something in place to deal with unpredictable emergencies. Yes we react but not like the NHS managers do in what we call "knee-jerk reaction". They react and then pass the buck to someone else but I have to deal with issues (to prevent conflicts arising) (Agent M)

If someone pees on the floor after it has been cleaned, I have to get it cleaned up in minutes, no fuss. That way we exceed our client's expectations (Agent M).

We would not supply services to a client who has been in the news in the last two years. Money is not everything. Our reputation is more important (Agents F and M).

Power relations:

The trust depends on us (contractors) they will never be able to do all this on their own because of their enormous overheads but we have to be subtle about it because they are our clients and we look after them (Agent M)

Before we became Areno, we were associated with a reputable hotel chain that every body knows and recognises in all the countries around the world, massive reputation and all that but we look after our clients that's what we do (Agent M)

Impact of outsourcing:

The trust saves on labour and personnel costs. We provide quality services as a one-stop shop for labour and conflict management and we give them value for money and exceed their expectations (Agent M)

We are international so we buy in bulk and save them money. They don't source any thing for us and if things change and prices go up we bite the bullet. We provide other benefits without asking them for more money and we innovate to push the business forward. So we exceed our client's expectations (Agent M)

I don't think we came here solely for the profits, we do a good job and get paid for that and if profits come along good but that is not our main aim (Agent O)

Community care:

All hospitals aim to provide for the healthcare of its local population but there are areas of interest. Here we have a very active blood disease centre (the first in the country) that reflects the ethnic makeup of our community. This is a major centre and looking to expand so in that sense it reflects the area we work in. Also this community has a strong history, which is reflected in the hospital building, decorations and paintings along the corridors here. When we move into the new building, all these will be there (Agent N)

5.3.4.2 Discussion:

Hotel service was outsourced here to acquire a continuous and uninterrupted quality service with guaranteed backup through all seasons. The services providers claim to have evolved as a one-stop shop for providing quality support services at a fixed price through all seasons. They are big, reputable and can "bite the bullet" if conditions change. There is a perception of added value through investments in new facilities, locally nurtured innovative ventures, Diners' Den and Café Locale and staff training to provide professional services.

The main advantage of relational exchange here is in the evolution of their relationship. First support services were outsourced at Victoria and County hospitals then as the client-provider relationship deepened, asset specific investments increased to include the design, build, manage and maintain operations at County hospital, involving a project contractor, Builders International, the Mayor's office and London Coaches in partnership. This is an

example of a complex, dynamic inter-related and inter-dependent relationship involving major investments hence the network effect of alliance relationships (Håkansson and Gadde, 1992; Gadde and Snehota, 2000; Jolly, 2003). Thus as relationships evolve and asset specificity increases, the focal organisation becomes the locus of a network of relationships and all concerned must manage the inter-dependence and balance the power asymmetry involved with the benefit of the relationship (Pesämaa and Hair, 2007). Indeed relationship networks are plagued by power influences and shifting coalitions. In time they become complex and consume managerial time and energy (Brennan and Turnbull, 2000). Consequently, observers advise those involved to balance the cost-benefit (enablement and constraints) effects of such relationships (Ford, 2003; Gadde and Snehota, 2000).

There is also a perception of creating value or relational rent in this exchange through investments (Dyer and Singh, 1998). It confirms the concept of capital theory (as part of market process theory) that profits and value reside in the modes of capital application (Kleinaltenkamp and Ehret, 2006). As relationships deepen services providers as investors can detect other options for their resources not already served or services not supplied and craft to implement a business solution to provide the client with superior added value and extraordinary profits for themselves. Thus relational exchange becomes a fertile context for relational rent (Dyer and Singh, 1998). Also capital invested creates resource advantage to maximise value for customer and enduring profits for investors (Hunt and Morgan, 1996).

The new facility at County Hospital meets all these criteria. The facility is owned, managed and maintained by the contractor for the next thirty years providing a stream of rent and profits for investors and an improved work environment for the support services workers as well as transforming the local environment. This hospital facility won the prestigious Commission for Architectural and Built Environment (CABE) festive five award as one of the foremost new health buildings in the country (Annual Report, 2006/2007). Indeed, FM built environment continues to win awards, like the (LIFT) award for excellence in building healthier communities and replacing old, antiquated NHS buildings (Bradshaw, 2008).

Most ancillary workers describe the new work environment as "a unique breath of fresh air" that benefits them, the patients (through infection control) and the local community as a focal point of interest, healing community differences and uplifting the local industrial area.

Furthermore, these erstwhile support services workers who hitherto occupied the dark dungeons of the basement, regarded by other professionals as the bottom of the skills heap (Restell, 2008), now "own" a beautiful, spacious, airy and aesthetics facility. They made good their newfound influence by allocating to themselves the vantage point on the last floor from which they can observe the picturesque view and walk on top of everyone else. What is more the staff canteen, out of bounds to visitor, patients, public and relations, is on the same second floor as is the kitchen, offices of the support services staff and even the rest room for the domestic staff!

Some members of the medical staff regard this arrangement as "the ultimate in control". No longer could they pick and choose their own office space as before or be able to convert any vacant prime site into a medical office, conference or teaching room. Although the catering staff, complain of "too much walking about along the long corridors", they are satisfied with their lot and can see for miles from their cleaner-air vantage points. The domestic managers were also ecstatic about their new location and privilege. Thus the support services staff, perceived as the underdogs of the health service have been enabled to liberate themselves as owners of facilities they control and others lease.

There is a no blame culture at this trust, as expressed by workers and visible management to encourage and support the workforce. There is flexible working to fit in with life and work patterns and other incentives like free meals and the ability to move from job to job to suit the needs of workers. Consequently, the workforce is motivated to work for the contractor despite the loss of London Weighting, sickness and pension allowances and lower pay.

The interacting parties have also created a value system that enables them prioritise against other projects to focus on creating commercial venture (Christensen et al., 2005). Conducive environment for innovation made it possible to nurture commercial ventures. Successful innovation requires a conducive, no blame, trusting culture and a cooperative working relationship between exchange partners (Jolly, 2003; Kanter, 1983). This allows creativity to thrive and innovation to flourish. Inter-dependence promotes knowledge sharing between specialists across disciplines and encourages risk taking to create something new and novel for commercial gains (Eriksson et al., 2007; Okorok et al., 2002).

The constant communication and willingness of the contractors to socialise all workers help to create a conducive environment for dialogue and taking initiatives without fear of failure.

The teamwork, risk sharing and having the same objectives for mutual benefit also create collaborating environment to nurture creativity and hence knowledge sharing and transfer for innovation. New knowledge is created, (Huber, 1999) and absorbed to create something new. The outcome is two commercial ventures, Diners' Den and Café Locale. Also every available dormant space in both hospitals has been creatively converted and rented out to generate revenue. These augment the management of vending machines, canteens, and visitors' cafés to generate further revenue to offset and reduce total costs. Consequently, the impact of services outsourcing here goes beyond the central focus of IMP— reduction of total transaction costs and safeguarding specific investments to include the nurturing of commercial ventures in a conducive and supportive environment of mutual risk and reward.

Legitimacy

Organisational effectiveness depends on the degree of its social support (Elmuti and Kathawala, 2000). Stakeholder theory states that a constituency in exchange relationship with a firm has legitimate claims on the firm (Hill and Jones, 1992). The contractors provide this trust with investments and innovative ideas in exchange for opportunity to supply support services and make profits. The social environment in which the hospitals are situated, provide land, local workforce, public image and free promotion or publicity as their local health centre. The credibility of the trust can be jeopardised if it fails to maintain legitimacy with all its stakeholders especially the special interest groups. Consequently, this trust has sought and obtained credible permission from the Local Partnership Associations, the Mayor's office, London Coaches and the Local Authority. Most of these groups have donated funds and provided network links in other areas.

For example the social environment provides the non-executive directors, a critical resource of local workforce and a critical mass to lobby Government and investors for funds, tax breaks on antipollution and ISO trade agreements (Pfeffer and Salancik, 1978). Thus support services managers here have built a bridge and buffer to their social environment through valuable social network relationships. This confirms the tenets of interaction model (IMP) that for business support, survival and possible success, parties to interaction should maintain legitimacy with the social context in which they are situated. This would increase their visibility, improve image, plug skills gap and enhance local legitimacy and reputation. In time such organisations are enabled by local acceptance, patronage, publicity and recommendations to survive, thrive in a competitive environment and maybe become successful.

Table 5.4 Summary of outsourcing in the 75% outsourced NHS trusts

NHS trust	Motives for outsourcing	Themes elicited	Theories in use
Karena Hospital	-Ancillary staff recruitment and retention problems -Cost savings	Value for money Staff training Investments Relationships Power asymmetry Learning (Innovation)	TCE (economise on costs) RBV (acquire resources) IM (safeguard investment) ST (dialectic of control) Learning (innovation)
Victoria And County Hospitals	-Need for reliable service guaranteed -Value for money -Lack of expertise in support services	Value for money Investments Relationships Legitimacy Learning (Innovation)	TCE (economise on costs) RBV (acquire resources) IM (safeguard investment) Market process (rent) Stakeholder (legitimacy) Learning (Innovation)

5.3.5 **Featherstone Hospital (FH)** 50% outsourced

Featherstone hospital is located on four sites in London. It is a specialist, teaching hospital renowned nationally and internationally for research in collaboration with other research colleges two of which are situated within its grounds.

It has the largest 200-bedded renal unit in Europe and is a centre of excellence for mother and child medicine at its Maternity Hospital in London. Its partnership with research colleges, means that medical research findings are quickly translated into healthcare benefits for patients hence its worldwide reputation as a centre of excellence. At its orthopaedic unit, close to the maternity unit, elective surgery is undertaken to complement the work done by other national orthopaedic centres. Featherstone hospital covers both undergraduate medical education and post-graduate medicine at two of its centres in London. The four hospital units were amalgamated into a trust with sixty-four specialities in 1994.

The extensive research and teaching facilities at this trust means that it receives rather a generous grant for teaching medical and post-graduate doctors as well as for research. But it chooses to outsource 50% of its hotel services (where it lacks expertise) to commercial operators in order to focus on its core competence of healthcare. Assured (Premier Group) is the services provider for the hospitals while other catering firms (Eviance) within the Premier Group serves the research colleges and research centres within its grounds. Featherstone hospital group has benefited from services outsourcing.

Featherstone Hospital (FH) outsourcing—excerpts
Five people were interviewed at this trust (Agents R, S, T, U, and V) and their views were triangulated and collaborated with those of the workforce for accuracy and clarity.

5.3.5.1 Motive for outsourcing:

You have to recognise what your core business is and what resources are put into non-core business. Our business is healthcare not catering, cleaning, building maintenance or anything else (Agent R)

We outsource hotel services (soft FM) because we don't have the expertise in-house to manage and maintain it. There is also the degree of training involved. Where other companies have the necessary knowledge, equipment and better facilities to do a better job or give better service and have the technical knowledge to maintain the equipment, there is no reason not to outsource such services to them. Where we cannot afford to have trained personnel to manage a service or equipment, we will outsource that service. But it makes no difference whether services are outsourced or done in-house the key to it is really the management (Agent R)

We outsourced our information technology maintenance and servicing to outside contractors and we also outsource our own expertise in building maintenance to local companies to raise money for the trust. All the trust is really interested in is having suitable facilities to carry out its core business of healthcare (Agent R)

We seem to have created a multicultural environment in this trust, which has many challenges and problems so we work with the contractors, Assured, to make changes that we feel will make a difference and improve patients' experience through the trust. Many years ago patients could get by with tea and sandwiches for lunch but not any more. The multicultural patients we have here demand certain diets that only professionals like Assured can consistently provide so we work with them daily to make that possible (Agent V).

Staff training:

The trust spends a lot of money training staff and we in estates and facilities (Hard FM) also operate an apprentice scheme. Not many organisations do that now (Agent R)
The reason is ownership. We in estates and facilities run a 24/7 operation 365 days a year. It would be difficult to obtain this degree of ownership and loyalty we have here with an outsourced company (Agent R).

At Premier Group (Assured), everyone gets training and it is free. Before you start work you get training in food hygiene and safety, personal hygiene and health and safety. Every week we pick out some people and send them for training in the areas where they work and we rotate till everyone has done the necessary training. We also do training in management and dispute (conflict) management (Agent S)

I used to be a cleaner but the company helped me to train in night school and now I manage other cleaners and I have worked all over the country in our contract places (Agent T)

At Premier Group, you can ask to be moved to anywhere in the world where we have contracts and you can go. Premier sends out vacancy lists every month and anyone can apply. We also have staff of the month prizes and three prizes for employee of the year to motivate and encourage the staff (Agent S)

We have a great workforce and they are always cheerful. Cleaning job is hard and no one wants to do it but here they don't complain. They work hard and we have a great time (Agent T)

Innovation:

We look to the soft FM (contractors) for innovation in food and services (Agent R)

We have now implemented the new (A1-plus) special group of cleaning equipment and cleaning practices here and the hospital is cleaner and more hygienic. No more wet mops and buckets or chemicals (Agent T) A1-plus is a range of equipment created at Premier for better cleaning. There is the linco-machine that is driven to clean and polish public areas so no more sweeping, mopping and polishing by hand. There is a special vacuum machine that sucks up broken glass or medical waste so cleaning is easier and contamination or cross infection by staff is reduced. Then there is the microfibre flat cleaning cloth. It is new, not disposable but has disinfectant incorporated in it so no more chemicals and buckets for toilets or dirty areas. Cleaning with this cloth, we can kill 99% of the bacteria in those places so it is good for Premier Group and the cleaners. It is really good for cleaning and does it in less time so we have less staff to do the work and do it better. It helps with hospital infection (no MRSA here) (Agent T)

Other areas the agents regarded as innovation but could be classed as improvements:

We refurbished the new building to make it more work-friendly for all concerned and reduce domestic intrusion. When it is finished you will see the difference between there and the rest of the wards in the trust The new floor we built are padded and softer so our feet don't ache from walking all day and night, very good for nurses and doctors and for cleaners too (Agent T)

We have this new catering steam simplicity dishes you just microwave and it retains its taste and flavour even though it is cook-chilled (Agent T)

There are new automatic washing machines with computerised correct temperature for all kinds of soiled linen and equipment so no more cross infection while cleaning laboratory areas or washing out the rags and cleaning cloth we use (Agent T)

All our cleaning equipment and cloths are electronically marked so they are automatically returned to designated areas and not lost or cross used like before. So we are more hygienic and moving with the times. We also have the electronic palm pilot for monitoring cleaning areas, which makes it consistent every time because it is standardised (Agent T)

Relationships and Communication:

We work in partnership with the trust as a team for the patients and we work well together (Agent S)

Premier is the biggest food provider in the world with regional and international networks everywhere. We only use Premier approved suppliers. Suppliers to Premier are checked weekly by Premier standards for food hygiene and quality. We have very good relationships with all our suppliers (Agent S)

We have the research centre and the research college on our grounds and we work in partnership with them. If you are doing medical research you need research material and the cooperation and collaboration of organisations that with a flow of patients through them. Because of our partnership, patients probably get a higher standard of care due to the highly qualified experts taking care of them (Agent R)

Our non-executive directors, I would say were probably chosen for who they are, their standing in the community, the work they do now or have done in the past and their standing in other healthcare organisations. Some of them have been influential in many ways, some are still voices to be heard in certain areas and many are professionals of international standing so all together they are very beneficial to the trust (Agent R)

We meet every day informally to discuss and agree on issues for the day but formally we meet monthly with the board members to discuss operational matters (Agent S)
At Premier, we have a no-blame culture and team spirit. We show appreciation for hard work (Agents T)

Community and environmental concern:

There is a waste and energy management project due to Government commitment to climate change and the KOYOTO agreement. We also strive to meet all the ISO standards and our waste disposal is done in an environmentally friendly way. All these initiatives save us costs. We have a new waste recycling initiative with the local council which was launched by the local Mayor (verified) and a police crime watch with CCTV at both our hospitals. There is the snug bus arrangement with London Coaches to enable our staff and the locals travel safely outside working hours. The bus changes its routes to take in the housing estates and becomes a fare-paying bus for passengers at night (Agent R)

Impact of outsourcing:

We look to the soft FM for innovation in food and services. That has impacted us more (Agent R)
We (hard FM) also generate revenue for the trust by outsourcing our own services to local companies.
We benefit from scale economies of the contractors. If you are a smaller organisation, you benefit from being part of a larger concern. That way we gain from not having to train and manage our hotel services staff. We also benefit from not having to keep up with technology or maintain our equipments (Agent R)

Outsourcing is good. If the company does well, the hospital will be good and they will say Premier was good. We help the trust to maintain cleaning standards and give them good service. We have our reputation and we keep to Premier standards. We use the rulebooks (SOP) and everything is fair (Agent S)
We manage the canteens, restaurant and vending machines for the trust and make money for them so the trust benefit from our services. We motivate the staff and they get 10% discount, which is good (Agent S)

On the issue of foundation status:

Our application has been made (verified). It would raise our financial freedom, to be able to look at different ways of doing things and get us a bit more independence from the Strategic Health Commissioners. Our agreements will then be legally binding and we will be able to operate on a more sound financial footing. Presently our service level agreements (SLA) with the commissioners and other health institutions are not legally binding. They can decide not to pay for the medical care we give their patients and there is nothing we can do about it. With foundation status all that will change. We will have more freedom and better financial footing to operate from (Agent R)

The analysis of Featherstone Hospital is presented in table 5.5.below

Table 5.5 (FH) Data analysis using structuration theory (Giddens, 1984)

Structures	Signification	Domination	Legitimation
Efficiency	-utilise scale economies -Be part of a larger concern -Outsource own services to generate funds -No technical/ knowledge or equipment update	Must show value for money in resource use	Avoid budget deficits and overspend
Investment	-Revamped kitchen -Built canteen -Trained ancillary staff	To lengthen contract Control ancillary staff	Avoid services disruption or contract termination
Innovation	-In food and services -A-1 plus cleaning kit -Steam simplicity -Better padded floors	Contractors help us to keep out hospital infection and meet diverse dietary needs	Avoid media attention and patients' complaints
Workforce development	-Spent a lot of money training ancillary staff -Apprentice schemes -incentives, job mobility	-Contract staff are happy and work hard -We have a strong team culture here	-Better staff retention -Avoid exit and has lower absenteeism
Community concern	-Environmentally friendly waste disposal used -Snug bus, CCTV security -Local youth employment	KOYOTO agreement and ISO standards to maintain	Avoid disruptions from special interest groups
Legitimacy	-Board members of social standing, -Local council partnership in energy savings	Maintain local relevance and reputation	Avoid possible closure or disruptions
Foundation status	-Sound financial footing -Generate revenue -More legally binding service-level agreements	Freedom from Strategic Health Commissioners	Autonomy with more choices but accountability

5.3.5.2 Discussion

This trust outsourced support services to concentrate on its core function of healthcare. The managers here went for efficiency of operation. The outsourcing of both soft and hard FM to reduce distraction from core activity is a measured of efficiency (Davis, 2004; Hamel, 2000; Peters and Waterman, 1982). As managers focus on their areas of expertise, they save time, effort and energy using them to find better ways of working, to reduce waste and duplication hence become more efficient. This enables them to realise outsourcing aims and to outsource their own hard FM to generate funds to offset costs. Thus efficiency gains are made by better focus on core activities and transaction costs.

Contractor investments help to improve processes and enable the staff work better. There is staff training by the contractors with incentives to motivate them. There is also client investment in training and apprentice schemes to improve workforce ownership and loyalty above their professionalism. Their team spirit, no blame culture and constant communication encourage creativity for innovation in food and services and motivates the workforce to work harder despite lower wages and lack of sickness benefits. Thus like other outsourced concerns there is added value as innovation in food and services.

There is also a concern for the local community and the environment in crime prevention, local transportation, waste disposal, community and environmental care for legitimacy. The courting of goodwill to improve the social context in which they are situated helps to stabilise operations for survival and success and reduce the power asymmetry between the focal organisation and its network of social relationships. Thus, the service managers here have managed to make their relationships valuable bridges and buffers to the social environment for support and local legitimacy while reducing the politics and power-play thereof with their social goodwill and community care.

However the most notable impact here is in community care. The services managers went out of their way to appease the local community by providing snug buses, CCTV linked to the police station for crime prevention and waste disposal in environmentally friendly way. This trust is very much involved in jobs for local youth and enlisting of the Mayor's office and non-executive directors, some of who are still international voices to be heard. Consequently the issue of legitimacy for social support comes to the fore here together with the quest for freedom and liberation from Strategic Health commissioners.

They went out of their way to court relationship with the locals to improve organisational visibility, public image, reputation, local goodwill and legitimacy (Barringer and Harrison, 2000; DiMaggio and Powell, 1983; Tsang, 2000). The goodwill and social support so created will help them in their bid for foundation status to liberate them from the dictates of commissioners and enable them function on a more stable financial footing. Hence the services managers here realise the benefits of having favourable relationship networks with all stakeholders for support, stability, survival and success. Thus, the concepts of stakeholder theory are evidenced, where services managers, as agents of the firm, exchange local goodwill and investment in apprenticeship schemes with reduced conflict from environmental pressure groups. The social support gained enhances their lobbying power to free them from commissioners in their bid for foundation status. It also gives them local promotion and publicity from a loyal, motivated and committed workforce.

The services managers sought to reduce the environmental uncertainty of scarce resource (Ajauro et al., 2003; Pffefer and Salancik, 1978) with regards to hotel services. They have aligned their processes and procedures by allowing the contractors free reign in using their company rule books in the management of daily routines. These help to provide evidence of fairness and equity amongst staff members and reduce conflict. This sense of fairness and equity helps to maintain adequate staffing levels of workers to do the work. The supportive social environment they created enables them to co-opt non-executive membership from which to build a critical mass of interest groups for collective lobbying or favourable resource acquisition. More importantly they can save on total transaction costs by using their common membership to trade associations to align the conduct of coalition members and stakeholders to gain much needed local acceptability. Thus through goodwill, services managers enhance local acceptability, reduce transaction costs and their vulnerability from the uncertainty of resource acquisition.

There is a tangible quest for freedom and liberation from the dictates of the Strategic Health Commissioners. This would be achieved through gaining foundation status for which the NHS trust has applied. The services managers, as agents of the trust, will be free to chart their own course and be enabled to make more legally binding contracts, keep surplus money and be able to borrow money to do all the things they want to do instead of waiting on Government handouts. Consequently, the partnership with services providers has been meaningful in areas of learning and commercial knowledge transfer that enable services managers imbibe the idea of commercial ethos for future use.

5.3.6 Reinhard Hospital (RH) (50% outsourced)]

This NHS trust is both a teaching and post-graduate specialist medical centre located in pleasant surroundings outside London. A club-footed medical physician and philanthropist named William John Little founded the hospital. He wanted to make the treatment of this Victorian condition available to other sufferers. By 1840 the institution has opened in Barmsbury in a house, said to be formerly, occupied by Disraeli's father. From there, three specialist hospitals merged to form the present one. Now based in a London suburb, it is the largest specialist orthopaedic hospital in Britain and has international renown as a teaching, post-graduate training and surgical centre. The hospital focuses mainly on correction of deformities and treatment of diseases of the bone and joints. There are twelve specialist units treating different aspects in the institute. The hospital has a bed capacity of 245 with 906 staff 170 of whom, are ancillary staff (10.5%). This is the largest ancillary to total staff ratio in my sample. The reason for this ratio may be because of the large expanse of land the hospital occupies.

This trust focuses on its core competence of healthcare outsourcing 50% of its hotel services like catering, cleaning and portering to Assured, a branch of Premier Group. Premier is a leading foodservice company based in Surrey and dedicated to finding foodservice solutions and quality services that add value to the client's business. The company operates globally in ninety countries through teamwork, lasting business relationships and a passion for quality in the hospitality, leisure, travel and healthcare industries, providing innovative high quality solutions in food and domestic services. In this small study Premier Group was involved in 50% of all those who outsourced services as well as in the other far flung hospitals that were investigated but not part of the final study because it was thought that they had nothing new to contribute.

Reinhard Hospital outsourcing—excerpts

Two people were interviewed here (Agents W and X) and their views collaborated and triangulated with those of the workforce for accuracy and clarity

5.3.6.1. Motives for outsourcing:

The hospital is spread over a large area. It was very hard to get domestic and catering staff to come and work here, reason being the large area we cover. All the wards are separate as you can see and far from the residential areas where people live so we could not get staff to stay till we outsourced the services. Also we are a specialist hospital not good at cooking and cleaning so we get Assured to help us out (Agent W)

We pay one set price, which is helpful, they recruit, train and retain their own staff and they are specialists in what they do. I must say they have invested a lot of money in the trust with the restaurant, canteen and kitchen, so there must be some savings made. We are not using money from the trust for refurbishment and staffing on the soft FM side (Agent W)

We provide better food for the patients here and a nice clean hospital to work in. Assured, is responsible for catering and feeding both for patients and staff in the new restaurant, it is also open to visitors, the public and whoever. Patients have more choice of food. Also we do security at the main gate. You see this place is like the country, far from the city so security is important too (Agent X)
Assured is a very big company and we serve all over the world. We are specialist in food service and we buy cheaper from our many suppliers so we must save them money (Agent X)

The trust does not have the strain and stress of cooking, cleaning and portering, we do all that for them so they can treat patients better (Agent X)

We are quite satisfied with their (contractor) services and they have not reported any problems with staffing. They always seem to have loads of them serving and cleaning. The contractors have their sources for recruiting staff. We seem to have mainly Filipinos here and they do a great professional job (Agent W)

Staff training and motivation

The contractors recruit and train their own staff. No problems of staff shortages has been reported since we outsourced the services (Agent W)

Premier trains all staff in food hygiene, health and safety and NVQ levels. Many of my staff when they came here could not speak English but Premier trained them and now they are good, some have many skills, like generic workers (Agent X)

We pick staff of the month and they get prizes like vouchers then Premier picks staff of the year and they get 1st, 2nd and 3rd prizes and it helps to motivate the staff to work well (Agent X)

Investments:

We revamped the kitchen and restaurant when we won the contract. Now the staff, patients and visitors have a more pleasant place to meet and eat. There is more opportunity for us as a company to help the trust. We have more leeway than under the NHS to help the hospital evolve (Agent X)

I have been on both sides. When I was young, I worked for the NHS, it was just a job for me but now I can see the good things my company, Assured, brings here. We have better uniforms and strict standards to keep. In the NHS the uniforms were always tatty and never washed properly, it may be a little thing but it is important to look clean and good for patients and visitors. Now my company, Assured, makes investments here but in the NHS there was no equipment, we were always waiting for things to come and sometimes they never came because they said they were short of money (Agent X)

Relationships and Communication:

We have contracts with neighbouring hospitals in Watford, St. Albans, Hemel Hempstead and other places. So if we are stuck for something, we can get help or call for advice or whatever and those other units can also call on us, it is good (Agent X)

They (the trust) are our client and we look after them. No we are not in charge, we work in partnership as a team for the patients. We meet every day and once a month with the people from health and safety, infection control and the rest of them. If they say there is a problem we work quickly to correct it (Agent X)

We have a total of eight Premier-approved suppliers, vetted by the purchasing department at Premier and they supply everything from chilled and frozen food to confectionary that meet Assured standards (Agent X) Assured has very strict standards so we don't have problems with suppliers or our clients will complain so we use only Assured suppliers and we have very good relations with all of them (Agent X)

Innovation:

Premier is basically a food company with a business edge so they know about food. It is not good having medical people to be messing about with food.

Food wise —I don't think that there are masses of changes with the NHS but there is more innovation with Assured. Ideas come in to help patients get better service through Assured. Also Assured has its own people on site teaching others hands-on and as new ideas come in they try them out and then dissipate them to places they have contracts so patients can benefit. On this site we have a green acre garden a kind of a la carte for the children to get better choice of menu. There is a housekeeper on site to cook it straight away for them no matter what time of day. It helps keep the children happy while in hospital (Agent X)

Impact of outsourcing:

The contractors have greatly improved the services. There are less complaints and the kitchen and restaurant function better now. There are no recruitment or retention problems any more. In food and services we look to them for innovation. I mean they are professionals in food and hotel business so they know their job and we are satisfied with what they do (Agent W)

We (contractors) save them money. We use our networks of suppliers to buy cheaper than in the market and they pay one fixed price so we must save them money and effort (Agent X)

We help the trust to maintain Government standards and they get good scores so that is good (Agent X) Our uniforms are better, we have enough staff to do the work and people are happy in their work so they don't call in sick like in the NHS. I don't have to run after the staff to do their work or check them all the time, they know what to do and they do it without complaining (Agent X)

We revamped the kitchen and restaurant when we won the contract. Now the staff, patients and visitors have a pleasant place to meet and eat. Hopefully, the community will also think that this is a nice clean hospital when they visit and so they continue to use it (Agent X)

5.3.6.2 Discussion:

Hotel services were outsourced to attract and retain ancillary workers. Now there are no support services personnel problems. The managers realise innovation in food and services with the reliability of a continuous un-interrupted support services at fixed price. The contractors are perceived to do a professional job and there are no complaints. The contractors use their own network of suppliers and have neighbouring contracts for support and help with staff or equipment as needed. Consequently the services providers have met the need of their clients and added value through staff retention and innovation. The contractors invested in improving their clients' processes through refurbishment of kitchens and canteens to make them better places to work and eat and to safeguard their contract for streams of economic rent. Thus by crafting a business solution to add value to client processes and profits for themselves, the contractors confirm the concepts of capital theory and prolong to retain their contract (Kleinaltenkamp and Ehret, 2006).

They also invested in training to motivate (with incentives) Filipino workers who could not speak English when they came and managed to liberate them from manual workers to support services professionals, able to give better service. The service improvement, lack of staffing problems, better staff retention and the satisfaction of the client voiced, confirm this. These outcomes reaffirm the tenets of interaction model (IMP) that relational exchange can develop into valuable relationships that safeguard specific investments and reduce total transaction costs through professionalism and reduction in monitoring costs. Thus the relational exchange at this trust has added value beyond cost reduction and safeguarding of investments to include better staff retention and the liberation of support services staff from manual workers to motivated and loyal professionals.

The contractors use their network of relationships with neighbouring hospitals to maintain support, visibility and social presence that enable them provide a reliable uninterrupted support service to keep their jobs and maintain reputation. This also confirms the tenets of social networks in maintaining legitimacy and offering support to buffer the external environment by reducing the complexity and uncertainty of services provision and ensuring the availability of scarce resources. These reduce organisational vulnerability to enable the organisation survive and succeed (Pfeffer and Salancik, 1978; Nichols, 1993). Thus the contractors obtain a negotiated and predictable environment through social support and succeed in meeting their contractual obligations to their clients' satisfaction.

Furthermore, the services managers and their context organisation (the trust) are enabled to focus on their core activity as contractors remove the distraction of support services from them, thus improving their efficiency in use of their time and effort (Hamel, 2000). With the help of contractors, the demands of all stakeholders, with respect to support services (workers, service managers, employing organisation and Assured suppliers), are met, improving the perceived effectiveness of the services suppliers and their clients (Pfeffer and Salancik, 1978; Hill and Jones, 1992). Thus their relational exchange goes beyond staff retention and cost reduction to improve the efficiency (better focus on core activity) and the effectiveness of contractors and clients through stakeholder acceptability.

Power

Although the ability of contractors to meet the needs of their clients make the clients dependent on them for the scarce resources they possess (workforce retention, investments in equipment and staff training, creative ideas for innovation), the contractors claim "not to be in charge". But rather they prefer to look after their clients mindful of the interdependence of their relational exchange (Ford, 2003; Pfeffer and Salancik, 1978). Consequently services providers manage their power asymmetry through constant dialogue to reduce misunderstandings and conflicts (if the client says there is a problem we work quickly to rectify it). Indeed they also manage to appease both customers and patients, as was the case on one occasion when I visited the hospital for an interview. The resultant interdependent relationship of mutual benefit also requires negotiation and consensus to liberate parties to interaction from domination (Clegg, 1989; Machiavelli, 1958). Thus both parties survive. The providers retain the custom of their client and earn streams of profits while the client gains staff retention and innovation in food and services.

Table 5.6 Summary of motives for outsourcing in the 50% outsourced services

NHS trust	Motives for outsourcing	Themes elicited	Theories in use
Featherstone Hospital	-Concentrate on core healthcare and offload burdensome function -Cost savings -Enhance patient experience	Efficiency Management Relationships Investments Innovation Legitimacy	Efficiency (better focus on core activity) IM (safeguard investment) Resource Dependence Stakeholder (legitimacy) Learning (innovation)
Reinhard Hospital	-Ancillary staff recruitment and retention problems -Gain value for money	Investments Staff training Relationships Innovation Learning Efficiency	IM (safeguard investment) Capital theory (gain rent) Learning (innovation) Legitimacy (support) Efficiency (better focus on core activity)

5.3.7 Charlston Memorial Hospital NHS trust (CMH) 10% outsourced

Charlston memorial hospital is a teaching, specialist hospital, reputed for its liver and kidney transplants and Government funded for its medical research, medical and nursing training schools. The hospital was founded by, William Marsden, a philanthropist, in 1828 to provide care for those who could not afford medical treatment. It gained a royal charter from Queen Victoria in 1837 in recognition of its work with victims of the cholera epidemic.

It was reputed as being the only hospital in London offering facilities for clinical education of women hence its association with other Schools of Medicine for women. It later became the Charlston Memorial School of Medicine. It moved to its present location from central London when it was amalgamated with other local hospitals. The current Queen Elizabeth opened the present hospital building on its 150 years' anniversary on November 1978. In April 1991, Charlston memorial hospital became an NHS trust, amidst controversies rancorous conflicts and acrimony as one of the first trusts established under the NHS community care Act of 1990. This trust status was to aid competition and the efficient use of resources during the internal market era (1991-1997). Charlston memorial has three satellite centres at a national ear, nose and throat hospital (added 1996), an elderly psychiatric care centre and an infectious disease hospital, each with its own support services staff but all managed as in-house concerns.

Charlston memorial has 1100 bed capacity and 4727 staff members 500 of whom, are support services workers (10.5%). It serves an affluent and expensive community with a high level of HIV (Human Immunodeficiency Virus) cases and a thriving gay community. It also covers an area of London, where some television, media and film people live. This closeness to an affluent area may have necessitated the trust keeping a low profile out of media attention or reluctance of the management to outsource more services and hence invite or attract outsiders to the hospital.

Its main focus is on clinical excellence in renal, liver and bone marrow transplants for which it is affiliated with Theresa hospitals to share facilities and contain costs.

Charlston Memorial Hospital—in-house service

Four people were interviewed here—Agents Y, Z, AA and BB and their views triangulated with those of their workers for accuracy, relevance and clarity.

5.3.7.1 Motives for in-house service:

We are very much tailored to doing things ourselves. With contractors, there could be a lot of problems like quality of service and control over the level of service. Every time you want to make a change it will cost you a lot of money with outside contractors whereas you could be more flexible with in-house services (Agent Z)

While in the private sector, I was always delighted to hear trusts say "I would like to change so and so" because it always costs them extra to make variations from set specifications and prices. But the variations helped me make money for my bosses. Basically it was less flexible than in-house services (Agent Z)

In-house service just gives us more flexibility to make changes without added costs. We find that having contracted out services, there is no continuity (should contractors fail) and the service is quite expensive to use and the quality of food produced is dubious but it is actually working out more economically to have things done as in-house service (Agent AA)

With private contractors, they are profit-making firms so they try to cut corners to reduce their costs and make profit but ultimately it is the patients that lose out. There are six catering managers here and we all come from the private sector so we are aware of the methods they use to save money. Here we have our own overheads but they are specific to us and not to a company and we don't have shareholders to pay dividends so any profit we make is ploughed back into the service to benefit patients (Agent AA)

The in-house team won the first tender in 1986/87. When that tender ended in 1991, the trust was going through so much change to become a hospital trust that they decided not to re-tender it. It has been done in-house ever since and rolled over every time. I think as long as you can show that you give value for money, there is no legal reason to outsource services (so it has been kept in-house) (Agent BB)

The advantage of in-house services is that you have control over the services so you can be flexible, able to contain costs and you don't have the problem of failing contractors (as once happened in our transport department when the contractor went into liquidation). There are always risks with contractors who are always trying to cut costs and to make profit (Agent Z).

The advantage with contractors is that you transfer all risks to them but the down side is that you have to manage the contract (relationship). If there is a problem with the contract or the contractor goes into liquidation, you won't be able to take the service back in-house straight away even though you are still responsible for providing the service (fear of failing contractors hence in-house services) (Agent Z)

It is far more difficult to change things when it has always been in-house but if you go through the change once and that change is acknowledged and accepted probably with great difficulty, it is less difficult next time whereas if it has never changed, the people don't know any different and some of them have been here too long and become set in their ways like "deadwood" (Agent BB).

We outsourced linen service to Sunlight due to space issue. We don't have the space here to wash linen and we needed the laundry space for other things (Agent AA).

Staff training and management:

We have lots of training schemes and computer skills training available for everyone. There is the NVQ for porters and domestic workers. There is basic education sessions available for staff, who want it (Agent Z).

We get lots of money from the NHS for training so we are able to help our workers. Every domestic worker has NVQ training. Anyone who wants it can do literacy, numeracy or computer training, completely free of charge. They are very keen and we don't have to force them (Agent BB)

The training makes them more confident on the wards as an added benefit. Some of them have trained and gone on to do other jobs in the trust, which is great (Agent BB)

We have professional managers who are well trained with both technical and professional qualifications. Some are studying to gain full diplomas, others higher-level management or masters degrees (Agent Z).

The last time we had the Healthcare Commission and patients' representatives in for inspection, they did not say that our result was awful but that it could be better if we actually had enough domestic workers to do the work, so it was not as bad as it could have been (Agent BB).

Staff control is not a problem provided you have a good clear strong management structure. That helps people in their jobs to stay motivated, knowing that they have the support and it carries them to make decisions and to take pride and responsibility in their area of work. It helps flexible working (Agent Z)

When I worked in a contract job, I found the staff more flexible with work and more manageable (Agent BB)

Human Resource:

We have a very large Human Resources department with policies on everything. They know all the theories but not the practical aspect of managing situations like dealing with drunken domestics (Agent BB)
The HR department has full procedures on most things like training opportunities, performance, changes to contracts, trust policies, infection control, health and safety and procedures on work plans (Agent Z)

We operate a basic hierarchy system, which works well but it does restrict action and wastes a lot of time. For example I cannot discipline my staff without reference to HR policy on the issue, which I first have to get from the intranet. Then I will have the HR personnel come and tell me how to discipline a drunken domestic even though I am trained to manage my staff. It restricts your authority. So discipline is up the spout. Staff members know that they can flout the rules and get away with it because they have the HR and the unions on their side and this is the NHS (where they have security of tenure). If we ever get outsourced, many of the "deadwood staff" here will be retired or found more suitable work to do and the staffing will be streamlined. No contractor can stand for it (Agent BB)

Besides I am not allowed to spend money from my budget without clearance from HR. I know what my department needs and requested for it but when the money comes, I am not allowed to spend it without their clearance. For example, I can engage agency staff if we are really short staffed but I have to justify it

every time and take action to remedy the situation but I am not allowed to get extra staff on permanent basis because they cost too much. So everyone has to muck in to get the job done to save money (Agent BB)

The chief executive wants us to cut costs to meet budget deficits and we are doing all we can. But how far can one cut costs? The vacant posts are frozen and staff reduction is an on-going process. This cost cutting is driving everyone mad. They say we have a zero-rating, how can such a big teaching hospital be zero-rated and still manage to treat our patients well? (Agent Y)

Investments:

We have revamped some of the chilling equipment in the kitchen and we are building to provide accommodation for the staff (Agent Z)

We have Government funding for the university and for specific areas of service and healthcare. We are looking to charitable organisations to liase with them and share in the provision of services (Agent Z)

We get lots of money from the NHS for training so we are able to help our workers. Every domestic worker has NVQ training and other training sessions are completely free of charge (Agent BB).

There are lots of things going on here. Our eight years refurbishing programme has been going on forever because we start and stop till more money comes in. We just cannot invent a pot of money to enable us do things so we look at what we feel is more important like infection control and do those then we do the rest of them in small chunks. That is how we manage to do things here (Agent BB)

In the previous 10-15 years, money was taken away from support services when hospitals had to balance their budgets. Perhaps they thought that the support services have grown too fat and needed to be toned down a bit but I think that they went too far and we are now cleaning up the problems we created for ourselves in Greater London hospitals. But things have improved in the last 5-6 years. Also the buildings were not refurbished as often as was needed. There was no preventative maintenance work in the years gone bye that would have stopped some of the rot we see today. Also the expectations of patients and the public have changed and they will not accept anything not working properly, so more investment is needed to put things right than would have been the case (Agent BB)

Relationships and communication:

We use PASA approved and vetted suppliers. In this catering department we have sixty suppliers for food, and cleaning equipment for the kitchen (Agent AA)

PASA provides us with basic templates for national contracts. They help to streamline tendering processes through PFI or ordinary contracts and they are experts in contract management. They are very valuable to us. We also buy things off national contracts that have been vetted for quality by PASA (Agent Z)

The NHS to my knowledge does not share staff, equipment or whatever but the nature of domestic services is that you get to know people as you move around and work in different places over time. So when you are in trouble you ring up (informally) and get help (Agent BB)

I think as in-house, we have better communication with the nursing staff. The domestic staff members are treated as part of the ward team and they are loyal to the ward staff and they help the patients (Agent BB)

We use the NHS centralised support for hospital departments. We look at trusts of similar sizes and budgets to find out the cost of things and compare like with like in every category of service. We have the central agencies for benchmarking and the national networks like Hospital Caterers Association and Institutes of Healthcare Management and other professional bodies for support if we need them (Agent Z).

Innovation:

We get a lot of representatives come here with their cleaning equipment and they let us try them out to see if we like them. Sometimes we buy the good ones if we have the funds or the companies give them to us. But basically we wait for the representatives to give them to us free or we can forget it (Agent BB).

Impact of in-house services:

The advantage of in-house services is that you have control over the services so you can be flexible, able to contain costs and you don't have the problem of failing contractors. There are always risks with contractors trying to cut costs and make profit (Agent Z).

We provide hotel services and meet the changing needs of the trust in a more flexible way. Support services provide the trust with a clean hospital environment from which to operate (Agent Z)

The impact of in-house services I must say is rather constraining and constricting. For example, I have to get my line manager's permission to spend some money from my budget. I have to get HR permission to discipline my staff. Even though I was trained to manage budgets and people (Agent BB).

In-house service and outsourcing compared:

When I worked as a contract manager, I was the manager in that remit answerable to no one in the unit (I was in control). I managed the staff, other managers and supervisors. But in this in-house service, we have all the hierarchical levels with managers upon managers and they do get in the way (Agent BB)

When I worked as a contract manager, we were part of a bigger team because the contractor will have a number of contracts say in London. We had the opportunity to meet up with people on regular basis because we all worked for the same company, using the same manuals and doing the same routines. We had the same issues, problems or whatever. I felt a sense of belonging then (Agent BB)

When I worked as a contract manager, it was easier to borrow staff. For example if I had a particularly good floor team and they had a floor problem, I could easily send them my floor team for a few days to help them.

Getting equipment then was as easy as pie because every 3-5 years a contract would finish and we could go and pick up equipment we needed and they were mostly the same as ours if not better. There was never any shortage of equipment then but here in the in-house service, if we have no money to replace equipment, we have to wait until we do. So many things were easier in the contract jobs. I was more in control and felt a sense of belonging but here in the NHS you are part of a hierarchical system without a say about what goes on (Agent BB)

Contractors know the life of a contract is limited so they have to perform or be out at the end of the contract. When a contractor comes in, it is like a breath of fresh air because a lot of staff that should have retired or got something more suitable to their needs years ago will go. A good contractor will make sure that they only take on NHS staff that are not set in their ways or have become pillars of the establishment you cannot shift, trying to justify spending their days at work finding reasons why they should not be doing what they know that they should be doing. So contractors streamline the staff and work to earn their fees (Agent BB)

In-house service is rather constraining. For example, I have to get my line manager's permission to spend money from my budget. I have to get HR permission to discipline my staff. Even though I am trained to manage budgets and people. If I feel I have a situation, I can follow the rules but I don't need permission to do my work. I cannot even suspend someone for a serious offence if I thought they were seriously out of order and that I could deal with it. You could get your hands chopped off for trying to spend capital on staffing or spend money earmarked for staff. Whereas in a contract job you could move money around as needed as long as you justify it. In-house service is very constraining and constricting (Agent BB).

When I worked as a contract manager, I had the freedom, autonomy and flexibility to deal with my staff according to the procedure books and company policies and everyone knew it was fair because that's what the books say and the network was fantastic so we had no problems. It would be a bit of fresh air to outsource this contract. It will bring in experience from the commercial sector especially in senior management and they will have more accessible rulebooks and policy manuals (SOP) (Agent BB)

Support services are the underdogs of the NHS and every time they needed to cut something to save money or balance their budgets, they cut the service and they may have pruned it so much that now it is very difficult to get it to an adequate level of service again. No one wants to work down here (in the lower basement). We are trying today to get a rapid response team to come and deal with all the repair work because some people are off sick. Support service has always been a basement job and we are still in the basementII (Agent BB).

Tabulated analysis of Charlston Memorial Hospital excerpts are shown in Table 5.7 below

5.3.7.2 Discussion:

According to the respondents, the in-house team won the contract for support services and it has been rolled over ever since. There is no legal reason to outsource services provided it can be shown to give value for money. Although transport was outsourced, the

contractor went into liquidation and the service had to be rebuilt at great cost and brought back in house. Consequently, the services managers developed aversion for outsourcing, which they attribute to the possible risk of contractors failing. Thus in-house service is justified on the grounds of flexibility with making changes without added costs and control over services without the stress and strain of managing contract relationships.

The impact of in-house service is seen as having control over services, ability to contain costs, with the flexibility to meet the changing needs of the trust. But the system is also deemed constraining and constricting with regards to discipline and budget spending.

Table 5.7 (CMH) Data analysis using structuration theory (Giddens, 1984)

Structures	Signification	Domination	Legitimation
Efficiency	-It is working out more economically as in-house -Government agencies help us to save money -We have no shareholder	-Must show value for money -Can get hands chopped off for spending money on staff	Avoid budget deficits and relegation
Management resource	Good, clear, strong management structure is key to flexible working	-Managers upon managers get in the way -Very constraining getting their permission on staff discipline and budgets	Discipline is up the spout
Ideology	-Very large HRD with policies on everything -Ancillary staff flout rules and regulations -I tend not to have views on Government policies	-Must find out what new procedures HR managers has dreamt up overnight -Managers not allowed to discipline staff without HR permission	HR on side of deadwood staff to avoid their exit No sharing of ideas—isolation
Investment	-No money to replace equipment so we wait -Cannot invent a pot of money to make changes	-Refurbishing project lasting forever -We wait till Government comes up with the money	Projects are extensively delayed

Even though there are managers upon managers that get in the way, the emphasis is on cost control and efficiency through frozen posts and reduced staffing levels, prolonged refurbishment that seems to be going on forever, lack of equipment and adequate staff to do the job. Consequently, worker absenteeism is rife, discontent and lack of commitment to efficiency drives reign with managers resulting in budget deficits. Even the Healthcare Commissioners commented on their staff shortage and need for improvement. The lack of fresh external input and their risk aversion mean that there is neither visible change nor innovation. Thus in-house services remain in what Giddens (1984), calls the status quo.

Furthermore, although there is Government funding for staff training and development, the staff are still in the basement physically and mentally within their "psychological contract". There are no fresh ideas from without to bring in changes in perception or make visible ones. Consequently, although the workers are trained, they are not yet liberated from manual to professional workers hence they remain in their "basement jobs".
The main issue here is power for the control of services and staff. This is expressed through flexibility to make changes favourable to the dominant coalition, with others find constraining, the restriction on budget spending and the flouting of discipline by staff.

Power for control and domination has been in bureaucratic organisations since Weber's (1904) theory of economic organisation. Organisations are political entities, where power struggles for control and domination are rife (Clegg, 1981 and 1989; Perrow, 1986).
The power of the Human Resources (HR) managers to control services through policies, procedures, efficiency drives and discipline enables them to dominate budget spending and the rules of engagement, which in turn constrain managers and workers in their daily work. Indeed Clegg (1989:239) regards such organisational power as "irreducible" in sustaining and reproducing to perpetuate the same power. Thus, the formal authority position of HR managers is both the medium and outcome of their interaction with support services managers and their workers (Giddens, 1979; 1984). Because the managers and workers are unable to mobilise countervailing power the outcome is seen as discontent of managers as workers vote with their feet through absenteeism and exit to distance themselves from such oppressive working conditions (Goffman, 1969; Fincham, 1992).

The reliance of the organisation on Government funding and charitable organisations makes them vulnerable with regards to funding and their annual income uncertain (Pfeffer, Salancik and Lebleici, 1976) This vulnerability and uncertainty further enhances the power of the HR managers to tighten the economic belt in the guise of efficiency drive and to restrict budget spending, thus worsening the constraint and discontent produced. Consequently, the support services and the organisation struggle for survival. This is shown in the removal of the chief executive and the relegation of the trust to two stars.

The services managers seem unwilling to share power through relational exchange. Such relationships would dilute their autonomy, question their quest for stability and the ontological security of tenure they take for granted (Giddens, 1984). They have enacted their own environment of control and flexibility to make changes but are mired in budget

deficits and incremental change going on forever (Weick, 1995). But relational exchange can bring in the needed resources of investment funds, skill, fresh ideas and equipment. Consequently there is no external investment (apart from Government funding), no fresh ideas to nurture change and some workers have become "inflexible" to manage. There is also a lack of support (except private ones), which further alienates managers and workers in their daily work. This reinforces the tenets of both the IMP and resource dependent theory (RDT) that those unwilling to manage business relationships and avoid their ugly prisons, retain autonomy, control, stability and familiar routines but may lack access to scarce resource and social support (Ford, 2002; Pfeffer and Salancik, 1978).

On issues of change

Most changes result from human intervention through new technology, shifts in ideology or struggles for the redistribution of power, which act as triggers for change (Greenwood and Hinings, 1996; McNulty and Ferlie, 2004; Pettigrew, 1987). Consequently, change in complex organisations involves power struggles, as change and control seem to be inextricably linked together (Bachmann, 2001; Reed, 1996). Since there is no change agent or trigger in this trust, the managers plod on in their stable, secure environment. They exhibit uniformity of conduct in daily routines and avoid struggles that rock the boat. There is no risk to bear, no alien culture to cope with and no failing contractors to manage thus the services manager remain constrained, workers absent themselves from work and everyone has to muck in to get the job done while the HR managers rule the roost.

The HR managers have the authority positions to impose rules of conduct as seen in budget spending and staff discipline and demand compelling obedience as expressed by Weber in his model of bureaucracy (Freund, 1968; Weber, 1962 and1978). The majority accept the imposed rules and work within them while the rest acquiesce to it but may have different opinions as exemplified here in the outburst of the support services director and the complaints of constraint elicited. Consequently, in closed relationship evidenced here, the managers and workforce enjoy their inalienable rights of tenure without the cost of relating to external others or dealing with interference from anyone. The motivation for their exclusivity can spring from the responsibility of the dormant few to protect the jobs of the majority, convenience, appropriateness or usefulness of in-house operations. Thus in-house service has been allowed to go on despite Government directives to the contrary and the abounding evidence of outsourcing around these support services managers.

5. 3.8 Dickson Memorial Hospital (DMH) 10% outsourced

Dickson memorial hospital is located in a run down area of London with buildings as old as Highgate cemetery and serving a high population of immigrants. The present hospital was formed from a leper colony of 1473, a small pox hospital built in 1848 and two independent neighbouring hospitals added in 1866 and 1877. All three hospitals were amalgamated in 1900 with a total of 2000 beds. However in 1946, the hospital was rebuilt on its present site with a reduced bed capacity of 472. The current bed capacity for all three sites is 575 with a total staff of 2068, 133 of which are ancillary workers (6.4%).

The hospital focuses mainly on blood disorders like sickle cell and thalasaemias and has a thriving women department. Many historic and listed buildings abound in the area. For example, a listed Tudor mansion, reputed to be the home of a king's mistress, Gwynette, is close by as well as other neo-classical listed building in the surrounding hearths and parks. The hospital serves the local communities of about 300,000 residents. It regards itself as a community hospital with limited (10%) outsourcing.

But despite its apparent handicap and location, the services managers here, who act as agents for the trust, seem to have gone further than was the case at Charlston memorial hospital. For example, they have kept to 10% outsourcing but have market tested services to obtain best value for money and have accessed funds for a new hospital building through business relationships with a consortium of banks and contractors.

Dickson Memorial Hospital in-house services—excerpts

Three people were interviewed here—Agents CC, DD and EE and their views were triangulated with those of their workers for accuracy, clarity and consistency.

5.3.8.1 Motives for in-house services

We did actually think about outsourcing but when hotel services was tendered, about five years ago, the in-house team won the contract and since then, they have not revisited outsourcing (Agent EE).

We are an in-house service and we look after the housekeeping needs of the hospital, within housekeeping department we are further divided into three parts, doing domestic, portering and hostess chores (Agent EE).

Our objective is to ensure value for money or best value. If that includes market testing then that is the route the trust will go down but the trust does not necessarily see outsourcing as the best way to get best value. When we market tested for hotel services, five years ago, the in-house team put in a bid and convinced the trust that theirs was a better option. The in-house team, work within the NHS they are not contractors. So the

outsourced elements here are the car parks and the linen services. The contractors provide on-site operational management of the car parks and Sunlight does linen services for us (Agent CC).
The core of our hotel services includes domestic services, catering, portering, security, accommodation and estates. They are all done in-house (Agent CC).

We have not gone down the route of outsourcing but we continually look at the services in terms of cost and quality but we tend to benchmark ourselves against other comparable hospitals, in terms of the work they do and the size of beds they have, using database provided by our estates and facilities (Agent CC).

We tend to be heavily influenced by what is happening in the NHS as opposed to the private sector. We develop working relationships with other NHS agencies in terms of initiatives, objectives and targets and how we achieve those targets and objectives, rather than going out and looking at the private sector hospitals or trying to adopt some of their practices (Agent CC).

Staff training:

We have a local initiative here in the housekeeping department. Our staff are multi-tasked generic workers. Basically they are trained by the trust up to NVQ 1 standards to be able to do both domestic and portering chores. There are also hostesses and facilities services assistants (FSA). The ward managers can use them whichever way they like knowing that they can serve both patient needs and do domestic chores (Agent EE).

The facilities services assistants act as a rapid response team within the hospital. Their responsibility is to respond to specific portering duties like getting patients off and on the ambulances and transporting them to other parts of the hospital. They help the pool of other porters to get the job done. The hostesses help to prepare the meal trolleys and trays and assist in serving the meals to the patients. They play an integral part on patients' meal services by advising them on what is available and how to access things (Agent EE)

Here in estates department we don't have an army of fitters, plumbers and builders. What we have is a small core of individuals able to respond to emergency calls. But if say an office needs lighting, we would use contractors to buy in what we need as opposed to using the emergency team (Agent CC)

There used to be three of us (catering managers) but since one left, both of us now share the work. I am supposed to work part-time but we share alternate weekends so she can get time off. She cannot work seven days a week (Agent DD).

When we are short staffed, which is often, I call the agency and they send me staff. Then I train them. I have to teach them everything about food and personal hygiene. Now we have eight staff members (five staff and three from the agency). The agency people don't stay long because of all the work they have to do.
In the kitchen we have eight cooks, two from the agency but they stay two weeks and they go (Agent DD).

Staff incentive:

No we don't have staff of the month or things like that. If a staff works well, I just thank them that's all. No prizes and nothing else, no appreciation we are all worker/managers, and we work. But the workers are very helpful. If I want something done they just do it, nothing is hard for them to do for me (Agent DD)

Investment through the PFI

I think it is basically access to capital. We in the NHS don't have the funds to construct buildings so we have to go out and seek partners to help us but it is purely a financial partnership (Agent CC).

The Government was not prepared to fund the building so there was no other option, since we did not have the funds. The money has to come from somewhere and if the Government provided it, it would potentially mean an increase in taxes. That is why the Government set up the PFI scheme (Agent CC).

We are using the PFI for the new extension to the hospital. It is very good although the building is extensively delayed and late but when it does come on it will be good for us (Agent EE).

Our contractors, Burgess, will build and maintain but not manage the new building for the duration of about thirty years. They have to guarantee the building when they hand it over to us so they keep a tight rein on the upkeep throughout the period when they have control of it. But in the mean time as we use the building to transport patients, if we damage anything in any way, we will get a bill for it (Agent CC).

We serve cook-chill because we don't have proper kitchens to cook for the patients only for staff. We have vending machines here for drinks and technicians come to fill them up and collect the money (Agent DD)
All the staff get 10% discount on meals but catering staff they pay for food. No one eats free (Agent DD)

Relationships and communication

We have a strong working relationship with all our contractors. Crown Foods, supplies our cook-chill meals. There is flexibility within the contracts and we meet regularly to discuss and settle issues (Agent CC)

We visit Crown Foods' sites and do regular food tasting there. We also monitor them through patients' questionnaires. Crown Foods' people also do their own monitoring when they visit monthly. We tend to pool data from both our visits and patients surveys to monitor our contractors. We are satisfied with their services and regard them as stakeholders (Agent CC).

We will have an operational working relationship with the staff of Burgess, when they complete the new building. Because it is bolted onto an old building, the contractors will maintain but not manage it (Agent CC)

We have about ten suppliers for the catering. They supply different things. The store (Procurement) manager checks them as PASA approved, to make sure they are safe (Agent DD)

There are no hospitals we share things with. We just cook for the restaurant that's all (Agent DD)

Innovation:

No we have not cooked anything new this year but the new menu will be out soon then we will know if there are changes to the menu. We cook according to menu, nothing special and no one complains (Agent DD)

The impact of hotel services:

In a nutshell we basically contribute to the continued comfort and well-being of the patients in their journey through the hospital, starting from when they come in to when they leave. Our department impacts on the patients' journey, transporting them to wards and clinics and helping with the services they receive in terms of comfort, cleanliness and dietary needs while they are here. We work towards the Government's directives, like every other hospital, on health plans. So our impact is on the environmental influence we have as part of the NHS Plan on the patients' experience on the stages of their journey through the hospital (Agent EE)

We basically help to keep the hospital environment clean. Cleaning is one of the main things on the patients' views of the National Health Plan that all hospitals must adhere to. When the new building comes on stream, we will be doing the day-to-day cleaning. The contractors will be in charge of maintaining it but we will manage and help to keep it clean as part of the hospital environment (Agent EE).

At the moment the ward managers manage the domestics who work on their wards. They are flexible in the duties they perform for the wards, doing both domestic and other duties, to help out on the wards and improve the patients' experience through the hospital. But hotel services, as a whole is moving on. I think that the boundaries between clinical and hotel services will reduce. As time goes on we will see more authority and autonomy devolved to them (as professionals in hotel and clinical services) (Agent CC).

Last year we had three stars but this year, we are down to two stars because we did not meet some of the national criteria, which includes cleaning, housekeeping and patients' views of their experience through the hospitals (Agent EE).

5.3.8.2 Discussion

This trust managers said that they thought about outsourcing support services but the in-house team won the initial contract tendered and it has been rolled over ever since. Again there is no obligation to outsource services as long as the services managers can show that they give value for money in the use of human and material resources. The services managers claim that they do not see outsourcing as the route to that. However the main emphasis here is on control over services and flexibility of staff as generic workers to meet the changing needs of patients in their journey through the hospital. There is a reaching out for financial partnership through the PFI for contractors to construct a new building since the Government was not going to fund it and they did not have the funds. The managers also use market exchange to buy in resources needed for maintenance work. Consequently, these services managers have limited partnership with the PFI

contractors while using market exchange, where they control the goods and services purchased at prices they are willing to pay, for services they are unable to provide in-house. Thus, the services managers at this trust economise to minimize total transaction costs by internalising operations when transaction costs are high and using market exchange to purchase resources when production cost is high (Williamson, 1975, 1996).

They also enact their own stable environment by doing most of their business in-house without external interference, distraction or competition (Weick 1995; Czarniawska, 1992). They enjoy autonomy of control and stability with familiar routines and independence from external others and so avoid the risk of managing contract relationships. Thus they realise their expectation of in-house services and avoid the needless disruption and complexity of change. Inter-dependent and collaborative conditions of relational exchange are shunned and avoided. Consequently there are no power struggles and no meaningful change seen (except the new building, with extensively delayed completion date).

In-house services conserve jobs for the workers. From Government funding, workers are trained to generic workers but are under the control and dictates of ward manager to use them as seen fit. The expansion of work through generic duties results in overwork as seen in the worker/managers who man the tills, do the chore and manage others in the same shift. Consequently, staff members remain overworked and constrained manual workers, most of who do not stay long. There is no evidence of their professionalism, motivational incentives or liberation from "manual chores". Thus, these in-house services workers retain their jobs and privileges of tenure but are not liberated from manual labour.

The lack of input form external sources means that there is no investment and projects are extensively delayed, there is no exchange or sharing of ideas, no learning and no innovation and the bureaucratic culture of blame and risk avoidance seen in complex organisations remains. Consequently, the managers are content to work in their enacted, stable and predictable environment, giving value for money, where they attempt to achieve maximum efficiency or value for money with minimum resources as seen in the use of agency staff and generic workers. They too have been relegated to two stars.

Table 5.8 **Summary of key motives for outsourcing in 10% outsourced NHS trusts**

NHS trust	Motives for outsourcing	Themes elicited	Theories in use
Charlston Memorial Hospital	-Flexibility to control services and costs -Ability to make changes without added costs	Legitimate control Value for money Relationship (with charitable organisations)	Bureaucratic control TCE (search for efficiency) IM (relationships)
Dickson Memorial Hospital	-Inertia (outsourcing not revisited or seen as route to value for money	Legitimate control Limited relationship Value for money Investments (PFI)	Bureaucratic control IM (relationship) TCE (search for efficiency with market mechanism)

5.3.9 Research Question:

How do the key people involved in the hotel services outsourcing relationships structure their experiences?

Having analysed the motives for services outsourcing from the excerpts of those directly involved in outsourcing relationships and elicited the relevant themes from the eight NHS trusts investigated, how does this analysis answer the research question posed?

5.3.10 Research question answered

From the foregoing analysis, these key people involved in outsourcing relationships and in-house services structure their experiences in terms of their context of operation, locales or the NHS trusts where they work and the content of their daily work. The content of their work encompasses jobs, work situations and working conditions they find themselves in. These structures reflect the significance, essence, meaning or importance they attach to their daily interaction with contractors, stakeholders and others. Some structures feature as satisfaction, fulfilment or lack of contentment from working relationships that depict a sense of belonging, constraint or alienation.

For example, the respondents framed their responses with reference to their locales or hospital trust (context) as in these excerpts:

We believe that contract services provide the trust with value for money (Agent B)

In this trust, you have trained staff (Agent A)

This is what a hospital should look like—clean, airy, roomy and with privacy for patients (Agent C)

We are an aggressive team of professionals, here to save this NHS trust money (Agent G)

Others framed their responses and experiences in terms of the significance, essence, meaning, benefits or importance they attach to the content of their work. From these responses themes such as relationships and reputation are elicited. For example:

Relationships

Good teamwork is all about relationships and how you work well with people not discipline (Agent I)

We network with other NHS trusts to learn best practice and know what others are actually doing and to know who is who in purchasing (Agent F)

We use PASA approved suppliers to ensure that our products are of the highest quality (Agent A)

We have good relationship with all our contractors. It is important that we maintain good relations with them because we depend on them for services to continue (Agent K)

Reputation:

Before we became Areno, we were associated with reputable hotel chains that everyone knows and recognises, everywhere, massive reputation. We are in all the countries around the world. We would not supply services to clients who have been in the news in the past two years. Money is not everything, our reputation is more important (Agents F and M)

Other themes framed are efficiency (as value for money or relief from distractions allowing them to focus on core functions), investments, staff training, innovation, learning, power and control, externalities, trust, commitment and loyalty or ownership of duty, community care for local relevance or legitimacy and staff retention. These themes are discussed, compared and contrasted below with reference to the context of the respondents.

A third group of respondents structure their experience by comparing their periods in the NHS with their lived experiences in commercial contract jobs. For example some said:

The contractors train the ancillary staff workers better. The NHS did not train ancillary staff because they were regarded as the bottom of the pile and there was no point in training them (Agent E)

When I worked as a contract manager, I was in control, managing staff and supervisors. I felt a sense of belonging but in this in-house service there are managers upon managers that get in the way (Agent BB)

Assured makes investments here but in the NHS, there was no equipment and we were always waiting for things to come and sometimes they never came because they said they were short of money (Agent X)

A fourth group relate their experiences to a longing for a better future, anticipating the freedom to operate as a business making legally binding agreements. For example:

We will never be autonomous. There will always be an aspect of Government in the shadows telling us what we should be doing but with foundation status, we can go out and borrow double the money that Government can give us. We will be able to see healthcare as a business and run it successfully (Agent I).

Foundation status would raise our financial freedom to be able to look at different ways of doing things on a better financial footing and get a bit more independence from the Strategic Health Commissioners (Agent R)

Others structure their experience in terms of personal achievement or in terms of future expectations. For example:

I used to be a cleaner but Premier trained me in night school and now I manage other cleaners (Agent T)

We look to the soft FM contractors for innovation in food and services (Agent R)

As a result of their varied experiences, different history of their locales of operation and the varied lengths of their tenure, there is a multiplicity and duplication of structures grouped as themes for ease of discussing their differences, commonalities and contradictions. In sum the themes elicited arose from context of operation or locales, content of working relationships and interactions, comparison between private and public sector jobs, a longing for a better future freed from constraints and liberated from domination, personal achievement since outsourcing or future expectations.

The discussion now turns to comparing and contrasting themes in their contradictions. A comparative analysis of the motives for outsourcing with outcomes for each of the eight categories investigated is presented in (Table 5.10). The combined analysis of elicited themes is tabulated in (Tables 16a-16c) at the end of the chapter.

5.3.11 Comparative discussion on motives for outsourcing

The comparative motives for outsourcing elicited were diverse and varied ranging from the flexibility to control costs, show value for money as in-house or outsourced operations through to the need to focus on healthcare, outsourcing burdensome non-core functions. The need for a continuous, reliable, uninterrupted guaranteed services and ancillary staff recruitment and retention were also major motives for outsourcing support services. Thus these motives for outsourcings are the needs services providers must meet to earn their contract price (Ford, 2002:55). Some observers note that services outsourcing is essentially contracting for results be they reliable, continuous and uninterrupted service, a more efficient way of cost containment or indeed value for money spent (Cross, 1995; Fill and Visser, 2000; Peisch, 1995:32). Hence where the opportunity or means for obtaining such results are lacking internally, organisations will outsource to access resources they need. From (Table 5.10 below), all the support services managers perceived that their NHS trusts achieved their outsourcing objectives and more. This confirms the essence of

Table 5.10 Combined comparative motives for services outsourcing with outcomes

NHS Trust	Motives for Outsourcing	Outsourcing outcomes through agency
Theresa Hospital 100%	To concentrate all services on one site (ultimately)	-Now operates as a business on one site, using services contractor investments -Enabled to make legally binding agreements -Patients' choice in food and services is enhanced -Ancillary workers liberated into new facilities
Helina Hospital 100%	Lack of managerial skill expertise and experience	-Contractors advice managers on matters of commercial interest such as current PFI plans -Help facilities manager gain value for money
Karena Hospital 75%	Ancillary personnel recruitment and retention problems	-Achieved aim of outsourcing and raises funds from innovative new canteen and café. -Contractor's ideas and investments help support services managers achieve their goals. -Professionalism of ancillary staff has improved the image and status of support services
Victoria And County Hospitals 75%	To a gain reliable un-interrupted support services, guaranteed	-Achieved aim plus gets funds from innovative new cafés. Contractor investments and staff training are perceived as value for money -Ancillary staff liberated into professionals and managers into new facilities they own and manage
Featherstone Hospital 50%	Relieve a troublesome non-core function to concentrate on healthcare	-Able to concentrate on healthcare -Enhanced patients choices in food and services -Innovation in cleaning and new floors to relieve aching feet. Legitimacy enhanced -Freed from special interest groups
Reinhard Hospital 50%	Ancillary staff recruitment and retention problems	-Achieved outsourcing aim with innovation in food and services –Contractor investments make better dinning facility possible for staff, patients and guests. -Liberation of manual workers to professionals
Charlston Memorial 10%	-Need to retain control of service quality and costs -To make changes without added costs	-Previous unsuccessful outsourcing, now cautious -Fear of losing control and having to rebuild services from scratch hence risk averse -Capital projects (refurbishments) are delayed
Dickson Memorial 10%	Inertia (outsourcing not seen as route to achieve value for money)	-Initially in-house team won contract, since then outsourcing not re-visited. Only needs to show value for money in support services -Limited relationship as (access to building funds) -Capital projects are extensively delayed

services outsourcing as contracting for results. The findings also reinforce the central premise of the resource-based theories that organisations lacking in resources can access them from the external environment (outsourcing) to meet their internal needs or build capabilities for competitive advantage (Helfat and Peteraf, 2003; Teece et al., 1997).

Support services outsourcing, was perceived by some respondents, as a clean up exercise of previous cost cutting measures and lack of investment in non-core functions like ancillary services. For example agents said:

> You have to recognise what your core business is. Our core business is healthcare, not cooking, catering, cleaning or building. So there is a balance as to what resources are put into non-core business (Agent R)

> The NHS did not invest money in support services, instead money was taken away to run other more important services so now that they need cleaners to keep hospitals clean and proper meals for patients, the support services have come to the aid of the hospitals (Agent E)

> Support services were the underdogs of the NHS and any time they needed to cut something to save money or balance their budget, they cut the services and they may have pruned it so much that it is now difficult to get it back to an adequate level of service. Now all of us in the Greater London area are cleaning up problems we created for ourselves (Agent BB)

> In the past 10-15 years, money was taken from domestic, catering and portering services. The hospitals had to balance their budgets and they took money from support services which maybe because they had "grown too fat" and needed to be toned down a little bit but I think that they went much too far. Also the buildings were not refurbished as often as was needed. There was no preventive maintenance years ago that should have stopped the rot. Things are better now but much damage was done to the services and now we must live with it (Agent BB)

These statements confirm the argument in the literature that the NHS is trying to "undo twenty years of downward pressure on facilities budget" by accessing vendor investments to complement in-house resources (Moore, 2007). On the other hand, observers note the unprecedented investments the Government has made in recent times to counteract the effects of this under-funding (Carlisle, 2007; Eaton, 2007; Kaletsky, 2008; Watson, 2006).

Some agents acknowledged the vital role of support services in supporting the core function of hospitals—healthcare with its liberating effect on some managers and workers.

> These contractors have invested a lot of money in equipment and personnel here. Support services must continue or the hospitals will grind to a halt (Agent K)

The contractors have also managed to let the public know how important the support services are. Hospitals are usually thought of as doctors and nurses, but without the support services, hospitals could not function. The support services are critical to this trust (Agent I)

This is more investment than I have seen in the thirty years I have been here. At least we have come up from that hole in the ground called an office. I was there for thirty years (Agent K)

These statements reinforce the observations made by others that support services and their staff are key players in professional settings, enabling others to focus on their specialities, where their skills and knowledge add value (Moore, 2007; Sveiby, 1997). Thus this study builds on to complement previous work in support services outsourcing and the resource-based theories but with a focus on its liberating effects on workers.

However the central motive of whether to outsource services or retain them in-house stems from what Freund (1968) calls the dialectics of appropriation based on monopoly or competition, which others call the "paradox of consequences" (Dunne, 2006; Greenwood, 2002). Managers are inundated and confronted daily with a plurality of conflicting goals, values and choices. They have a duty of care to workers, consideration for the dominant coalition and personal views from lived experiences, custom, knowledge and training. Consequently managers prioritise daily choices against conflicting views like monopoly power to control resources (in-house) against relational power sharing (partnership) for competitive advantage (outsourcing).

Some choose between contracts that deal with future rights and responsibilities, conduct and expectation (Freund, 1968) against authority rule of compelling conformity for control and domination and the punishment of disobedience (Weber, 1962 and 1978). Thus the choice to outsource services is neither simple nor easy but depends on balancing control with collaboration, interdependence with monopoly, closed versus open relationships, voluntary union of self interest versus relationships of mutual benefit. These choices are based on expediency, past experience, convenience, appropriateness, usefulness, cost versus benefits, meaning, suitability to needs against the dictates of the dominant coalition and the courage of decision makers. Thus the expressed motives recorded here are the culmination of all that went before to make the choices for either decision.

The analysis now turns to unravel the consequences of services outsourcing grouped as themes.

5.4. Efficiency theme

5.4.1 Introduction

All the managers investigated in the eight NHS trusts expressed the need to show value for money, control total costs or what I collectively interpret as efficiency (Table 5.11 below). For example:

Many years ago, outsourcing was mainly for cost control but now it is best value for money or best provider.
Cost control now is imperative in outsourced services. We (contractors) give value for money (Agent A)
When we tendered the service, we looked at costs and expertise (Agent F)
We are here to save them money and that is the bottom line (Agent G)
We outsourced for two reasons—cost savings and better ancillary staff retention (Agent I)
We outsourced services to save money, managing people is costly, I know (Agent K)
We save them lots of money. Employing one contractor with the knowledge of all the experts within one massive organisation is more economical for them. They save on consulting fees, tendering fees, raw material, food and labour costs. There is a lot of savings (Agent O).

From the in-house operators, the managers said:

In-house service is working out more economically for us because contractors have to cut costs to increase their profits but we have no shareholders to pay dividends (Agent AA)
With in-house services, we can contain costs and have the flexibility to make changes without added costs (Agent Z)
The objective of in-house service is to ensure value for money (Agent CC)

From these excerpts, a common theme was cost savings or value for money either through managing people, employing a single contractor with all the expertise in one massive organisation to use scale economies to contain costs or aggressive cost cutting to benefit the bottom line. However these observations contradict the argument of some critiques of services outsourcing "as purely an obsession with market driven policies" since the expected cost savings has not materialised. Cost saving is regarded as the purpose for services outsourcing while value for money reflects the level of risk transferred to vendors and the resultant consistency achieved in service provision (Rodney and Gallimore, 2002; Moore, 2007). Respondents' statements agree with the literature on services outsourcing, where hidden costs and the inability to properly measure costs make it difficult to realise cost savings. Value for money reflects hidden rewards like freedom from distraction to focus on core activity or relief from personnel issues that compensate for disappointment. The in-house operators also achieved their expected control over services and the flexibility to make changes to services without added costs. For them the containment of fear of loss of control and having to rebuild services was evidence of value for money.

Furthermore, there is bundling through services outsourcing. Bundling is regarded as procuring within one service contract, those services that would have been tendered separately (Rodney and Gallimore, 2002:53). The purpose of bundling is to increase the use of scale economies to encourage innovation and make services outsourcing attractive to a diversity of vendors. Thus through services outsourcing some NHS trusts can use one massive organisation to tender for many services allowing them to pay one contract price and so save costs, manage budgets and encourage innovation in food and services. For example, some trusts capped all their services and transferred all risks to the contractors while some combined real estate management with hotel services in one contract price.

The theme of efficiency (cost saving) or what Williamson (1975, 1996) calls economising is central to transaction cost economics (TCE). Support services were outsourced because internal production was deemed costly, inefficient and ineffective (Boyne, 2002), resulting in huge deficits (Dobson, 2006). The health service has tried market mechanism and found it unworkable hence the present hybrid structure of contract relationship. The theme of efficiency and the resultant provider specific investments to mitigate possible opportunistic self-interest are in keeping with the economising tenet of transaction cost economics. Consequently outsourcing and in-house operations aim to economise on transaction costs through different routes. But the findings of this study go beyond the purpose of TCE to add value through more risk transfers to vendors or bundling as in total outsourcing. This contradicts the critiques of TCE that it is only focused on economising while neglecting the value adding aspects of transaction (Hunt and Morgan, 1996; Zajac and Olsen, 1993). Thus through economising on transaction costs and adding value to services offerings the findings of this small study adds weight to both sides of the TCE debate.

5.4.2 Examples of commonalities

Efficiency theme could be inferred as common to all the trusts studied. All the services managers in the outsourced concerns reported that all their ancillary workers were sold by their trusts to the contractors to save money. Furthermore, their pensions and allowances were frozen since they could not be transferred but they hope for compensation from the Government for their losses. They also said their trusts save money by not employing accountants to pay ancillary staff wages, pensions, allowances and benefits.
All the trusts reported networking with Government agencies, PASA, or NHS Logistics to save money. These issues were common in all the outsourced services. For example:

PASA provides us with basic templates for national contracts. They help to streamline our tendering process because they have expertise in contract management. They are valuable in saving us money (Agents F, Z).

The trust now has more freedom to save money. There are no accountants to employ to pay the wages of 400 ancillary staff. No worries about personnel matters or staff disciplinary measures (Agent A)

We network with agencies like PASA, they save us lots of money (Agents A, F, K, Z, CC).
We retain Government agencies like PASA and the suppliers they approve because they save us money (Agents A, B) and because they are more competitive (Agent F).

Outsourcing provides us with economies of scale. Being a small firm it is best to become part of a bigger concern. We also gain by not having to train ancillary staff, manage them or pay for them to keep up with knowledge and technology (Agent R)
Having all our services provided in one place (by contractors) is much cheaper than transferring patients around eight hospitals on a daily basis (Agents C, D).
There is a marked price difference with the contractors, we know (Agents I, K).

5.4.3. Different routes to efficiency gains

Although all the managers were at pains to stress that their in-house or outsourced services were value for money, their routes chosen to attain it differed. For example:

For the in-house concerns

With in-house services, we are able to contain costs and have the flexibility to make changes without added costs (Agent Z)
The objective of in-house service is to ensure value for money. The trust does not see outsourcing as the best way to get value for money (Agent CC)

But from the outsourced services came these comments:

Outsourcing provides us with economies of scale. We also outsource our own services to generate revenue to offset our costs. Our waste disposal is also outsourced to save on costs and do it in an environmentally friendly way. We also burn waste for energy so there is efficiency all round (Agent R)

We undoubtedly save them on labour and food costs. They don't have to worry about personnel issues, and don't have to source anything for us we exceed their expectation (Agent M)

We outsourced services for economic and operational advantages. Companies are in the business of making money but firms also have to be as effective as they can with a long-term view to serve the needs of their customers through better tendering and world-wide contacts of knowing who is who in purchasing and dialogue with others to learn best practice that we can apply here to get value for money (Agent F).

From the foregoing the two in-house concerns in support services seem to concentrate on productivity or cost saving. As agents for hotel services in their trusts, they seek best value for the money spent by using less workers to do the job while "everyone mucks in to get it done" (agent BB) or "supplement the workforce with temporary staff" (agents BB and DD).

But in the other six outsourced services the contractors are perceived (Agents I, M, V and X), to have added value to their clients' offering through better customer service, revenue generation to offset costs and more areas for cost savings like cheaper raw material from an international network of relationships (agents A, F, M, S and X), contractor scale economies and applied best practice (agents F and G) to become more effective. Thus these six outsourced support services managers seem more effective and efficient judging by the bundle of benefits they perceive to have gained through outsourcing. The services contractors are said to exceed their clients' expectations (agents I, K, M and X).
And the clients were satisfied with their services as shown by these excerpts:

They would not have renewed our contracts if they were not satisfied with our services (Agent H and L)
We transferred a lot of risk to them and they procure all our services within one contract price. They come up with ideas to help us achieve our goals and objectives and we are satisfied with them (Agents I and K)

While in-house operations can minimize total transaction costs through efficient system of reward and punishment that mitigate employee opportunism, they also save outsourcing costs of searching, negotiating, coordinating, monitoring and delivering hotel services. But outsourced services benefit from intangible rewards like savings in time, effort and risk bearing, increased focus on core competence (agent R), contractor relationships and innovation (agents F, G, I, M and X) as valuable resources. These benefits suggest that outsourcing is more meaningful and effective than efficiency considerations alone. Thus operational efficiency means different things to different managers as shown by different language in use from value for money or best provider to operational advantages.

In-house operations also conserve managerial jobs that will otherwise be lost to services providers. It allows supplies department and other departmental managers to exchange reciprocity for distorting procurement decisions in favour of internal supply. What is more in-house operations promote convergent expectations, easier to manage through existing hierarchical control that attenuates the uncertainty of interdependent parties with private motives, agendas and different ways of operating (Williamson, 1975). Consequently, the in-house operators, insulate their sunk costs in facilities, processes and programs against

displacement and enjoy the flexibility of making changes to suit internal operations without added costs or interference from external others. Support services managers keep their jobs and focus on controlling total costs. Thus, for these reasons some support services may choose to keep their hotel services in-house rather than outsource them. Hence in their pursuit of efficiency gains or cost savings there can be hidden benefits for both the in-house and outsourced concerns to balance non-attainment of cost saving or non-trying.

The six outsourced services benefit through contractor scale economies and paying one fixed price despite seasonal variations (agents R, E, I, M, O, S, and X). Furthermore, the relationship of facilities managers with commercial contractors has enabled some gain advice or insight into disposing many properties on prime sites that were previously left to weeds and squirrels. For example, Theresa hospital, disposed of its property in Edgware road that previously housed few elderly psychiatric patients raising funds to augment its bank balance in preparation for foundation status. Without the aid or central management of their contractor, those patients will still be there rather than at Chertsey and there will be no new flats built on that site. Consequently, some NHS trusts have become adept at disposing dormant functions to raise funds and reduce their total costs (Jennings, 2002).

Some support services managers benefit from outsourcing troublesome functions like hotel services where they acknowledge lack of expertise in cooking, cleaning and feeding patients (agents N and R) and so avoid frequent disruptive industrial actions by ancillary workers due to low wages or bad working conditions (Shifrin, 2005; Smith, 2002). Thus, some teaching hospitals can now focus on their core activities and research to gain competitive edge in medical expertise, create value for their patients and so become more efficient while contractors provide support services where they are specialists. Consequently while in-house services managers operate in a more stable and predictable services environment (agents Y, Z, AA and CC) the outsourced managers achieve varied benefits (agents C, D, E, I, J, N, R and W) irrespective of efficiency gains or cost savings.

Examples of contradictions (as opposed to differences)

Although the in-house operators perceived the attainment of value for money in their operation (agents Z, AA and CC), some of their managers felt constrained, not in control of their departments, alienated and frustrated (agent BB and DD). They did not have enough staff to do the work because they were "not allowed to spend money on permanent staff and could not invent a pot of money to do things" to help their meagre staffing levels

(Agent BB). Furthermore there was human misery of unemployment, stress related problems and retrenchment due to constant workforce streamlining to reduce costs. Observers call these inherent contradictions the "paradox of consequences" (Dunne, 2006; Greenwood, 2002; Sherwell, 2005; White, 2002), where efficiency gains that should make departments like support services more stable and smooth running leads to human misery. For example: The facilities manager at Dickson memorial claim to liase with Heathrow airport to learn how they operate and that his department was running smoothly, managers could engage staff to help them do the work. But these claims were not evident at this hospital as shown by the comments of agent DD, who was recalled from retirement to manage, serve at tables and man the tills because there was not enough staff to do the job properly. She could count and name all her eight staff members on her fingers! They had to cater for the whole hospital serving 800 meals per day. For example one agent said:

The objective of in-house service is to ensure value for money. The trust does not see outsourcing as the best way to get value for money (Agent CC)

We have an opportunity to work with the private sector. We have been to Heathrow airport to look at their cleaning regime and catering since airports are like hospitals working to provide services 24/7. We went to similar establishments to see what they are doing and if there are any lessons to be leant (Agent CC)

In contradiction to this assertion, the catering manager, said:

We don't have proper kitchens to cook for the patients. They all eat cookchill meals and nobody complains. Two of us are like work managers. Sometimes we get agency staff but they don't stay long (Agent DD).

On the issue of staff incentives she said

You must be joking, when we get good staff and they work hard, we just thank them that's all. The staff members here pay for their meals just like anybody else. No appreciation, that's what I say (Agent DD)

At the other in-house service, the Director of services said:

With in-house services, we are able to contain costs and have the flexibility to make changes without added costs (Agent Z)

But Agent BB from the same hospital said:

When I worked as a contract manager, I was the manager in that remit, not answerable to anyone. I managed all the staff, managers and supervisors (in complete control). But here (in-house service) we have managers upon managers and they do get in the way. There is no sense of belonging as in the contract job.

There was never any shortage of equipment then because when one contract ended we shared the equipment and they always fitted in with ours because it was the same contractor. Here if we have no money

to replace equipment we have to wait. We cannot invent a pot of money to do things so we wait sometimes for ever for repairs. In the contract job I felt more in control and had more say in my department but not so here. You can get your hands chopped off for spending money from your own budget without permission from your line manager. It is very constraining (agent BB)

The issue of overwork and lack of investment are evident as agent BB commented that: "they could get their hands chopped off for spending money on staff". This contradicts the views of their bosses with respect to their departments being more economical and running more smoothly, perhaps at the expense of their workers.

However, "as long as you can show that the trust is giving value for money for services", the discretionary allowance will be paid and the star-rating helps to increase the amount gained (agents B, E, F, G, M, BB and CC). Consequently, many services managers use the mantra of "value for money or best value" to anchor consensus for action, explain the paradox of their situation or non-attainment of the elusive efficiency gains expected. Another contradiction was the assertion by in-house managers (agents Z and AA) that their department was running smoothly and more economically. My observation was that the departments were chaotic, un-kept and workers overworked even by NHS standards.

Furthermore agent BB, with commercial experience, longed for the contractors to come to her department (perhaps through outsourcing) and bring in "a breath of fresh air" by streamlining the "deadwood" staff who mill about doing nothing and get paid for doing so. Perhaps she echoed the joy of agent E who had the contractors do just that in her department hence advised support services managers to spend time with private concerns "to open their eyes" (gain broader based experience) on managing services. For example:

It is far more difficult to change things when it has always been in-house but if we are dragged through the change once, it is less difficult next time. When a contractor comes in it is like a breath of fresh air because a lot of the staff that should have retired or got something more suitable for their needs years ago will go. A good contractor will make sure they take on only the good staff from the NHS and get rid of all the "deadwood" staff. Working for contractors, staff are more flexible and much more manageable (Agent BB)

Another outsourced concern manager confirmed that:

Things are done more professionally than before. The staff realise that you cannot have people hanging around doing nothing while you pay them for it. Contract work is very useful experience. A lot of people working in the NHS should also go and work in the commercial sector to help open their eyes (Agent E)

Thus a contradiction exists where experienced managers are recruited from the private sector into in-house concerns constraining and frustrating them by not allowing them to use their knowledge, management skills and experience to benefit their departments.

It was interesting to note that agent AA asserted that contractors are able to cut costs to increase their profits yet in her department, with six commercially trained managers but working in an in-house concern, they could not overtly reduce costs to benefit the department or engage more staff to reduce the stress of other workers. Perhaps they did and had the funds invested else where to their detriment (subject of another study)!

5.4.4 Explaining the contradictions

Structuration theory (Giddens, 1973; 1979:193) identifies three main areas for these contradictions. Firstly where sectional interest is represented as the universal one as in maintaining in-house services or attaining legitimacy through representing dominant interest, seen here as the need for flexibility to control service level and make changes without added costs. Perhaps this is a case of in-house operations and their departmental managers and directors, distorting procurement decisions in favour of internal supply either to preserve their jobs or as reciprocal favour for other career advancement or both. Furthermore in-house operators can always move funds around to insulate their sunk costs and protect their departments and pet projects from displacement and interference from external others. Thus managers keep their jobs and the status quo reigns.

Secondly, maintaining resource asymmetry for the purpose of control and domination. Here the departmental managers have no power to spend their budget or employ permanent staff without approval from their dominant line bosses that control both the financial and human resources. As stated above if funds are already earmarked to insulate sunk costs, it is not available for departmental managers to spend on staff or equipment. Financial control is a source of power for domination. Human nature enjoys being powerful and in control hence those who control resources, tangible and intangible can bask in their privileged positions and ensure that others are dependent on them!

Table 5.11. Analysis of Efficiency theme using Structuration theory (Giddens, 1984)

Theme	Agent's code	Knowledge base	Communication
Signification	A	Specialisation (division of labour)	-They (clients) concentrate on healthcare while we provide them with support services
	S, X, E, K		-Its not good for medical people messing with food -Things are done more professionally, you no longer have people milling around while you pay them for it
	A F, M, K,O,S, X, I,	Cost control (to aid planning)	-They pay one fixed contract price and if prices fluctuate, we (providers) bite the bullet
	F	Value for money	-We looked at price and expertise to provide the trust with value for money
	F		-We outsource services for economic advantage
	E, M, B		-We provide better quality service at competitive prices, not the cheapest but value for money (as perceived by the client)
	C, D	Cost savings	-It cost our transport department a fortune to keep transferring patients and staff from one location to another, now we all work on this one site
	A, M, M, L,		-We save them labour, food and raw material costs -We save them cost of re-tendering and contract renewal. We source everything ourselves
	A, O, M		-Client engages one contractor with knowledge of all the experts in one massive organisation
	I, K		-There are cost savings, we procure all services at one set price, Price has marked difference – we know
	K, E	Standard	-Managing people is costly, huge load off my back
	A, S	Operating	-Trust is running better and more efficiently
	Z, AA	Procedures	-It is working out more economically for us
	AA	(SOP)	-Private firms tend to reduce costs to increase profit
	R		-We generate revenue from our own outsourcing and outsource to benefit from economies of scale
	A, L, M, O, I	Tacit Commercial	-Contractors generate revenue for the trust through vending, canteens and non-variation of PFI prices
	F, G, M	know-how	-The trust benefits from our network of contacts
Domination	G	Dominant commercial know-how	-They engaged us to be more commercially aggressive than say in-house teams. We are here to save them money, that's the bottom line
	A		-Clients demand that providers provide services at a higher standard now but we will still be in charge
	A, M	Multinationals	-We (providers) have financial backing from banks and building societies. We're a massive organisation
	M, O, S, G, M,		-NHS cannot provide services due to huge deficits
	Z, CC, BB	Dependence on allocations	-We have to show value for money in resource use
Legitimation	Z, CC	Rights and	-Avoid deficit sanctions, collect budget allocations
	I, J, R	Obligations,	-We balance funds providers generate against costs
	A, E, M	SLA	-We meet and exceed our Service Level Agreement (hence retain or renew contracts)

Key to Table 5. 12:

Signification: Language in use, important codes, verbal themes or games respondents play

Domination: mobilisation of resources for administrative or economic decisions or the ability to control resources

Legitimation: actualisation of rights or enactment of obligations. Deep structures may not be overt as topics or themes but can be inferred

Thirdly, where contradiction in terms are denied by dominant groups, like bosses on issues of cost containment and efficiency but with inadequate staffing and lack of equipment to do the job properly. It is the culture of the NHS and perhaps large complex organisations to deny all or refer to a higher authority to gain time and lose issues or complaints in endless hierarchical referrals. Thus, contradictions favour dominant groups who control resources, have networks of people in authority and access to information and generally have a voice or a platform from which to present their interests as the universal or official ones.

In sum all the managers investigated sought efficiency gains but through different routes. While in-house operators economised on resources like staffing and equipment, and used efficient system of reward and punishment that militate against employee opportunism to save costs, outsourced concerns benefited from other rewards of outsourcing like focus on core activity, innovation and learning to compensate for the elusive costs savings. Thus the tenets of transaction cost economics are upheld and this thesis contributes to both sides of its debate. The findings here suggest that hotel services outsourcing goes beyond the purpose of TCE (economising on transaction costs) to add value to services offering.

5.5 Relationship theme

5.5.1 Introduction

Business relationships are valuable bridges and buffers to the external environment (Ford, 2003, Möller and Wilson, 1995). They are bridges to access the resources organisations need for building capabilities (Das and Teng, 2000; Gadde and Snehota, 2000; Tsang, 2000) for competitive advantage (Powell, 2001; Prahalad and Hamel, 1990). These may be skilled managerial experiences, funds and personnel or expertise in services provision as in outsourcing (Cross, 1995; Davis, 2004; Jennings, 2002). Business relationships also act as buffers to protect organisations from competitive pressures and threats from the external environment like resource scarcity or pressure groups (Westphal and Khanna,

2003; Maitlis, 2004). Consequently organisations engage in business relationships to access the resources needed, neutralise real or perceived environmental threats to their acceptability or legitimacy and engage in knowledge transfer to retain competitive edge.

Indeed one of the tenets of the new Labour Government in 1997 was the introduction of integrated care based on private sector partnerships, cooperation and collaboration but driven by performance and accountability (The NHS Plan, 2000; The New NHS, 1997). Support services outsourcing was to help bridge the gap between the public and private sectors thus bringing business relationships as valuable resources and bridges within the NHS. These contractual relationships are the access bridges to resources, financial and human of the commercial services providers. Through such relationships support services managers are enabled to access resources like experienced, skilled managers deemed experts in support services to run their hotel services or advice them on matters of commercial interest (Agents E, F and G). Some managers accessed more reliable and guaranteed hotel services through all seasons at one fixed price (Agents M and O) while others met their need for better ancillary staff retention (Agents I, K, W). Thus contractual business relationships enable some services managers access scarce resources for the provision of support services some agents (A, B, E, F, I, J, M, Z, CC) regard as critical in supporting better and more effective healthcare delivery in their trusts.

The perceptions of the value and problems of business relationships from different support services managers are shown in (Table 5.12) below.

5.5.2 Commonalities

Relationships are valuable:

Many services managers (both in-house and outsourced operations) perceived that their business relationships with Government agencies, PASA and NHS Logistics or private services providers or both are valuable (value for money) beyond the cost of managing such relationships over time (agents C, D, E, G, I, K, M, N, O, Z, AA and CC).

Relationships are built on trust:

Many managers (client and vendor) admitted that their business relationships are built on trusting relations of mutual benefit. Some agents explained it thus:

Trust plays an essential role in our relationships. Trusting relationships are allowed to evolve as the contracts evolve for without that trust there is no contract (Agent F).

This NHS trust allows us to provide services the way we feel best due to the trust they have in us (Agent O)
Our relationship is mainly based on trust (Agent I)

We provide them with the service so a trusting relationship is important and helpful for our business in keeping with Government regulations and directives (Agent M)

Relationships are also partnerships:

Almost all the managers in the outsourced services stressed that they work in partnerships with contractors or clients, as teams, for mutual benefit (Agents A, E, F, G, I, K, L, M, O, R, S, T, X). This is exemplified in these statements:

It is all about relationship and how you work well with people. If you work with contractors in partnership as a team, you will work well and quickly to achieve goals and if you don't you won't. It is simple (Agent I).
We maintain good business relationship with all our contractors, working together in partnership, as a team. That keeps everyone alert and available to do the work (Agent E).

It is one of our goals to maintain good relations with all our contractors. It is a partnership (Agent K).
We have a no-blame partnership culture and that's how we work here (Agent O)

They are our clients and we treat them as partners (Agents M, X).
We (contractors) work in partnership with the trust for the patients. We don't have different views we have the same objectives (Agents L, S).

The partnership with private contractors has enabled this trust outsource its own hard FM services (estates facilities) to the local community and earn needed revenue for the trust. So we work in partnership with the contractors of all outsourced FM services (Agent R)

Relationships managed by constant communication: to help resolve conflicts

Constant and timely communication is key to benefiting from relationships (Flack, 2002). Lateral robust communication and constant dialogue help managers to proactively agree on issues resolve disagreements or misunderstandings and thus prevent problems arising. Most managers accepted the increase in communication as a price to pay for the benefits they get from their relationships (Agents A, E, F, I, K, M, O, R, S, U, Y, Z). For example:

Things are done more professionally now, it may have added a layer of communication but that's not bad, it helps to reduce the need for control and gets people working (Agent E).

We meet informally daily to sort out any difficulties and prevent problems arising (Agents A, E, F, K, M, S).

We meet face-to-face in constructive, informal ways daily and have contacts by phone or e-mail (Agent M)

The formal meetings happen fortnightly when we meet with directors from health and safety, security, catering, domestic and laundry to discuss goals and objectives, performance levels and scores, cleaning standards and contractor updates, reviews and generally smoothen out problems (Agents E, F, M, R, Y, Z).

We have a client for life philosophy so we keep in touch with even our past clients. We use personal influence to push the business forward and put in the time and effort to make all our relationships work (Agents F and M).

From the above excerpts, NHS managers met routinely while the contractor managers put in more effort and time to actively make their relationships mutually beneficial. This maybe because contractors have to earn revenue and retain contracts so they are committed to satisfying the contracted needs of their clients. Thus for the contractor managers, timely communication and speedy conflict resolution with a no-blame culture are important. For example:

If there is a problem, it is not their (clients) problem or our problem but a problem shared (Agents L, M, S, X)

If there is a problem we rectify it immediately, they are our clients and we have to look after them (Agent L)

We will discuss and dialogue to find solutions to problems and implement them right away to rectify the problem. They are our clients and we look after them (Agents H, M, O, S, X).

When there is a problem I can react as professionally and swiftly and competently as possible to rectify it because we always make sure that we have something in place to deal with unpredictable emergencies. Yes we react but not like the NHS managers do in what we call "knee-jerk reaction". They react and then pass the buck to someone else but I try to make sure that I have something in place so that I can deal with issues as professionally and swiftly and as competent as possible (Agent M)

If someone pees on the floor after it has been cleaned, I have to get it cleaned up in minutes, no fuss. That way we exceed our client's expectations (Agent M).

Indeed during one of my interviews with (Agent X), I had an opportunity to witness him resolve a catering conflict speedily and effectively without fuss.

On this interview day, a man decided that he was overcharged and refused to pay. The catering manager went out to settle the dispute and according to their rulebooks, the man gladly paid the requisite amount and no ugly issues arose. There was no referral to a higher authority or buck passing observed. The catering staff dealt with it all competently and cheerfully without blame or abuse. Thus contractor managers, equipped with standard operating procedure manuals (SOP) or rulebooks are able to routinely resolve conflicts.

Relationships provide support:

Relationships provide much needed personal support within NHS organisation for the in-house operators (Agents E, Z, BB, CC, EE) or local and regional support for the services providers (Agents A, F, H, L, M, O, S, T, U, X). This is echoed thus:

There is no support from neighbouring hospitals but I have no problems with that. I have informal contacts if I need them and they are quite useful to me personally (Agent E).

There is a network of London hospitals and we try to keep in touch and every three months we meet and swap ideas or problems. Otherwise the NHS, as far as I know, does not generally share equipment, staff or whatever. But as you move around different hospitals, you get to know people personally so when you are in trouble you can ring up and get help, that's how I operate and it works well for me personally (Agent BB).

We are regional but there is local support from other hospitals where we have contracts, we can share staff and equipment to support each other (Agents X).

My company is the biggest catering company in the world. We have contracts with airports, industries and ministry of defence and we help and support each other (Agents H, S).

We have three different contracts in this compound and we help and support each other (Agents S, T).

There are three different contract caterers on the eight sites of this NHS trust, we share equipment or staff if we need to and support each other (Agent A).

Relationship for skill and knowledge transfer:

There is learning and knowledge or skills transfer from the commercial services providers to other managers personally (Agent N) and corporately (Agents E, I, L, M, X). Indeed two NHS managers (Agents A, E and BB) advised their colleagues to go and work in the commercial private sector "to help open their eyes and broaden their experience".

For example:

The trust learns a lot from us but they will never be able to do what we do themselves because of their enormous overheads (Agent M).

I have learnt a lot since working with the contractors on this project (Agent N).

They (contractors) are professionals we learn a lot from them, we are able now to see healthcare as a business and keep within our budgets (Agent I).

The trust learns from us, we have a different structure and ways of working (Agent L).

Things are done more professionally now we learn a lot from them (Agent E).

We learn from each other everyday. No one knows everything, we are constantly learning (Agent L and X).

Furthermore some services managers perceived that they use their business relationships with other trusts to share facilities to optimise their usage and benefit patients while they learn from each other (Agents R and N). For example, Featherstone and County hospitals share their more up-to-date facilities and equipment to benefit orthopaedic patients and day surgery cases respectively (Agents R and N). During these exercises, medical skills are transferred to benefit the local workforce. Thus sharing facilities through relationships can benefit patients and aid learning through knowledge and skills transfers.

5.5. 3 Differences

The contractor managers were more eager to find early solutions to potential problems and prevent ugly scenes arising either with clients, visitors, patients or their personnel. This was evidenced by the constant visible management and supervision observed during all my visits at the different hospitals. The catering and domestic managers were always on the scene pacifying irate customers, ensuring the smooth running of the canteens or encouraging workers to do more. This was not the case in the in-house operations. Indeed at one hospital, the office of the domestic manager was so chaotic and confusion was allowed to reign that I wondered how she (Agent BB) could manage her department. They were short of equipment to do the job and some of the staff were either off sick or have not bothered to turn up for work. This was the same on more than one occasion.
Thus it seemed that the contractor managers were more proactive at problem solving to prevent ugly scenes than their in-house counterparts.

Reputation and image management:
The contract managers were more zealous at guarding their reputation or promoting their image, financial status or credibility hence their dominant position over their clients (Agents F, G, L and M). For example some of them said:

We would not supply services to a client who has been in the news in the last two years. Money is not everything. Our reputation is more important (Agents F and M).

What is a dodgy client? I have never met one my company will not get involved with what you call a dodgy client (Agent L)

My company is one of the biggest food companies in the world. They have a business edge that comes through in what they do and the business they provide (Agent X).

Premier is the biggest food provider in the world (Agents S). We are multinational with thousands of contracts outside (Agents A, F, G, H, L, M, O, S, X), massive reputation (Agent M). We have a "can do attitude" in our work and do it (Agents M and T).

We are on the stock exchange with financial backing from banks and building societies (Agents A, M and S)
We have thousands of suppliers worldwide and can supply anything from tea to power stations (Agent M).

Relationship for building legitimacy through social care:

While some contractors had worldwide relationships networks with clients or financial institutions that increased their bargaining power (as shown above), the services manager used such networks to ensure local relevance and maintain legitimacy. For example:

We are running an energy campaign in conjunction with the energy trust (Agent R)
We joined in with the local council in a waste recycling initiative, which was lunched by the Mayor.
We have also joined in with the local community and local council to save energy and reduce waste in an environmentally friendly way (Agent R)

We did a deal with London Coaches to run a shuttle snug bus and extend the service outside working hours to benefit our staff and act as a fare-paying bus service for the local housing estate residents especially in the evenings. We have a local youth employment and apprentice scheme here, not many companies still do that. We extended our CCTV network to include the two local train stations and linked them to the police station to help crime prevention (Agent R).

The non-executive directors were chosen for their social standing, or who they are in the community, the work they have done in the past and their standing in healthcare organisations (Agent R).

We work very closely in partnerships with London Coaches, the Mayor's office, the Local Government and most of the community leaders we consulted are also involved. They all support the scheme and the Government gives their blessing so we can go on (Agent N).

Indeed there is a transport rank within the hospital compound making it possible for local residents to have easy access to the hospital either as patients or visitors and for shoppers at the local superstores to travel with greater ease. Thus these two NHS trusts have endeavoured to improve their local image and relevance through support services.

Relationships make externalities possible:

Contract managers claimed to have spurned externalities due to their satisfactory provision of services that are guaranteed with technical support and financial backup and their massive reputation. Some of the claims proved to be true. For example they said:

If they (contractors) do well they use the contract as a springboard to provide other services elsewhere. It is also an incentive for contractors to continue to perform well here (Agent F)

Another person gave our name (Areno) and we have been asked to produce a document as benchmark of a new unit, if that is not writing the specifications for the trust, I don't know what is (Agent M).

We supply services to Ministry of Defence, schools, colleges and local authorities (Agents A, M, O and S). We (contractors) give a lot of hospitality services to other hospitals from here (Agent O).

We have no external boundaries only financial constraints. The sky is the limit. Someone asked our client who they use. They gave our name and they rang us up to supply them with services. We get our tentacles into Local Governments, health authorities and private hospitals. We have seventy NHS contracts (Agent M).

5.5.4 Discussion

From all the forgoing, the parties to interaction perceive their relationship as built on trust, commitment and cooperation for mutual benefits. This is in keeping with the tenets of IMP interaction model, where trust develops through prolonged interaction and transaction. Trust in relationships reduces the relational risk and uncertainty inherent in depending on external others for services provision and moderates the performance risk of professionals not delivering on the quality and standard of services expected. Consequently, the built up trust in these contractual relationships balances the need for power or control (Hunt and Morgan, 1996; Reed, 2001). Trust in relationships also attenuates behaviour, reducing the relational risk of opportunism, hence monitoring costs (Williamson, 1975 and 1999). Furthermore, through their trusting relationship, agents help to build in and institutionalise "systems trust" where goodwill (obligations) and sanction or rule-based trust alone are inadequate to moderate the behaviour of economic actors or agents (Bachmann, 2001). Systems trust is trust placed in expert professionals to minimize risks (section 3.7.9).

There is also a perception of teamwork (partnerships) to smoothen their daily interaction and enable some achieve goals more effectively. The relationships are managed through constant robust communication that helps to reduce misunderstanding and make conflicts functional (Reeve and Warren, 2004). Consequently, the parties to interaction manage their interdependence through the dialectic of control (Giddens, 1984) to reduce total transaction costs and institutionalise system trust in the expectation of future benefits.

Business relationships also provide personal and corporate support for the parties to interaction. As relationships deepen actors learn more about each other and their business processes and are enabled to offer support through their networks and trade associations. This is in keeping with the IMP framework and its network effects of business relationships (Barringer and Harrison, 2000; Ford, 2003; Sheu et al., 2006). The cooptation of non-executive members by some trusts can turn some would-be foes into helpful allies and ensures social support, access to scarce resources and local acceptance or legitimacy.

There are opportunities for knowledge and skills transfer through learning and the sharing of facilities and equipment. These can help to build capabilities for comparative advantage, find new ways of producing products and services or build more efficient systems that add value to services offerings (Grant and Baden-Fuller, 2004; Tsang, 2000). Consequently, there is a lot of learning in the areas of problem-solving, conflict management without blame and relationship management. Thus this study adds weight to other studies in IMP and its network effects in offering support, learning opportunities and legitimacy (Barringer and Harrison, 2000; Ford, 2003; Ford et al., 2006).

5.5.5 Reputation and image management (that aids externalities)

The reputation of both parties to interaction helps to further strengthen their relationship bonds. The credibility of the contractors which they refuse to compromise by supplying services to dodgy clients or those who have been in the news, enables them gain recommendation for externalities thus increasing their areas of influence and network of relationships to earn revenue. This is in keeping with the IMP model network effects. As interacting agents build trust and commitment, their credibility improves with time to enable them increase areas of influence, relevance and legitimacy through networks of social contacts and common memberships to trade or professional organisation. Thus this study confirms the tenets of IMP model and the findings of other studies on relationship networks (Ford, 2002; Easton, 1992; Gulati, 1998; Health Emergency, 2004; Øvretveit, 1995).

But some managers expressed the need to interact with contractors on strictly business terms, keeping the fine line between business and personal relationships separate in order to avoid tensions, compromising their business relationships or being accused of having "cosy relationships" that can tarnish their image or jeopardise the fair competitiveness of contractors at contract renewals (Agents F, I, K, R). Consequently, some client managers personally choose to keep their social distance in liasing with contract personnel.

Furthermore these public-private sector relationships have also brought changes to some trusts raising the profile of support services as crucial to healthcare delivery. It has also liberated some ancillary workers from manual labour to professionals with image and personal pride, no longer waving banners during pay negotiations or demonstrations but instead motivated to be productive at their work stations, giving professional services.

5.5.6 Power and control

The contractors also felt that they were in charge of their clients' departments because they had massive support from mega multinational organisations, insurance companies, banks and a pool of skilled, experienced and knowledgeable managers that form a knowledge base from which they operate. Thus their financial resources, commercial know-how, international connections (enabling them source raw materials more cheaply) and the ability to supply support services that some trusts could not supply due to their huge financial deficits and massive overheads accords them allocative (Giddens, 1984) and expert power (Courpasson, 2000; French and Raven, 1959) for domination. Therefore their clients become dependent on them for daily provision of services. But some contract managers (M, S and X) recognised that the client also had the countervailing power to terminate their contracts even at a price. Consequently, the services providers' perceived dominance plays out in subtle, behind the scene ways because of their interdependence. For example: Some managers best echoed what others said.

Premier Group is the biggest food company in the world. They (clients) outsourced services to save costs and we are very good at what we do (Agent H)

We (contractors) are international. We have financial backing from banks and building societies. The company is so diversified that we could be putting up apartment complexes in the Falklands or building bridges in Malta (Agent A)

We are in many countries. We are experts in providing catering services. We are the best in what we do. They (the NHS trust) will never be able to provide the service because of their massive overheads. They depend on us to do it and we look after them because they are our clients (Agent M)

We (NHS trust managers) have the power to penalise them (contractors) by taking money away from them. They know all that from the start. We don't have penalty clauses in our contracts because they can be fiddled and they get in the way of good teamwork but if we can show that the contractor has not done the work as required, we can take money away from them provided you are fair and can provide evidence that they have not performed (Agent I).

The possession, access and ability to regulate scarce resources accord the vendors, in these relationships, sources of power (Pfeffer and Salancik, 1978). The contractors have expertise in needs and risk assessment, procurement, contracting and support services provision (Belfield, 2007). This is also their allocative capacity or power (Giddens, 1984). But services managers also have authoritative position power. Although they may not have enough experience in relationship management skills, they can harness the expertise of their suppliers in weak areas (Bradley, 2005). As both forms of power are required to

smoothen and facilitate transaction for mutual benefit, they use constant communication to reduce the intensity of disagreements or misunderstandings, negotiate and agree on a consensus and so reduce the need for power plays and make the relationships work for both parties (Flack, 2002; Reeve and Warren, 2004). Thus, overt power politics that consumes time and energy and distorts information is lacking from the excerpts.

Valuable business relationships are exercises in power and control (Flack, 2002). As clients and vendors struggle to meet their contractual obligation, the subtlety with which they handle their relative perceptions of power can derail their relationships. For example: agents (A and B) perceived that they are in control because they manage and run the facility from which their client operates while agents (S, T, X) said that they were not in control. But agents (L, M and O) said they negotiated the minefield of their contract price variations with care and subtlety giving the client lengthy notices to absorb the facts.

Contractors perceive that they are in control because without the provision of support services to sustain healthcare, hospitals will grind to a halt (Agents E, I, K, M, R). Such a dominant vendor, with access to and possession of vital scarce resources and financial connections can be intimidating. But the NHS also has a reputation as the largest employer in the UK if not Europe. Consequently, contractors play down their dominant position, cooperate with a spirit of partnership to benefit patients and look after the needs of their clients. Thus control and domination are attenuated through the dialectic of control (structuration theory) and the expectation of future interaction (interaction model). This results in both parties to interaction, managing their relationships for mutual benefits and making overt power plays redundant. These power plays are in line with the tenets of both Interaction Model (IMP) and structuration theory (Giddens, 1984) that knowledgeable agents, differentially endowed with resources, can interact meaningfully focusing on actions that will ensure a favourable outcome in order to maximize their capacity to make a difference while avoiding the use of overt power for control or domination.

5.5.7 Foundation status

Since payment by results, there is observable financial transparency within some trusts (Cowper, 2007). Some NHS managers striving for foundation status have also come to regard healthcare as a business and have improved their financial standing to attain it (Kmietowicz, 2006; Timmins, 2007). There is a suggestion from the excerpts that the financial awareness and learning gained by these services managers result from their

prolonged interaction with commercial services providers. Consequently, the relationship between the contractors and some services managers has been shown to be beneficial. This builds on other studies in the areas of relationship management for mutual benefit and successful outsourcing that delivers beyond contracted specifications and expectations. Foundation status has led to the liberation of some trusts from the dictates and constraints of Strategic Health Commissioners and constant budgetary constraints. Observers watch to see if these managers continue to learn and grow (Seltzer and Bentley, 1999; Senge, 1999) in the new culture of commercial awareness (Schein, 2004). Valuable relationships however come at a cost and engender constraints.

5.5.8 Relationship costs and constraints

The benefits and opportunity cost of business relationships are extensively discussed in chapter three and I don't wish to repeat them here. However business relationships can be limited and marred by the opportunity costs of alternative relationships foregone and their lock-in effects without the flexibility to develop independent ways of working (Ford, 2002). These are the golden cages or handcuffs and ugly prisons of IMP business relationships. There is a loss of organisational competence in the outsourced services and a cost to rebuilding services should their outsourcing relationships fail (Agents Z, AA, CC).

There is also a relationship management cost. The problem of matching mixed cultures and personalities that demand personal influence to avert clashes cannot be over-estimated. There is a need to retain the clarity of responsibilities, inter-dependence on duties and commitment towards mutual goals and benefits. Changes in support services personnel can also necessitate a change in vendor, thus escalating the total cost of services provision. This was not the case during this study as all the contractors are still in place at the time of writing. Thus the cost of relationship management both personal and corporate can constrain and limit the benefits that accrue from valuable relationships.

Another relationship cost is a financial burden needed to initiate the contract relationship. Contractors must have a proven track record of being able to guarantee the service they provide with all the necessary technological update and needed backup. This was most noticeable with agents (F and M). Consequently contractors are said to be "aggressively in the market place looking for contracts to bid for" (Agent N). They have worldwide networks to be able to meet the varied needs of their clients competitively in price, skilled personnel and quality of service provided beyond the clients' expectations.

Having secured a contract, the services provider must then deliver on the contract agreement at a fixed price. If conditions change and there are adjustments to be made on prices, contractors "bite the bullet" because the cost price is fixed (Agents F and M). Thus contractors must manage competitive pressures and deliver on their contracts.

Customer relationship management (CRM) makes it possible for contractors to manage their clients through constant lateral communication, social environment of goodwill and motivational incentives in the form of social events, free meals, life and work balance and other perks in order to retain their clients and earn longer streams of revenue. Constant communication makes demands on contract managers, consumes time, effort, and emotional energy, demands personal influence and commitment to provide satisfactory services beyond clients' expectations (Reeve and Warren, 2004). But it helps to prevent minor issues turning into major problems later. There are courtesy calls outside official times that are said to 'keep the wheels of business relationships turning' (Agents F and M). These also demand time, effort and commitment. But the contractor managers perceive them as a necessary part of doing business more effectively (Quilgars, 2000) and so are committed to making them to keep their relationships productive and earn revenue.

The contractors are committed to providing a relaxing social environment for their staff and those of the client organisation to show their goodwill. All are welcome to relax and have the opportunity to get to know each other and build relationship bonds (Agents H and L). Others use them as opportunity to build up personnel and get communication going (Agents M, O, S, T). There are inter-departmental competitions, annual cricket matches, socials, barbecue and beer nights, also Christmas evenings and staff parties for leavers and joiners (Agents M, O S, T, X). These events are at the expense of the contractors to pacify their personnel, build bridges to the clients' workforce, to show appreciation for their clients' custom, in order to retain a productive workforce and earn their revenue streams.

In all the outsourced services, contract personnel eat free as their duty deal (Agent A) while the client staff get discounts from 10% to 20% which some contractors say "bankrupts them" (Agents A, B, H, L, M, O, S, X). These are incentives to motivate staff and retain a loyal and committed workforce. Thus, contractors invest time, money and effort as costs to them in building and making their business relationships more effective.

Table 5.12. Analysis of **Relationship** theme

Theme	Agent's code	Knowledge base	Communication
Signification	E,F,I,M,	Open, honest, timely communication avoid tensions and conflicts	-Contract management is all about relationships and how you work well with people -We meet informally daily and formally every fortnight to discuss issues and agree on them
	Z, CC	Beneficial bridges	-We tend to network with government agencies and charitable organisations rather than private -Government agencies save us a lot of money
	A, F, K, F	To enforce good business ethics	-We network with other trusts and dialogue with them to learn best practice and to know who is who in purchasing
	F, I	Single contractor may have faults or weaknesses	-We use two or more contractors to even out the risks and not to play one against the other -Long term use of a single contractor may be anti-competitive and can lead to "cosy relationships" that can tarnish our image
	I K	Cooperative work for mutual benefit avoids tension	-If you work with contractors as a team, you will achieve results but if you don't, you won't
	AE F I K L M N O R S T X		-Team work is the main thing-simple -We all work in partnership for the patients
	E I K		-We interact with them as professionals and they do a professional job.
	F, I, K		There is no social contact by personal choice.
	R	Bridges and Buffers	-We engage non-executive directors for their social standing and work they have done before
Domination	F, I, K,R	Blurred relation-ship lines can cause tensions	It is good practice to liase with people from a distance to keep professional and personal interests apart otherwise they get blurred
	F, I		-We can extend or revoke their contract. It gives them (contractors) the incentive to perform
	E, F, I, K		-It is one of our goals to maintain good relations with all our contractors (we need each other)
	K		-They are professionals but we manage them because we get complaints
	E	Mutual respect based on personal influence	-I don't manage them (contractors)
	E, M		-We relate to each other on a personal basis
	A, B, M	Subtle negotiation	-We are in control although seen as contractors
Legitimation	F, I	If there's no trust there's no contract	- Trusting relationships are allowed to evolve as contracts evolve. Trust plays an essential role.
	F, R	Formal contracts spell out rights and obligations. Penalty clauses can be fiddled	-It is good practice to have contracts that are formally agreed to and legally binding
	F, I		-There are no penalty clauses. They get in the way of good team-work and use up a lot of manpower without achieving much. Contractors know from the start that we will penalise them for non-performance to all agreed standards.
	M, O, X	Bridge-building clubs	-We have a social club on site. All are welcome

Some managers agree that the public are not as forgiving in their unrealistic expectations as before (Agents B, E, BB). Many patients now expect their hot meals on time more than they expect doctors to turn up or getting their painkillers on time (Agent E). Sometimes the public expect what support services cannot provide (Agent BB). For example the domestic staff cannot predict when someone is going to throw toilet tissues, water or waste product all over a just-cleaned toilet. But the public and patients expect toilets to be clean every time. Such expectations are unrealistic and the cleaners, who cannot defend themselves or answer back are constantly blamed for lack of hospital cleanliness when there are many contributory factors, such as levels of personal hygiene, ethnic mix and aging facilities.

There is a burden of investment to Government and professional bodies to keep up with technological advancements and updates required for the job (Agents F, M, R, Z, CC). Consequently, many support services managers benefit from their business relationships but at a cost and constraint to the contractors, who pay them. Thus relationships become golden cages of benefits and ugly prisons of commitment and obligations (Ford, 2002). In sum, most managers interviewed on both sides of the relationship perceive that their business relationships are productive, valuable and mutually beneficial but constraining and costly. Such relationships of mutual dependence must be managed with mutual respect, trust and commitment and constant communication to keep them beneficial and avoid conflicts through misunderstandings or disagreements that can derail them.

5.6 Investment theme

5.6.1 Introduction

The central problem of the health service that observers note is lack of adequate funding due to many competing demands on a finite public purse or the difficulty of assessing what is adequate for providing a service with ever-increasing demands (Enthoven, 2000; Klein, 2001; Levitt et al., 1995). The legacy of chronic under-funding can be seen as observable decay in the old buildings and shortage of staff and equipment, wastage, the inefficient use of available resources and the variations in performance across the health service (Portillo, 1998; Moore, 2007). Similarly, public organisations providing social services like the army and navy also need continuous investments to protect their buildings from decay (Harding, 1999). Furthermore, the level of investments in health service projects reflects, the value of that project (Turrill, 1993). Hence where investment for change efforts is lacking, success is doubtful as services managers regard such projects as of little value and not worth wasting time and effort on to make it work. Against this backdrop, support services were

outsourced partly to get private investment into the health service and partly to improve the quality, standard and efficiency of services by professionals. Thus there are many areas of investment by the commercial services providers ranging from relationship-specific ones through staff development, capital projects investments to improve the work environment to investing for interest. The perceptions of the managers are depicted in table 5.13 below.

5.6.2. Commonalities in staff development

One of the major areas of contractor investment is in ancillary staff development. All the ancillary staff were transferred or sold by the NHS to the contractors where services are outsourced. The contractors then streamlined the staff to "remove deadwood" of those unwilling or refusing to work under them or needed more suitable work than what was available under contract (Agents A, B, E, F, I, M, R, S, W, X).

The contractors then invested funds to train the staff free of charge and develop them for the work they do. The following excerpts exemplify the perceptions of managers:

When we won the contract, we reduced the number of staff and selected those willing to work hard and we rewarded them for their hard work with incentives like free meals and prize competitions. They are willing and dedicated to their work after their training so they work hard to keep the hospital clean and Assured gets a good report as a good services provider (Agent T).

We were sold by the trust to this company, I did not wish to become an employee of this (private) company but we had no choice. If we did not wish to become an employee of the company, we would have made ourselves unemployed. There was no freedom. All our pensions and contributions were frozen when we moved over and now they tell us that they cannot transfer a pension scheme (Agent A)

At Premier everyone has training and you do management training in dispute and learn other things as well (conflict management and budgeting) and it is free of charge (Agents H, S and X)

My staff are impeccably dressed, they are better trained, look more professional and are well motivated. This improves morale and they do a better job. Contract relationship is also about staff development (Agent M).

The contractors train ancillary workers better than the NHS ever did (Agents E, M, X and BB).

I used to be a cleaner but Premier trained me at night school and now I manage other cleaners (Agent T)

Some workers developed by the contractors have also changed their professions to do other jobs (Agent P)

The commitment of the NHS to staff training was very low. Now we have more staff, better trained than the NHS ever did, especially in food and personal hygiene which have direct effects for all who eat and work here both patients and staff (Agent A and B).

The NHS did not train ancillary staff, they were the bottom of the pile and there was no point in training them (Agents E and BB). Now they are better trained, get better uniforms, look more professional and even their salaries have improved. They have better recognition for what they are and the work they do (Agents E & X).

Still on contractors, staff development enables them provide reliable services to clients.

We have our own dieticians and quality managers on site so that whatever the client demands we can provide it. Some hospitals don't have them but that is our commitment to this trust. We are the best at what we do be it supplying services to Royalty or the people in the street. We invest in the business (through staff development) to provide value for money and quality service. We believe that we are the best (Agent M).

Here we have multi-task generic workers. Some are facilities services assistants (FSA). They are all trained to NVQ1 level and are able to assist the ward managers in cleaning, portering and any other duties they can to help with the smooth running of the wards. It is a local initiative and works very well for us (Agent EE).

Further to investment in staff development, the services providers also invest in incentives to appreciate their staff and keep them motivated, loyal and happy. For example:

All ancillary staff eat free meals as part of their duty deal built into our contract (Agents A, B, H, L, M, O, S, X). There is staff of the month and employee of the year selected by Premier. All our staff can work anywhere we have contracts from London to Milan and it is open to everyone (Agents H, S, T and X).

At Premier, we have a no-blame culture but team spirit and show appreciation for hard work (Agents S, T)

In the NHS, they don't want to know where you live or what you have to do, you just turn up for work that's all (Agents P and Q).

At Areno, they allow us to work flexible time. It is good for me because I can go home and pick my children from school and then come back in the evening. Also when I moved house, Areno let me change hospitals nearer to where I live. Before I used to spend two hours on the bus to and from work and it tired me out. Here at Areno they let us eat free meals on duty and I can save money too (Agent P)

Because of the investment we have made, the trust has more freedom to save money. They don't have to employ accountants to pay wages and salaries to ancillary staff. They have no worries on pensions and contributions. They don't have to deal with personnel disputes, discipline, conflict management or people management. They can concentrate on their expertise of healthcare while we concentrate on ours (Agents A and B).

The contractors are able to move resources like personnel and funds around the world to wherever they are needed due to their worldwide networks. For example:

Their (contract) staff can work anywhere within their organisation (anywhere in the world) and also with other (local) contracts whereas NHS staff employed by this trust will be confined to the trust or work in different departments. As a result (of the incentive for workforce mobility) the contractors always manage to hold onto staff but we (NHS managers) can't (Agent I).

Consequently, at one NHS trust the Filipino staff "who could not even speak English" on arrival, were recruited, trained, socialised and "kitted out with lovely uniforms" and put to work. Since then, the trust has not experienced any further staff recruitment or retention problems. Similarly, at another hospital that could not keep ancillary staff especially the chefs who were lured away by the many catering firms and hotels around them, the contractors, Mediserve, took over hotel services provision, trained the ancillary staff to equip them with skills and knowledge for the job and employed them. Since then there is no more ancillary staff retention problems there (Agents I and K). Indeed their vacancy rates and turnover are greatly reduced (Agent I). Thus in hotel services where contractors train, socialise, motivate with incentives and reward ancillary staff well, they stem the tide of staff recruitment and retention problems.

Also in other outsourced services, NHS managers recognise the importance of staff development for building loyalty, dedication and increasing morale and motivation (Agents R and BB). For example:

The trust spends a lot of money in staff training. We in estates operate an apprentice scheme (Agent R).

Our staff, have a sense of ownership, they take pride in what they do (maintaining their equipment). There is loyalty and it helps to motivate them. Not many organisations do that now (Agent R).

My staff are impeccably dressed, they are better trained, look more professional and are well motivated. This improves morale and they do a better job. Contract relationship is also about staff development (Agent M).

The NHS now invests money to develop purchasing teams to make them more responsive and effective to local needs than before. Purchasing has always been a professional business not the past image of backroom boys (Agents F G and K).

Indeed staff development is credited as a reason for contractors' ability to attract and retain ancillary staff better than the NHS and has improved the profile of support services (Agents I and W). For example:

The contractors provide employment for their staff, they took over all the ancillary workers here and now they train and manage them better if you will (Agent I)

They (contractors) operate services all over the country and can get staff and retain them better. Our staff vacancy rates and turnover are greatly reduced (Agent I)

Developed ancillary staff, have managed to let the public know how important support services are without strikes or placards (Agents E and I)

But the in-house managers continue to experience ancillary staff problems and have been forced to rely on agency workers or have everyone "muck in to get the job done" (Agents BB and DD). Some "don't have proper kitchens to cook for the patients so they eat cook-chilled meals and since nobody complains", they assume that the staff and patients are satisfied. There is no investment or incentive for the staff. "The catering staff, pay for their meals like all other staff members". "Also when we see good staff, we just thank them for their work but there is no appreciation here for hard work" (Agent DD and EE). Consequently, where services managers invest in staff development and adequate supply of equipment there is perceived staff motivation, loyalty and ownership of work. Developed staff have improved their profile and enhanced the image of support services to the public. There is a perception that managers in Government agencies have been developed into professionals to make them more responsive to local needs and more effective in saving costs due to the influence and interaction with their "better trained" commercial managers. Obviously, this area needs more studies to validate and confirm what is suggested here.

Investment in management development will be discussed in management theme below.

Discussion of staff development

Observers note that investment in training employees to develop their potential with requisite skills and knowledge as organisational valuable resource or human capital is rewarded by improved competitiveness and enhanced productivity (Hailey et al., 2005; Hitt et al., 1994; Savery, 1996). Human capital refers to the appropriability of economic value from employee skills, knowledge and experience as internal resources of the firm (Becker, 1993; Hailey et al., 2005:51). Skilled, knowledgeable and experienced staff, are better motivated and committed to organisational objectives and can release their skills and talent for building corporate capabilities and improving productivity for competitive advantage (Cappelli, 2000; Drucker, 1992; Pfeffer, 1998). Such are the knowledgeable agents of change who endowed with resources can make a difference and change their organisations through innovation, creativity or improved productivity (Giddens, 1984). Indeed Drucker (1992:100) comments that organisations say that people are their most valuable resource but none believes it or they will not treat employees as commodities. The managers complained that they were sold to the contractors like commodities. Some did not wish to join the commercial services providers but they had no choice. While services providers have trained, developed and liberated the ancillary workforce from the dungeons of the basement into professionals with image and status, not everyone was

willing to work in the private sector. Their forced transfer lost some their pension and other contributions near their retirement age and till the time of writing they remain lost.

The neglect of human capital or employee training and development due to lack of adequate investment is seen by some as the reason for loss in competitiveness and recurrent staff retention problems (Cappelli, 2000; Hailey et al., 2005; Hitt et al., 1994). But the contractors who inherited all ancillary staff where services are outsourced are acknowledged as having developed their staff, made them more loyal, motivated and committed for better performance at delivering support services to their clients. Indeed in one hospital, in-house contractors won the support services contract, and developed their staff as multi-task generic workers. This is in accordance with shaping services around the needs of the patients for improved effectiveness (DoH, 2000; May and Suckley, 2005).

Although the relationship between human capital and productivity is yet to be proven, observers note that a well-trained workforce enhances sales and can reduce production costs through reduced absenteeism (better motivated and loyal staff) and learned skills incorporated into routines as valuable resources for capability building (Sveiby, 1997; Ulrich and Smallwood, 2004). Staff competence becomes non-transferable, unique, firm-specific assets for a more efficient production or innovation for wealth creation. This is in line with the tenets of resourced based theories where trusts acquire resources they need from the external environment (Pfeffer and Salancik, 1978), and through investments, develop them into firm specific assets (Teece et al., 1997). Through knowledge transfer and learning these developed staff improve their competence and skills (Akbar, 2003; Lam, 2000; Seltzer and Bentley, 1999) and hence increase the knowledge base of their organisations for building capabilities for comparative advantage and economic rent (Amit and Schoemaker, 1993; Huber, 1999; Knight, 2004; Powell, 2001; Winter, 2003). Thus this study builds on the literature on resource-based theories in the areas of resource acquisition through outsourcing, the building of a more heterogeneous skills base through learning and knowledge transfer for sustainable advantage and wealth or profit creation.

Others note that staff training and development, as intangible assets, are the greatest sources of corporate value for competitive advantage (Lev. 2004; Ulrich and Smallwood, 2004). Such trained staff can make the difference between organisational success and failure. From the excerpts, the services providers invested in staff training to develop and improve them for better returns. Through the association with commercial managers, procurement managers are now developed into professionals to be more responsive and

effective to the needs of their organisation. Consequently, contractor investments in staff training and development enable some services managers review and regard the problem of managerial lack of skills and knowledge (skills gap) in new ways leading to the training and development of procurement managers as professionals. Thus, contractor investment in this area is perceived to have led to returns for them in terms of reduced recruitment and retention problems, and made changes in liberating procurement managers from the backroom boys to trained, development and more competent managers. It also improved the stock of tacit knowledge and intangible assets of these managers and their trusts (more heterogeneous skills base) for comparative advantage.

Furthermore although downsizing or staff reduction can reduce costs in the short-term, it leads to job insecurity, loss of trust, increased employee stress and vulnerability and hence reduces productivity and increases managerial risk aversion. The adverse effect of downsizing prompted observers to advice organisations to treat employees as resources to be maximised not cost to be minimised (Jolly, 2003:35; Hitt et al., 1994:41).
But the contractors have managed to downsize their inherited staff and developed the remainder to improve morale and motivate them to do more. Thus downsizing may not always lead to loss of trust and job insecurity or increased staff stress and vulnerability.

Investment in equipment

The contractors are reported to have invested much in automation and support services equipment to bring them up to date with technological improvement. For example:

The contractors have changed our kitchen services completely from conventional cooking to cook-chill (Agent I and K). Cook-chill provides standard products every time (Agents K, X)

They invested lots of money in equipment and personnel to meet national standards (Agents I and K)

They invested a lot of money in kitchen equipment especially in the private wings of the hospital (Agent J).
We revamped the kitchen to bring it up to date with modern cooking (Agents H, L, M O, S, X).
We revamped the restaurant to make it a more enjoyable place to eat in (Agents H, L, M, O, S, X).
Thus contractors made relationship-specific investment as commitment to better serve the needs of their clients and to lengthen their contracts for future streams of revenue.

5.6.3 Asset-specific investment:

The importance of asset specificity lies in the perceptions of power to control the dependent party. For example one respondent at Theresa hospital said:

When we move over to the new building, there will be many challenges and changes. We are moving away from a simple catering manager to facilities management and maintenance. The roles will be different but we will still be providing all the services and manage the building for the next 38 years so we will still be in control (Agent A).

Special investment to withstand crisis

There is also a special investment or what agents (F and M) call a financial burden. It is a contingency fund that establishes the willingness and ability of the contractor to meet natural disasters and continue to provide services. Contractors without it, in spite of their financial standing, will not be engaged. For example:

There is a financial burden, if something happens can you sustain it and keep providing services? If conditions change or the set prices go up, we bite the bullet (Agent M)

The reasons for choosing the present primary contractors are their reputation, financial standing, management structure and their ability to withstand and bear added financial risk (Agent F).

Consequently being able to sustain the added financial burden is also an investment for services contractors and enhances their employability and possible retention by clients. However some support services managers may have benefited from these investments in exchange for dependence on the contractors.

But at the in-house organisations there was very little investment as they waited on Government to fund everything. For example:

If we have no money to replace equipment, we have to wait until we do" (Agent BB). Whereas in a contract job, getting equipment was as easy as pie because every time a contract finished, we could go and pick up any equipment we needed and they were mostly the same as ours if not better. We could also borrow staff and equipment from each other. Lots of things were easier and we felt more in control then (Agent BB).

Thus while in-house managers wait for Government funding, their counterparts get on with the job in hand because they have the equipment and personnel to do the work.

Discussion on asset-specific investments

Most of the investment for equipment, refurbishment and meeting financial burden can be classed as relationship specific and subject to what Williamson (1996:106) calls hold-up or contractual hazards (uncertainty). This is because they create bilateral dependence between transacting agents, increase total transaction costs and shift the behaviour of agents towards cooperativeness. Consequently, mal-adaptation costs can be incurred during disagreements of the self-interest type or bargaining in contract renegotiations. Asset-specific investment is at the core of TCE and increases the complexity of contracts.

They can increase the opportunistic tendencies of vendors who invest for self-interest. They reduce the freedom of choice for best alternatives in the outsourced services because they increase the contract duration for the contractors. For example, the investment of £5m by Areno at Victoria hospital lengthened the contract from five to ten years thus tying both parties to a long time of relationship management. They reduce the flexibility of clients to respond to changing need when prices are fixed or incur variation costs. They introduce significant asymmetry into future contract bids, where the incumbent may gain unfair advantage due to investment to exclude other parties (Gander and Rieple, 2004:64). Hence they can increase the switching costs to other vendors should contracts fail or major disagreements arise. Asset specific investments alter the perception of power balance within contract relationships and involve opportunity costs of foregoing other partnering opportunities (Barthélemy and Quélin, 2006; Brennan and Turnbull, 1999). However the influence of trust and commitment in valuable relationships can make the overt exercise of power, control and domination redundant. But with all the negative attributes, asset specific investments provide evidence of vendor commitment to a long-term relationship. Thus asset-specific investments force transacting agents to manage their interdependent business relationships for enduring mutual benefits.

These irretrievable investments also involve the adaptation of routines, procedures and equipment that increase the commitment of parties to long-term interdependence in what Ford (2002:90) calls the golden cage or ugly prison of business relationships. Hence in a world of incomplete contracts, contracts involving asset-specific investments attract other governance instruments such as trust and commitment, valuable relationships and the expectations of future benefits to ameliorate the constraining effects of asset-specific investments. Thus this study confirms the central role of asset specific investments in TCE governance framework that has enabled those involved to benefit with fewer in-house resources. The study also extends the validity of TCE for the outsourcing of support services in order to economise on in-house production.

5.6.4 Investing for interest

Contractors have networks of financial institutions and better access to national funds (Agents A, I, M, O, S, X). However public services managers cannot borrow money as an organisation (except foundation trusts) but are always short of money. For example:

We cannot borrow money as an organisation but we are always short of money in these old buildings crying out for money but the contractors, as private organisations can. That's just the way it works (Agent I).

The contractors operate services all over the country and have wider inputs. They have access to national funds and resources and can borrow money or get money from the Government and make it available to us. They invest for profit, we don't get the money for nothing. There is nothing wrong with making a profit, they are in business to make profit. So we have the privilege of having the money we need to function. We get the money we need to do the things we want and we pay it back gradually with interest over time (Agent I).

The contractors (Builders International) are aggressively in the market place so able to access national resources and make them available to the trust (Agent N)

The contractor investment enables some NHS trusts maintain old buildings and do what they want to stay operational, balance their books and repay debt with interest over time. But in the in-house operation, where managers must wait for Government funds to complete refurbishing, there is no investment and because "we cannot invent a pot of money to do what we need to do", project completion is delayed (Agents BB and CC). Thus, investing for interest increases contractor revenue and allows some managers to access resources from external others to become less dependent on Government funds.

5.6.5 Investment in facilities

Some contractors have invested in rebuilding facilities more suitable for their clients either through the mini Public Finance Initiative (PFI) or their own investment. For example:

At the Theresa hospital, the stakeholders said:

This is what a hospital should look like, clean, airy, roomy and with much needed privacy for patients and staff, we can now work better and not step on each other's toe all the time. The changing rooms are the best in the bargain, no more having to change into uniforms in cars, toilets, linen cupboards, broom cupboards and patient's bathrooms, we have our own place to change in and you can let your hear down without disturbing anyone, very good and very thoughtful of the trust, but it must have cost a lot though (Agent C).

Now I come to work with a spring in my step, not the former Oh Lord not that horrible place again, all day long (Agent D).

One contractor said: We are working with the builders to build this new hospital (Agent A)

At Victoria hospital, an agent said:

We refurbished the kitchens and canteens with extensions, built two new restaurants as commercial ventures *Diners' Den* and *Café Locale* and run them to collect revenue for the trust to offset their massive costs (Agent M)

At County hospital, an agent commented that:

The Government was not going to fund it (EDC) and we did not have the funds so (contractor investment through a PFI) was a way of raising money to build it (Agent N).

The lack of maintenance of hospital facilities is shown by this remark:

The buildings were not refurbished as often as was needed. There was no preventive maintenance years ago that should have stopped the rot. Things are better now but much damage was done to the services and now we must live with it (Agent BB)

Some trusts are enabled to acquire facilities fit for the 21st Century, through association with contractors who invested in new facilities. The creativity, quality and design of these buildings have greatly added value to services offering by improving the morale of the workforce, the image of the hospitals and impacting the local communities.

Contractors also built new facilities at Victoria hospital to help generate revenue for the client to offset costs from their enormous deficits. In the bargain, the contractors tie the hands of the trusts to lengthy mortgages and earn themselves long-term revenue. But contractor investments may have redressed years of neglect in facilities maintenance. There is a perception of value creation for economic rent in these exchanges through investments (Dyer and Singh, 1998) or the optimisation of client processes to add value. It confirms the concept of capital theory (part of market process theory) that profits and value reside in the modes of capital application (Kleinaltenkamp and Ehret, 2006). As relationships deepen services providers can detect other options for their resources not already served or services not supplied and craft to implement a business solution to provide the client with superior added value and extraordinary profits for themselves. Thus relational exchange becomes a fertile context for economic rent or wealth creation.

Discussion on investments in facilities

The advent of the PFI accorded the public sector the opportunity to assess, manage and reduce the risk of providing facilities suitable for its core functions (Jones, 2000c; Okoroh et al., 2002; Rodney and Gallimore, 2002). For the support services, the PFI enabled the services providers extend their remit to major project investment and risk management to some clients. For the services managers concerned, it was an opportunity to improve their duty of care to their patients, stakeholders and workforce by using vendor resources to provide suitable, more flexible and adaptable facilities to avoid business failure and so reduce the risk and uncertainty of services provision. In the design build and maintain facilities, the NHS trusts concerned also freed up capital by turning financial assets in facilities into business services and saving on maintenance costs. These investments through the PFI scheme have increased the participation of the private sector in helping to provide public services by acting as a catalyst in services redesign (Bosanquet and de Zoete, 2006; Walton, 2007). Thus, investment and know-how of contractors in FM

became the "sinews of power" (Harding, 1999) that connect and incorporate the PFI framework into NHS trusts to help some reduce the uncertainty, risk and cost of providing suitable healthcare facilities, while avoiding business failure and costly investments.

Facilities Management (FM) enables services providers extend the scope of support services by bundling support services with facilities management and maintenance (Rodney and Gallimore, 2002). FM and real estate management also offer NHS trusts, new ways of adding value to support services offerings and solving the problems of effective use of business spaces. These give support service managers the opportunity to learn how to combine resources (Akbar, 2003; Jamali et al., 2006). For example, University College sold its redundant real estate in London to turn its deficit into surplus and so profit the trust through resource combination (Gainsbury, 2008). Some managers share the control and management of the buildings where they work but do not own. The successful management of interdependent relationship helps reduce opportunistic tendencies and the complexity of contracts through trust, loyalty and commitment. Thus FM extends the opportunity of some services managers to develop in areas of resource combination and relationship management to avoid control and power politics.

The present state of FM

But FM is a young discipline with no solid body of theories and few published research (Salonen, 2004). It presently relies on general and relationship management literature (Ventovuori, et al., 2007). Also, studies in support services are relatively rare (Salonen, 2004), while those in risk assessment and management are lacking (Alexander, 1992; 2003; Okoroh et al., 2002; Rodney and Gallimore, 2002). But FM and real estate management are essential services, offering firms new ways of addressing the problem of optimising the use of business office spaces. Consequently there is a challenge to secure the future of FM as a credible discipline built on strong theoretical foundations dedicated to understanding and developing the discipline. There is also need for more research to identify best practice and benchmarking worth pursuing (Ventovuori, et al., 2007).

This thesis contributes to FM studies in the areas of inter-firm relationships involving FM built environments and estate management. It also adds to the literature on innovative designs and the change they bring to the workforce and the local community and hence accords FM providers the role of catalytic agents using their resources and knowledge (as inward investment) to bring about change to workers, managers and local communities.

Table 5.13 Analysis of **Investment** theme

Theme	Agent's code	Knowledge base	Communication
Signification	F	Investment in training ensures skill, knowledge and experience in serving customer	-One of the reasons for choosing the present primary contractor was their management structure and investment in personnel. It shows a long-term view of the firm for management effectiveness, success and better image
	F, K	needs	NHS has invested a lot in developing purchasing teams to be more responsive and effective today
	A, E, M BB S X	Ancillary staff were bottom of the pile so why train them	- The commitment of the NHS trusts to training ancillary staff was very low. There was no point -But (contractors) invested a lot in staff training
	A, E, M BB S X	Trained staff are more effective in	-Now we have better trained staff especially in food and personal hygiene, which has direct
	A, E, M B, S, X	responding to customer needs	effect on all who eat here both staff, patients and visitors. Also we do management training
	BB E X	Better trained staff means better quality products and services	-Now my staff are well trained, more motivated They get better uniforms, look more professional They have better recognition for what they do.
	R,		-We in estates invest a lot of money in staff training. The staff have a sense of ownership and pride in maintaining their equipment 24/7
	R	Bigger specialist firms invest in staff training to do more	-In areas where we do only a few a year, we outsource services because we cannot afford to have trained personnel on site to deal with them
	R	Local community involvement prevents possible disruptions	-We invest in a snug bus to help our staff and the local community with night time transport
	R, I, N		-Contractors have access to national resources. They can borrow money and make it available to the trust. We payback over time with interest
	E, H, I, K L, M, O S, X,	Relationship-specific investments lengthen contract tenure	-Contractors invested a lot of money in canteens cafes and revamping the kitchens to raise funds
Domination	R, I	He who has the gold, makes the rules	Contractors can get money from Government for new buildings but we can't. That's the way it is.
	R, I	Worth making effort to achieve autonomy	One benefit of foundation status is the ability to borrow money and do the things we want to do
	I, K	Dependence on contractors for	Our support services vacancy and turnover rate are greatly reduced due to the contractors
	I, K, M	reliable services	Support services are critical to this NHS trust
Legitimation	I,	Has right to profit via annual uplifts in cost	They are in business to make money we know that. We don't get their money for nothing

5.7. Pooled Managerial skill and experience theme

5.7.1 Introduction

The concept of management has been studied through different lenses resulting in varied views (Handy, 1997). The inability of the classical view of management, to deliver profit maximization through formalised control and co-ordination of economic activity, led to the search for alternative forms of management (Reed, 1984). These are management as a social process aimed at achieving organisational goals (Child, 1972, 1997; Dalton, 1959; Kotler, 1992; Mintzberg, 1973, 1990; Pettigrew, 1973) and management as a resource of skilled, educated and knowledgeable professionals using organisational routines and their formal authority to effectively neutralise environmental threats and access resources for organisational survival and profitability (Kanter, 1989; Kleiner and Roth, 1997; Thompson, 1967; Uhlenbruck et al., 2003). This pool of skilled and experienced managers are the knowledgeable agents of structuration theory (Giddens, 1979, 1984) who given access to resource can make a difference to their departments, roles, positions and organisations.

Management process focuses on the power struggles over resource allocation and the problems of reconciling different organisational views and diverse and divergent political agendas. Consequently, managers become skilled negotiators, (Mintzberg, 1990) adept at loosening controls on themselves and tightening them on others (Dalton, 1959) or using access to resources to build relationship networks of dependent coalitions for support and influence (Kleiner, 2003; Kotler, 1992; Krackhardt and Hanson, 1993). Some become skilled at resource mobilisation for organisational survival (Reed, 1984; Mintzberg 1990). Thus, management time and effort are expended on resource mobilisation and group manipulation to control and dominate decision-making agenda over resource allocation or change processes for the achievement of organisational goals (Perrow, 1986; Hall, 1991).

But salaried managers were not employed to make decisions on organisational design, operations and investments that determine the ability of corporations to compete, grow and maybe become successful (Chandler, 1990) until after the separation of ownership from control (Berle and Means, 1932; Fama and Jensen, 1983).
Professional managers were then expected and indeed engaged to discipline and control workers (Foucault, 1984) in effective production for the appropriation of surplus value and profitability (Burawoy, 1985; Marx, 1990; Stanworth and Giddens, 1974; Wood, 1982). The subsequent use of managers in large complex organisations to coordinate economic activity and their search for legitimacy helped to justify managerial role as disciplinarians

and controllers in support of productive functions in large complex organisations like NHS trusts (Britnell, 2004; Farndale and Brewster, 2005; Hailey et al, 2005; Wray-Bliss, 2002). Hence the role of services managers as controllers of financial and human resources in productive support services to provide better services to their local communities.

In the context of the NHS, medical consultants control the decision-making agenda and outcome, mobilising forces to neutralise decisions, policies and processes regarded as detrimental to their autonomy and professionalism (Llewellyn, 2001; Maynard, 2005; Thorne, 1997). Consultants and medical managers dominate resource allocation decisions through "priority setting" and the inclusion of "wider views" in budgetary planning hence such decisions become lost in pluralist agendas (Bachrach and Baratz, 1962). The refusal of some consultants to engage in medical audits and subsequent delay in implementing a uniform information technology across the health service, are cases in point (Anderson and Goodman, 2002; Foster, 2005; Haeksma, 2002). Thus the support services managers have had an uphill task in dealing with other healthcare professionals and managers as other researchers have also noted (Niven et al., 2005).

However, professional managers were not introduced in the NHS until after the Griffiths' Report (1983) which argued that the differences between the public and private sector organisations were much overstated. Subsequently, general managers were drawn from the private sector (with limited knowledge and experience in healthcare management) into the NHS to support and strengthen line management against professional doctors and nurses in decision-making and to be more accountable for public funds as better resource allocators (Klein, 2001; Pettigrew et al., 1992). This action was seen as a prelude to the separation of ministerial control from the daily operational management of individual NHS trusts in order to devolve power to frontline staff like support services managers for better accountability, transparency and local relevance (Levitt et al., 1999; Lewis, 2005).

5.7.2 Managers as key to departmental function (Depicted in Table 5.14 below)

Many managers were perceived as key to support services irrespective of services being outsourced or in-house (Agents E, F, G, I, M, R, Z). For example managers said:

If the facilities are well managed it make no difference whether they are outsourced or in-house. Depending on the size of the operation, the key to it is really management. We are a very big trust so we can afford to do things smaller organisations may not be able to do so there is a degree of training involved, affordability of trained personnel and the necessary knowledge and equipment to do a better job or give better service (economies of scale) and have the technical knowledge to be able to maintain the equipment (Agent R)

It all depends on how you manage the service. It is all about having a good clear strong management structure to manage the contracts because you are ultimately responsible for providing the services. If you are a very good manager, waste in catering should not be a problem (Agent Z).

One of the reasons for choosing the present primary contractor is their management structure. It shows that the company is taking a long-term view and is not just out for short-term profit. It is to the advantage of the trust to get better value for money through the contractors investing in management structure.
So when we tendered the service, we looked at cost and expertise that can benefit the trust (Agent F).
Experienced and skilled managers care for the customers, project a better company image and make the business more effective and successful (Agent F).

We went for the best services provider, not the cheapest. It all depends on the management (Agent E)

From these excerpts the skill, experience and expertise of the managers were regarded as key to management and getting value for money that benefits the client organisation.

5.7. 3 Contractors as professional

Many client managers saw contractors as professionals in their chosen fields doing professional jobs with pride and commitment in meeting their contractual obligations.
For example managers said:

They know what is expected of them and they are professionals so they take it seriously (Agents I and K)

Contractors are big conglomerates able to meet the needs of the trust. We interact with them as professional and they do a professional job (Agents I, J)
The contractors bring a lot of skills and knowledge and they are professionals in their chosen fields (Agent I)

They have their pride as professionals, we in purchasing know (Agent K)
They are very professional and they do a professional job we are satisfied with them. Patients now have more choices in food (Agents I and K). We won the best hospital award last week (Agent K)
Now things are done more professionally than before (Agent E)
They are professionals and work to set standards. We set rigid standards for them to meet Government regulations and we are satisfied with their work (Agent N)

The contractors also see themselves as experts individually and corporately in their chosen fields with the requisite training, skills, knowledge, expertise and experience to meet the contracted needs of their clients or in some cases exceed them.
For example some managers said:

It is important to see that people (managers) are properly trained and that they properly serve the needs of their customers (Agent F).
We (contractors) have pooled together a lot of experience here, we have come from different walks of life, we are very (very) experienced as purchasing managers, they (the trust members) benefit from what we have got, our contacts, knowledge, skills and experience (Agent G)

Oh yes we have professional managers who are well trained, they have both technical and managerial qualifications some are studying to gain their full diploma or second higher-level management degrees and some are going on to masters degree level (Agent Z)

As World Agents, we network with others to learn best practice and know who is who in purchasing. This is one of the advantages as purchasing contractors to the trust. We advise the facilities manager on matters of commercial interest and best practice. Purchasing has always been a professional business and we advise the trust with their commercial purchasing (Agent F).

We are a catering firm now in facilities management. We are experts in catering services to whosoever from Royalty to the man in the street. We believe that we are the best in what we do (Agent M)

At Premier everyone gets training and you do management training in dispute and learn other things as well (conflict management and budgeting) and it is free of charge (Agents H, S and X)

They employed Areno to bring in customer service rather than having to employ individual experts. They only have to employ one contractor with the knowledge of all the experts within one massive organisation as a one-stop shop (Agents M and O)

I am trained. I worked in the armed forces as an electrical and mechanical engineer. I then went and trained as a chef and worked in many hotels and restaurants in Britain, France, Austria, Italy and got into catering management and from there to facilities management. Now I manage the full facilities (Agent M).

I have worked for World Agents for eight years in different countries but before that I was in the armed forces so there is a lot of experience outside purchasing (Agent F).

I have qualifications in hotel catering and management. I have lots of experience in and out of the NHS. I have worked for contractors in the commercial and private sectors and will recommend it to my colleagues to help open their eyes and broaden their experience (Agent E)

I was head chef at a hospital in Melbourne before I went in to do the office side of the job. I started to understand about budgeting and ordering and slowly moved into where I am today (Agent X)

I have been in this chair for ten years, as a contract domestic manager for nine years and in and out of the NHS so I am qualified and have experience to manage this lot (Agent BB).

I used to be a cleaner but Premier trained me at night school and now I manage other cleaners (Agent T)

I have been in the NHS for twenty years having graduated with a degree in public administration. I then joined up as a graduate trainee manager in support services. I have had three commercial breaks working for public service companies and major hotel chains so I have experienced both sides (Agent Z).

5.7.4 Competence of contractors testified

The ability of services providers to satisfactorily meet the contracted needs of their clients was a testament to their competence. For example some said:

We adhere to the same Government benchmark of services and standards of service whether outsourced or in-house but a good contract manager makes the difference. If you have a good manager you will work well, and quickly with them otherwise you will have problems and conflicts and it becomes difficult (Agent I)

We have standardised monitoring systems for performance. The star rating is an issue. But they know what is required of them and they take it seriously and meet the needs of the trust (Agent I)

They would not have renewed our contract if they were not satisfied with our performance (Agent L)

We capped all our services within one contract price and transferred a lot of risk to them but they met all the needs of the trust. They bring a lot of skills and experience. We are satisfied with them (Agents I and J).

We have one primary contractor with all the expertise to maintain all our existing contracts and we are satisfied (Agents E and F). They bring a lot of skills and experience and we are satisfied (Agent K)

5.7.5 Skills and knowledge transfer

The professionalism of the contractors also resulted in skills and knowledge transfer to some support services managers in their work. For example some admitted that:

They are professionals we learn a lot from them, we are now able to see healthcare as a business and keep within our budgets (Agent I).

We learn from their network of prudent management to see healthcare as a business (Agent I).

The contractors bring a lot of skills and knowledge and they are professionals in their chosen fields (Agent I)

Things are done more professionally now we learn a lot from them (Agent E).

5.7.6 Dependence and control through expertise

Because of their individual and corporate expertise, services managers perceived their dependence on contractors for the smooth running of their support services, which they said is critical or vital to effective healthcare delivery.

For example some managers said:

On a daily basis, they are dependent on us (contractors), we save them labour and personnel costs, we come up with ideas to make them look good, we improve cleaning and performance standards so they get better scores, we exceed their expectations (Agent M)

Hospitals depend on contractors for support on patients' services to continue or the hospitals will grind to a halt. Support services are crucial for the smooth running of healthcare delivery (Agent K)

They will never be able to do it because of their massive overheads (Agent M).
Hospitals are dependent on them (contractors) for food and services (Agents J and K)

Things are done differently now. We provide services to a higher standard than the NHS ever did (Agent A)
We may be seen as contractors but we are still in control (Agent A and B)

The contractors have managed to let the public know how important the support services are. Hospitals are usually thought of as doctors and nurses, but without the support services, hospitals could not function (Agent I)

5.7.7 Discussion

Although services providers are aggressively in the market place and need no introduction from anyone (Agent N). There are certain criteria for choosing suitable ones. For example some were chosen on their reputation and credibility, which they guarded jealously, their financial standing or the ability to withstand a financial crisis and previous performance but mostly on the strength of their management structure as stated above. This was evidence of their commitment to long-term service of value to their clients. They are regarded as expert professionals and they perceive and regard themselves as such. The contractor managers come recommended due to their skills, experience, know-how and corporate reputation from all walks of life with diverse experiences they can transfer to their client managers.

To be a competent professional entails lengthy education, prolonged training and apprenticeship. Having served the requisite time and become approved by peers and officially accredited, professionals gain experience in their chosen fields to become proficient in the know-what, know-how and know-why of knowledge. Consequently, the knowledge, skill and experience of the services provider managers enable them to regard themselves and be regarded as professionals. Their professionalism is subject to ethical code of conduct that reduces the performance risk of sub-optimal service delivery and the relational risk of opportunism. Thus the support services managers involved have the opportunity to acquire skills, knowledge and expertise from their vendors to enable them negotiate with other healthcare professionals in resource allocation and decision-making.

There is a lack of leadership and financial management skills in the NHS, which has been blamed for their financial problems (House of Commons, 2003; Kmietowicz, 2006). The transfer of knowledge, skills and commercial acumen from providers to services managers is helping to meet this need and improved the financial standing of some trusts enough to attain foundation status (Timmins, 2007a). Furthermore, the lived experiences of these

managers from diverse works of life and their role help to structure their experiences and perceptions in their jobs. The vital role of support services is acknowledged, as is the importance of good contract managers. Both have evolved in the context of refocusing on core competence, the outsourcing of support functions and the need to access scarce resources from the commercial sector for mutual benefits. Thus, managers have become change agents (Drucker, 2004; Handy, 2000; Jennings, 2005; Senge, 1999), using the power of agency and the opportunity accorded by support services outsourcing to change their roles, positions and departments through learning and professional conduct to improve the image and status of support services and add value to patients' offerings.

Most of their clients are satisfied with their performance and renewed their contracts. At the time of writing no contractor has lost his contract. Managers as professionals with the knowledge to perform effectively use communication to inform all concerned, set priorities for action and so strengthen their relationships for improved services (Barnard, 1938). Meetings are also used to solve problems to prevent damage to relationships through conflict (Drucker, 2004) and reduce wastage through duplication of services.

Both client and vendor managers draw on the resources of their respective organisations (Giddens, 1984) to enable them listen, negotiate, and successfully prioritise and exploit opportunities and implement decisions (Drucker, 2004) to get the job done and obtain the scarce resources needed to reproduce organisational resources. Consequently, support services outsourcing investment in managerial expertise can be said to prove beneficial to services managers through professionalism and effective performance of the provider managers in coordinating activities to meet the contracted needs of the trusts. This confirms the tenets of the effectiveness of executive managers (Barnard, 1938) and the knowledgeability of agents in structuation theory (Giddens, 1984) as what they know and what they can do (Pleasants, 1999) to bring about changes (Kaspersen, 2000).

Indeed in some trusts, the client managers allow the services providers the freedom to provide services within the agreed specification. This is in line with the tenets of professional experts not requiring external control to function effectively (Giddens, 1984; Stephen and Pollitt, 1994; Weighman, 1996). Thus, their long-term relationships have endured with built-in trust and mutual respect to reduce the overt use of power and control.

But the client managers perceive themselves as being dependent on contractors for effective healthcare delivery through a more reliable and continuous support services. It has been established that the contractors have the power over the scarce resources needed for support services delivery. These are financial, expert know-how, knowledge and skills and in some cases, control over the facilities of operation. But the client managers also have authoritative power at their disposal. Consequently, both parties to interaction negotiate and agree on ways of meeting their objectives without resorting to power plays and organisational politics. Thus control is shared through interdependence using discretion and consensus in place of power or control for mutual benefits.
This study adds to the literature on successful inter-firm relationships, contributing to the debate on power and how those in contractual outsourcing relationships have managed to contain it for mutual benefit (Zukin, 1991). Thus, there is learning and knowledge transfer from the vendor managers to client managers who are being developed as professionals.

Observers watch to see if a bureaucratic organisation like the health services can become a learning organisation (Jamali et al., 2006; O'Hara et al., 1996; Senge, 1990, 1999) with the new partnership culture for comparative advantage (Reeve and Warren, 2004; Schein, 2004). Consequently, this study goes beyond the concepts of structuration theory and the requirements of effective executives to liberate services managers from backroom boys to knowledgeable agents coordinating hotel services activities and professionals able to negotiate with other healthcare professionals (Niven et al., 2005) in decision-making involving the effective use of scarce human and financial resources.

Table 5.14 Analysis of **Pooled Managerial skill and experience** theme

Theme	Agents code	Knowledge base	Communication
Signification	E, R, I	Expertise is the key	-If facilities are well managed, it makes no difference whether it is outsourced or in-house -The key to it is management -We outsource services where we don't have expertise in-house to maintain them -There is a degree of training involved -There is constant knowledge updating and keeping up with technology -When trained personnel are in place then you can benefit from economics of scale -Experts have the necessary knowledge, equipment and better facilities to do a better job or give better service -They have technical knowledge to maintain equipment -The key to a good contract is a good contract manager -They bring a lot of skills and knowledge as professionals in their chosen fields -The present contractors were chosen for reputation past performance, and management structure -All Premier managers have training -I am trained to manage the full facilities -We do a professional job
	I E, I, K, E, F H, S, X EMRZ LMOS TX		
	G I, J, K F G A, B	Experience & Know-how	-We have pooled together a lot of experience here -We capped all our services, transferred a lot of risks to them and they met the needs of the trust -Our staff canteens are based on commercial ventures. -They manage them, provide us with income to offset our costs -They recruit and manage their own staff very well -We engage a contractor with expertise to maintain all our existing contracts -We are more commercially aggressive and we are here to save them money-that's the bottom line -We provide a higher standard of service than the NHS
	I, K,W N	Skills transfer	-We learn a lot from them especially commercial skills -I have learnt a lot from contractors during negotiations
	A,B,H		-Support services is changing in ways managers work
Domination	E, K, R M	Dependence	-Hospitals depend on contractors for food and services -They depend on us to supply support services
	A, B	Commercial Know-how/	-We maybe contractors but we are in control -They are professionals but we manage them because we get complaints
Legitimation	M I	Rights and obligations	-We exceed our clients expectations -They met all the needs of the trust

5.8 Innovation theme

5.8.1 Introduction

Global competitive environment demands that firms use scarce resources like funds, personnel and expertise more efficiently and effectively to retain a competitive edge and profitability (Osborne and Brown, 2005). Commercial services providers routinely innovate to stay ahead of the competition in providing such services to more clients and hence increase their profits. One aim of support services outsourcing was for a more efficient and effective utilisation of such resources. Innovation is an opportunity to exploit the vendor resources to creatively produce something novel and new to benefit customers (patients and clients). Thus by association, innovation in food and services is implicit in the supply of support services to hospital trusts for mutual benefits.

Innovation is a specific form of change, radical, transformational, disruptive yet creative, a many faceted approach that can meet new needs in services, products or processes (Christensen et al.,2004; Henry and Mayle, 1991; Jolly, 2003; Osborne and Brown, 2005). Hence organisations both public and private engage in innovation to meet customer need. Innovation means different things to different people and at different times (Innovation, 2002:42). In short it is difficult to define but seen as the ability to turn creative ideas into commercial reality that meet changing needs (Christensen et al., 2004; Innovation, 2002; Seltzer and Bentley, 1999). Innovation is the life blood of development or upgrades (Jolly, 2003:27; Morita, 1992), central to wealth creation, driven by challenges to widen business scope, increase customer choices, meet latent demands or add value to market offerings (Innovation, 2002). Innovation is about profitability, economic growth, gaining competitive advantage and success in the market place (Jolly, 2003; Osborne and Brown, 2005). It is productive change, discontinuous with the past and said to be 10% inspiration 90% acquisition, changing values and creating employment (Kanter, 1983). It is also about creating surprise by doing something different or in a different way through the interaction between material, technology and the organisation (Harding, 2005). Thus, organisations are driven differently, to innovate or improve through continuous adaptation.

In the health service where budgets are perennially tight, specialisation and professional tribes rife, there are many obstacles to change hence innovation that is radical and destructive yet creative in meeting the changing needs of patients can overcome the barriers to meaningful change and progress in support services and in the organisation.

Thus contractor innovation has been the force driving change and innovation in hotel services. By the aid of services providers, many services managers found new ways of raising revenue, delivering care, serving food like the executive chef menus and cleaning with A-plus equipment to better meet the changing needs of their patients or departments.

5.8.2 Reasons for innovation (Analysed in table 5.15 below)

Innovation can stem from chance observation of a need. For example the visitors' café at Victoria hospital was a chance observation that visitors prefer places to meet with patients and relatives and chat rather than use staff canteens (open to the public). This observation spurned two cafés and two commercial ventures, *Diners' Den* and Café Locale, which are now in town making money for the contracted firm. The new cafés also provide revenue for the trust and help them to offset their total costs. This is shown as:

> We created two new restaurants, two new commercial ventures, *Diners' Den* and *Café Locale* for them and come up with other ideas to make them look good. We look after them. They are our clients (Agent M)

The same idea has been incorporated at County (Agent O) and Karena hospitals (Agents I and K) with success. Thus services managers in partnership with commercial services providers are enabled to mobilise provider's scarce resources of investment for innovation to generate revenue for their trusts and increase provider's profit or reputation.

> The idea for Café Novo here came from Victoria. We have Diners' Den there and we provide the same service here. Visitors like it because staff canteen is upstairs and some people prefer it down here (Agent O).

> Our coffee shop for visitors' restaurant and staff canteen are based on commercial ventures. The contractors manage them to provide us with income to offset our total costs (Agents I and K)

Services providers collaborate to enhance the profile and profitability or meet the changing need of their client in order to retain their custom or enhance their own reputation. This was the case at Theresa Hospital, where one services provider said:

> We are working with the builders to build this new hospital with creativity and imagination in mind
> It will be the flagship of the hospital and we are a part of it (Agent A).

Government agencies also have to find new ways of helping trusts function better or lose their relevance. For example:

> PASA now has electronic catalogues as well as hard copies so we can keep records and see what we are ordering (Agent K)

Commercial services providers need the edge provided by innovation to win new contracts to increase their influence or retain existing ones. For example:

We may be on site and have been up and down with the client but it is the innovation that helps us win new bids so we keep at it (Agent O)

You have to know how to cope with the new things that the trusts want done, that is the challenge (Agent O)

Clients expect innovation from services provider. For example:

We look to the soft FM (support services) contractors for innovation in food and services. There are things that the trust feels a moral obligation to do even though they are contracted out (Agent R).

Innovation is seen as a benefit from support services outsourcing. For example:

The main benefit of outsourcing to this trust is innovation. We may know what we need as an organisation but the contractors have visions and views of how they can provide more services and do it better with wider input and more sources of supply than we ever did (Agent I).

They (contractors) come up with ideas to help us achieve our goals (Agent I)

There are more patient choices in food especially on the private wing of the hospital (Agent K)

I think that Assured is doing a better job than when I was in the NHS. They are getting the latest products to the patients. It helps to give patients a choice and to reduce possible wastage (Agent X).

There are new products coming through from Assured. I think the next few years will be interesting (Agent X)

Premier has a business edge that comes through in the services they provide (Agent X).

We revamped the restaurant and made it a more enjoyable place to eat (Agent X)

Food wise —I don't think that there are masses of changes with the NHS but there is more innovation with Assured. Ideas come in to help patients get better service through Assured. On this site we have a green acre garden a kind of a la carte for the children to get better choice of menu. There is a housekeeper on site to cook it straight for them no matter what time of day (Agent X)

This place was a dump when we came here. Not just here at Featherstone but at the other hospital wings too. But look at it now, no more buckets and mops, no chemicals either. We implemented the new (A1-plus) special group of cleaning equipment. We use linco machines with microfibre cloth to clean and polish floors in public areas in no time at all, very efficient and saves labour cost. The hospital is cleaner and more hygienic (Agent T)

The new floor we built are padded and softer so our feet don't ache from walking all day and night, very good for nurses and doctors and for cleaners too (Agent T)

We also have the electronic palm pilot for monitoring cleaning areas, which makes it consistent every time because it is standardised. We work with the times and make the place more hygienic. (Agent T)

We have this new catering steam simplicity dishes you just microwave and it retains its taste and flavour even though it is cook-chilled (Agent S)

All our cleaning equipment and cloths are electronically marked so they are automatically returned to designated areas and not lost or cross used like before (Agent T)

Other benefits from outsourcing seen as innovation:

There is a special vacuum machine that sucks up broken glass or medical waste so cleaning is easier and contamination or cross infection of staff is reduced. Then there is the microfibre flat cleaning cloth. It is new, not disposable but has disinfectant incorporated in it so no more chemicals and buckets for toilets or dirty areas. Cleaning with this cloth, we can kill 99% of the bacteria in those places so it is good for Premier and the cleaners. It is really good for cleaning and does it in less time so we have less staff to do the work and do it better. It helps with hospital infection (no MRSA here so we keep out of the news media) (Agent T)

There are new automatic washing machines with computerised correct temperature for all kinds of soiled linen and equipment so no more cross infection while cleaning laboratory areas or washing out the rags and cleaning cloth we use (Agent T)

We seem to have created a multicultural environment in this trust, which has its many challenges and problems so we work with contractors like Assured to make changes that we feel will make a difference and improve patients' experience through the trust. Years ago patients could get by with sandwiches and tea for lunch but not any more. The multicultural patients we have here demand certain diets that only professionals like Assured can consistently provide so we work with them to make that possible (Agent V)

These excerpts reflect the variety of benefits managers perceived they received as innovation from support services outsourcing. Since the managers regard these as innovation, they are treated as such. However in some trusts, there was limited innovation because they were in an interim period as the agents explained:

There is no innovation here since we aim to close this site in four years and move into a brand new building but we have protected meal times and celebrity chef dishes for the patients (Agents A and B).

Discussion

Many managers in the contracted support services perceived that the contractors have brought innovation in food, services, new ventures to generate revenue and new facilities with alternative ways of working as a consequence of support services outsourcing. Some trusts outsourced for or expected innovative services from the contractor and got them. Thus innovation can be regarded as an extension of contractual relationship benefits.

Many managers reported working as teams in a spirit of partnership with the commercial operators. Team spirit and partnership provide the special environment for innovation to thrive (Christensen et al., 2004; Kanter, 1983). It allows the cross-fertilisation of ideas for problem solving to enable creativity to flourish. Innovative staff must be allowed to explore possibilities, spend time to imagine, take risks, experiment and be allowed to fail without ridicule (Jolly, 2003:34; Innovation, 2002). Through constant communication, managers negotiate, agree on consensus and implement their agreements and find new ways of providing support services to their trusts to meet the ever-changing needs of customers and save on total costs or generate revenue to reduce their perennial deficits.

The contractors must continuously innovate to stay ahead of the competition, avoid obsolescence, win new contracts or increase their areas of influence, maintain reputation and increase profits to retain their competitive edge (Drucker, 1998; Osborne and Brown, 2005). To spur them on in the race to innovate, some contractors coined slogans to this effect. For example, Assured has "unlock the problem and make it happen" showing their focus on problem-solving while NHS motto should read "refer to higher authority and if in doubt, deny everything". This reflects their lack of accountability and constant reliance on higher authority positions. Consequently, a confident "can do attitude" (Agents M and O) with the ability to take initiative and shun inertia (seen as enemy of innovation) can turn creative ideas into innovation. Thus an environment of team spirit and partnership for mutual benefit does support innovation and enable creative ideas to grow and flourish.

The creativity, combination of materials from complementary assets of services providers and their clients, technology and know-how have creatively produced something different in new ways of doing things. For example, domestic workers were content cleaning with wet mops, rags and dusters till the new A-1 Plus equipment from Premier arrived and displaced wet cleaning, mopping and media attention on hospital infections especially at Featherstone hospitals. Now Karena hospital has adopted the "linco-machine" that cleans and polishes and needs less people to clean the same square meter of floor space. Thus new products resulting from innovation can displace outmoded ones and spurn its own usage beyond its origins.

In the in-house operations there was very little sign of innovation but they incrementally improved services. This may be because the health service has been described as the embodiment of stability, conformity and continuity, being welded to political timetable of quick fixes, under constant financial pressures hence favouring only episodic incremental

and adaptive or non-disruptive changes (Moore, 1992; Osborne and Brown, 2005; Pettigrew et al., 1992). This maybe because most people in the NHS believe that they work *in* it (security of tenure) while contract workers work *for* their private commercial company and must prove themselves (by meeting contract obligations). Consequently, contractor workers have more ownership of their activities (due to incentives and no blame culture) than in some trusts, where people focus on their job levels and keep their heads low, out of the firing line hoping that the torrent fads of change may pass them by.

Although innovation has benefited some trusts beyond the confines of their origin, as in the adoption of new ventures (café Novo) and A-1 Plus cleaning equipment, the contractors lengthened their contract period through protracted mortgages or investments or both and aim to earn longer streams of revenue. Thus innovation can be a double-edged sword cutting both ways for most managers but mostly benefiting private contractors (Day, 2007). Innovation also entails costs as unintended consequences.

5.8.3 Cost of innovation

Although organisations that innovate reap rewards in increased business scope and customer choices or added value for competitive advantage, there is a cost to innovation. Innovation in hotel services such as cook-chill (frozen food) and the A-plus cleaning equipment have led to jobs losses and de-skilling of cooks (Barley, 1990; Wood, 1982). Although these creative ideas enable domestic staff improve hospital cleanliness or uniformity of food served to patients, their constraining effects on ancillary workers can reduce their social value hence themes, like innovation with beneficial outcomes can also exhibit unintended outcomes detrimental to a section of society like ancillary workers.

The effect of the job losses has been mitigated by ancillary staff job mobility within the health services and the ability of contractors to transfer staff wherever in the world they happen to have contracts. But the in-house ancillary workers have no such options. Consequently many trusts benefit from their partnership with commercial contractors in new ways of working (new facilities), new ways of revenue generation (new ventures) and improved food and services to meet the changing needs and tastes of multi-cultural patients. But such benefits can be marred by unintended consequences of job losses.

Another unintended consequence of innovation is perceived dependence of the client managers on their services providers since they have lost in-house skill, knowledge and

know-how to provide their own services. The loss of jobs and deskilling of cooks, cleaners and ancillary personnel forces some to change jobs or be moved to where contractors have other contracts. But the trusts that outsourced services were not disappointed with their overall benefits gained. Thus this thesis adds to the literature on the benefits and costs of innovation this time in the context of pubic sector support services.

5.8.4 Innovation in facilities

FM innovative open plans turn real estate into tools that can be used to improve business results and achieve objectives (Jones, 2000c; Okoroh et al, 2002). This is done through revenue generation from dormant spaces, new ventures like canteen and change in work place relationships and working environment. The improvement in work places inspires workers to give of their best and improve the support to the core function of the NHS and their accountability to public funds (Alexander, 2003). FM designs also improve health and safety and reliability of facilities as well as customer satisfaction (Drucker, 1998). It enables private investors assume responsibilities for risk assessment and its minimization in support of organisational effectiveness and business transformation (Linder et al., 2002). Thus FM services are beneficial to some services managers and their trusts.

FM built environment promotes change by providing a facilitating environment for task performance and fostering mutual staff interaction and collaboration for more effective work (Alexander, 2003; Ilozor et al., 2002). They are of low cost to trusts and offer them the flexibility of adapting them into more suitable facilities without relocation. The case of Department of Social Services (DSS) sited by Jones (2000c), and Theresa hospital in this study are testaments to this. Thus FM built environment can enable some public sector managers achieve quality, innovation, cost savings, revenue generation and distinctiveness in affordable and deliverable facilities (Clews, 2005; Walton, 2007).

5.8.5 Other areas of change

The shift in ideology from state sponsored to commercial partnership has spurned change and organisational transformation in outsourced support services beyond their department into other areas of the trusts. For example, there is more private-public sharing of medical facilities to share costs, utilise capacity and improve quality of patient care. In the trusts with new facilities, the patients have more privacy, better food choices and frontline staff have less patients to deal with due to contraction in bed capacity to achieve better privacy. Some services managers have imbibed the ethos of seeing healthcare as a business instead of a perennial cost to the national purse.

Table 5.15 Analysis of **Innovation** theme

Theme	Agent's code	Knowledge base	Communication
Signification	E, I, K	Cook-chill provides standard products every time	-Contractors helped change our kitchen service from conventional type to cook-chill to suit the needs of the trust
	E		-Patients are less forgiving now. They want their meals hot and on time more than they want their doctors or painkillers so cook-chill meets the need
	A	Innovation through partnership	-We (contractors) are working with the builders to build this new hospital facility with a lot of creativity to make it the flagship of the hospital
	A, B		-We can't embark on creative ideas while waiting to close this hospital and move into the new one
	H	Commercial ventures help generate revenue	-There is the new Nevitto canteen we nurtured here. They are at many petrol stations nationwide
	M, O		-Diners' Den and café Locale are doing well Coffee shops have been included to serve visitors
	I,J,K		-Our staff and guest dinning services are based on commercial ventures to provide us with revenue to offset our total costs
	I	Contractor's creative know-how acknowledged	-The main benefit of outsourcing in this trust is innovation.
	I		We may know what we want but contractors have visions and ways of providing more and better services with wider input than we ever did
	I		-They (contractors) come up with creative ideas to help us achieve our goals
	I, J,	Commercial Knowledge transfer	-Contractors advice us on new ways of estate management to increase income to offset costs
	I, J, N		-Our unused spaces are rented out for income
	F, K, Z	Government agency is also creative	-PASA helps us with new ways of tendering and purchasing to save money. There are now on-line templates in line with European standards
	M, O		-We innovate and push the business forward. We created the Café Locale as our brand for visitors who don't like to use the patients or staff canteen
	T	Creative automation can reduce staff levels	-We created A-1 Plus cleaning equipment for the trust and the new carpets to relieve aching feet
	S, X	Contractors innovate for competitive edge	-I don't think that there are changes in the NHS but new ideas come in all the time from Assured to help patients get better service
	ABO X		-New menu system gives patients a choice and helps to reduce possible wastage
Domination	S, X	Food companies should dominate provision of food and services	Premier is the biggest food company in the world with a business edge and the latest products No good having medical people messing about with providing food for the patients and staff
Legitimation	I, R	Contractors obliged to innovate for profits	We look to the contractors for innovation in food and services to meet needs and avoid complaints

Indeed, some support services managers and their chief executives are now commercially aware. They no longer see profit making in the NHS as anathema to the ethos of a public service like the NHS (Vize, 2008). For example, the chief executive of University College Hospital and his managers assisted by their contractors have managed to dispose of their redundant real estate in a prime site in central London to turn their deficits into surplus and make a profit (Gainsbury, 2008). Perhaps this is why the said chief executive, Robert Naylor, was knighted (Evans, 2008). Managers have become financially prudent as their trusts are poised for foundation status (Featherstone and Karena hospitals) while Theresa Hospital has proven its prudent use of resources and attained foundation status.

The financial prudence of some chief executives, who have led their NHS trusts to gain foundation status has been recorded (Goldman, 2005). This same financial prowess has enabled the same chief executive to succeed in acquiring and absorbing a failing hospital and turning it into an operational one (Santry, 2008). This chief executive, with decades of experience of the health service succeeded, where teams from the private sector but devoid of the intricacies of the health services, failed. Consequently, managers already versed in the operations of the health service can succeed in turning around failing trusts, given the transfer of knowledge in the form of financial prudence and commercial ethos.

The "revolution" in healthcare facilities design and accomplishment enhanced the local landscape transformed some trusts' working relationships and mobilised community spirit as currency for legitimacy and relevance to their local hospitals. For example, FM built environment has won the (LIFT) award in Excellence in building healthier communities (Bradshaw, 2008) and the prestigious (CABE) award for architectural design, innovation and excellence at its facility at County hospital (one of the hospitals in this study).

But the redesign of new healthcare facilities has aided new working relationships and forced some workers to relocate, resulting in leavers and joiners for improved services.

Cultural considerations, design and serendipity have also forced changes in dominant values and beliefs to redistribute organisational power and control and confer legitimacy to subordinates. For example, there is now a change in the perception of some dominant groups regarding procurement managers and their workforce. These erstwhile underdogs of the health service, regarded as being at the bottom of the skills heap are now treated with some respect (Restell, 2008).

The culture of some trusts studied has also changed to include team-working partnerships and less caustic blame that has been the bane of the health service for so long.

The support services staff have been trained, educated and developed as intangible assets of their organisations able to generate higher efficiency and productivity for them. The resultant increase in knowledge and expertise and the professional standing of managers and workers add value and help to move their trusts towards knowledge organisations to further enhance their image and reputation. Hence some services managers are now able to effectively and efficiently deploy human and financial resources for their departments through better financial capital utilisation and perform better. Thus this small study has evolved to unravel some of the documented conditions for change, power for control and domination, organisational regeneration or transformation and community renewal with enhanced public image of support services and their institutions.

But the in-house operators have not made meaningful changes during this study perhaps due to HR dominant coalitions blocking the financing of changes through political intrigue and agenda setting and filtering of environmental information that sees most contractors as risky, unreliable and problematic or their cash constraints and tight budgets. These activities and conditions derail change efforts due to agents' inability to mobilise enough transformative capacity to overcome dominant oppositions. Thus, the management of organisational politics, managerial skills, access to cash and the ability of agents to draw on appropriate rules and resources for mobilising power become prerequisites for lasting change, organisational transformation and possible community renewal.

The unintended consequences common to all outsourced services are firstly the deskilling of cooks who will no longer be "roasting joints of beef and lamb or grilling big trays of fish and chicken but will be handing out ready cooked and chilled meals". Thus de-skilled chefs need motivating, encouraging and supporting during these changes till they can be found something more suitable or reassigned. Secondly, ancillary staff inherited by contractors were streamlined and trained to be more effective through active but friendly supervision (agents P and Q) in order to reduce total costs. Automation led to total staff reduction and reassignment of duties or unemployment with the attendant human pain and misery. But through it all services managers confess that the changes since services outsourcing have helped them to improve support services for better clients (patients) satisfaction.

Table 9a

RESPONDENTS' PROFILE

NHS trust Hospital	Job Title	Role	Age	Gen.	Education	Experience	Agent Code
Theresa 100%	Facilities general manager	Contractor in charge of support services on site for Kingsland	63	M	Rose from purchasing rank NHS management trained	32 years in NHS 3 years in post (contractor)	A
	Patient services manager	Controls support service for patients on site for Kingsland	42	M	Rose from purchasing rank NHS management trained	10 years in NHS 3 years in post (contractor)	B
	Stakeholder	Facilities Admin. manager	45	F	Graduate	10years in NHS	C
	Stakeholder	Facilities Admin. manager	43	F	Graduate	8 years in NHS	D
Helina 100%	Facilities manager	In charge of estates, facilities and support services for the trust	57	F	Graduate in admin.	25 years in post, varied commercial experience	E
	General Manager purchasing	Contractor in charge of purchasing for the trust	56	M	Graduate, Army trained	International commercial experience. 8 years in post	F
	Purchasing manager	Contractor for purchasing all medical supplies	36	M	Graduate	3 years in present post. Aggressively commercial	G
	Catering manager	One of 4 Contractor managers for all catering in the trust	59	M	Assure trained, rose from chef to catering manager	20 years with Assure working in their contracts	H
Karena 75%	Facilities manager	The boss, in charge of all estate Support & facilities for the trust	62	M	Rose from estates ranks NHS trained as manager	36 years in post. Has been there since outsourcing	I
	Estates & facilities manager	In charge of estates & facilities matters for the trust	52	M	Graduate engineer	10 years in post. Previous commercial experience	J
	Purchasing manager	In charge of purchasing all supplies for the trust	65	M	Rose from the ranks in purchasing	40 years in NHS. Retired In post since outsourcing	K
	Catering manager	One of 3 contractor managers in charge of catering for the trust	30	M	Mediserve trained as chef then as catering manager	4 years in post, 13 years with present contractors	L
Victoria 75%	Support services manager	Contractor in charge of all support services for NPH (in charge of other managers)	56	M	Graduate, army trained Areno trained as chef then in management	International experience in hospitality industry before joining Areno	M
	Project manager	In charge of support Services buildings (County hospital)	58	F	Graduate nurse turned project manager	Wanted commercial experience in projects	N
	Catering manager	Contractor in charge of all catering at County hospital	42	M	Graduate in hospitality	8 years in post. Worked in other Areno contracts	O
	Stakeholder	Cleaner turned nurse in training	30	F	Trainee nurse	3 years with Areno	P
	Stakeholder	Cleaner with Premier Group	28	F	Ancillary worker	6 years with Areno	Q

Table 9b

RESPONDENTS' PROFILE

NHS trust Hospital	Job title	Role	Age	Gen.	Education	Experience	Agent Code
Featherstone 50%	Facilities manager	In charge of estates and facilities for trust	52	M	Graduate engineer	8 years in post. Varied commercial experience	R
	Chief Catering manager	Contractor in charge of all catering for trust (4 managers)	58	M	Assure trained chef turned catering manager	7 years in NHS, 4 years in post. Worked in other contracts	S
	Domestic manager	In charge of all domestic services for the trust	57	F	Cleaner in NHS, trained by Assure as manager	20 years as cleaner in NHS, 4 years in post in other contracts	T
	Training manager	Contract trainer	35	F	Graduate. Consulting firm	6 years as Assure staff trainer	U
	Stakeholder	Nurse turned ward manager	46	F	Graduate nurse	10 years ward manager in trust	V
Reinhard 50%	Estates Department manager	One of two managers in Estates and facilities for trust	42	F	Graduate engineer	10 years in NHS trusts 8 years in present post	W
	Catering manager	Contractor in charge of all catering services for the trust	48	M	Trained as chef in NHS Assure trained manager	7 years as chef in NHS 2 year as manager with Assure	X
Charlston Memo.10%	Facilities Director	Director of facilities projects	56	M	Graduate engineer	30 years in NHS posts No commercial experience	Y
	Support services manager	Director of support services (covering for one on leave)	56	F	Graduate. On the job training all working life	3 months in post, 22 years in NHS. Commercial experiences	Z
	Catering manager	One of six catering managers covering the whole trust	38	F	Graduate in hospitality	2 years in post. Poached from commercial firm (all six were)	AA
	Domestic manager	In charge of all domestic services for the trust	58	F	NHS on the job trained	10 years in post, 9 years commercial experiences	BB
Dickson Memo.10%	Facilities manager	One of four managers in Estates and facilities	47	M	Graduate engineer	19 years in post. Other NHS jobs in facilities management	CC
	Catering manager	One of only two catering managers for the whole trust	64	F	Rose from ranks in NHS- From chef to manager	Retired after 35 years in trust Recalled, 3 years now in post.	DD
	Domestic manager	In-house manager in charge of domestic services for trust	48	M	Cleaner turned manager NHS and self trained	4 years in post, varied commercial experiences	EE

Table 16a **Data analysis of themes using structuration theory (Giddens, 1984)**

Structures	Efficiency	Relationship	Contractor Investment
Signification	-Reduce total costs -Generate revenue -Be flexible in controlling hotel services' costs and quality - If food prices increase we, contractors, bite the bullet. -We don't see outsourcing as route to gaining value for money. -You need to recognise what your core business is (where you can be efficient)	-Contract management is all about relationships and how you work well with people, not discipline. -If you work with contractors as a team you will achieve results /goals -We network with other trusts to learn best practice and who is who in purchasing. -We interact with contractors as professionals in the work they do -We engage non-executive directors by their social standing or work done -We meet informally daily and formally to discuss issues and agree	-To train ancillary staff -To refurbish kitchens, build cafés and restaurants. -To help clients function better -Contractors train own staff and relieve us of personnel problems —that's a huge load off my back - Support services staff are better trained by contractors the NHS did not train ancillary staff.
Domination	-Show value for money in use of our resources . -We procure all our services within one contract set price but there is a marked difference in the price we pay to contractors, we know	-We can revoke or extend their contract as incentive to perform well. -It is our goal to maintain good relations with all our contractors. -I don't manage them, we relate to each other on personal basis -We are in control although seen as mere contractors. -We can penalise contractors for proven non-performance	-Extend and retain contracts with client-specific investments -Contractors borrow funds and make them available to us and we pay back with interest over time.
Legitimation	-We avoid deficit sanctions -We collect budgeted Government allowances	-Trusting relationships evolve as contracts evolve. Trust is essential. -We have no penalty clauses, they get in the way of good teamwork. -We have a social club on site and all are welcome	-Better ancillary staff retention through job satisfaction and improved facilities hence no exits -The canteen is now an enjoyable place for all to meet and eat

Table 16b **Data analysis of themes using structuration theory (Giddens, 1984)**

Structures	Managerial experience	Innovation
Signification	- The key to better support services is good management whether services are outsourced or in-house -The key to a good contract is a good contract manager otherwise you will have problems and conflicts. Simple - I am trained as a chef, worked in the army and hotels abroad before going into catering and then facilities management -We have professional managers who are well trained - I have been in the NHS since 1984 with three commercial breaks	-We look to contractors for innovation in food and services -Contractors build new cafés and canteens to raise funds for clients -They come up with ideas to help us achieve our goals /objectives - We, contractors, come up with ideas to make our clients look good—we project their cleaning standards, they get good scores
Domination	-We advice the facilities manager on matters of commercial interest -We are commercially aggressive -We have worldwide contacts and know who is who in purchasing so our clients benefit from what we have and contacts - A lot of people in the NHS should go and work in the commercial sector to help open their eyes (in how to mobilise, manage and control resources)	-We (contractors) exceed client's expectations (so retain contract) -We rely on the contractors for patients' services or else the hospital will grind to a halt -We rely on contractors for changes in food for our multicultural patients
Legitimation	The client benefits from what we've got and know—our pooled experience (in order to avoid sanctions)	-We avoid patients' complaints about food and services. -Our clients are satisfied with our services (we are not sanctioned)

Key:

Signification: Language in use, important codes or verbal themes or language games played by respondents

Domination: mobilisation of resources for administrative or economic decisions or the ability to control resources

Legitimation: actualisation of rights or enactment of obligations. Deep structures may not be overt as topics of themes

Table 16c **Data analysis of themes within themes using structuration theory (Giddens, 1984)**

Structures	Reputation	Foundation status
Signification	-Staff work hard to keep down hospital infections and to -Deliver on contracts agreements -We won the best hospital award -We are the biggest food provider in the world - We are linked to erstwhile hotel chains with massive reputation - We are big and can guarantee the service and provide backups -No cosy relationships with clients or services supplied to dodgy clients. -Money is not everything, our reputation is more important to us.	-We can gain sound financial footing through commercial awareness, generate more funds and reduce our deficits. -We can look at services from a money-generating point of view—as a business, not drain us of resources. -We will have the ability to borrow money and be independent of others. -Probably to raise our financial freedom
Domination	-We help our clients keep out of media attention -And we maintain their star-ratings -We project our clients image and help to make them look good - Support services are critical to the smooth running of Healthcare delivery	-We are able to chart our own course, keep surplus revenue, choose our own patients and have legally binding service level agreements. -We will gain independence from Strategic Health Commissioners
Legitimation	-To avoid a tarnished corporate image -To enhance support services image	-We avoid monitoring sanctions. -Avoid the dictates and control of Strategic Health Commissioners

Table 17

POSSIBLE ANALYTICAL SCHEMA FOR HOTEL SERVICES OUTSOURCING

IDEOLOGY

NHS can operate like commercial organisations

→

MANDATE TO
Outsource services

↓

EFFICIENCY CUE

↓

BUT Local trusts have other concerns apart from cost control alone **(Value for Money)**

→

NHS Trust	Motives for Outsourcing	Outsourcing outcomes through agency
Theresa Hospital 100%	To concentrate all services on one site (ultimately)	Now operates as a business on one site, using contractor investments. Makes legally binding agreements. Patient choices in food and services
Helina Hospital 100%	Lack of managerial skill and experience	Contractors advice managers on commercial matters. Help facilities manager gain value for money
Karena Hospital 75%	Ancillary personnel retention problems	Achieved aim of outsourcing plus raises funds from innovation like new canteen and café. Contractor's ideas and investments help support services managers achieve their goals
Victoria Hospital 75%	To gain reliable un-interrupted support services	Achieved aim plus gets funds from innovation in new cafés. Other investments and staff trained by contractors mean value for money
Feather Stone Hospital 50%	Relieve a troublesome function	Able to concentrate on healthcare Gained patients choices in food and services. Innovation in cleaning and new floors to relieve aching feet.
Reinhard Hospital 50%	Ancillary recruitment and retention problem	Achieved aim plus innovation in food and services. Investments give better dinning facility for staff and guests.
Charlston Memorial Hospital 10%	Fear of losing control and rebuilding service	Previous unsuccessful outsourcing so cautious. Needs to maintain control of service quality, cost and changes
Dickson Memorial Hospital 10%	Inertia (outsourcing not revisited since)	Initially in-house team won the contract, Outsourcing not re-visited. Only need to show value for money

Chapter 6 Conclusion

6.1 Introduction

This last chapter attempts to draw the threads together without repeating what has been discussed in detail in the previous chapters. This thesis has been an enjoyable journey of discovery illuminated by the evolving patterns of change and perceptions of power in the selected support services studied. This reaffirms the decision to recast the thesis in the light of the predominant issues of change and liberation as perceived by those directly involved. The highlights of these changes are made through relationship investments resulting in institutional, personal and community changes. For instance, relationship-specific investments made by services providers in different outsourced services enabled them refurbish kitchens, canteens and provide cafés for visitors. From these canteens and cafés much needed revenue was generated for those concerned to offset their costs while refurbished kitchens became a more pleasant work environment for improved services.

Investment in ancillary staff training equipped them with skills and knowledge and gave some the confidence to venture outside the confines of the drudgery of manual labour into frontline services and so improve their job mobility. Services managers also gained skills and experience in negotiations and conflict management and commercial matters while capital project investments have changed some community landscapes. These findings strengthen and support the notion that knowledgeable agents differentially endowed with access to resources (investments) can maximize their transformative capacity to intervene in pre-existing state of affairs and make a difference to change their earning power, role, organisation or perceived power differential and help to transform their local community.

Furthermore support services were outsourced to solve problems of resource scarcity such as ancillary staff retention, lack of expertise or managerial skills. In return many outcomes elicited from this study suggest that services outsourcing is beneficial beyond resource acquisition, cost savings and some services managers' expectations. Thus the economic uncertainty and resource vulnerability that necessitated support services outsourcing, the innovativeness and ingenuity of commercial services providers and the agential capacity of services managers have acted co-determinedly to achieve a bundle of benefits for possible comparative advantage. These findings also support and strengthen the use of resource acquisition theories in the context of the public sector.

The theoretical and empirical conclusions, which can be drawn from this research, are discussed in the sections below. They begin with implications for theory and areas for future research through to management applications and concluding remarks.

6.2 Implications for theory

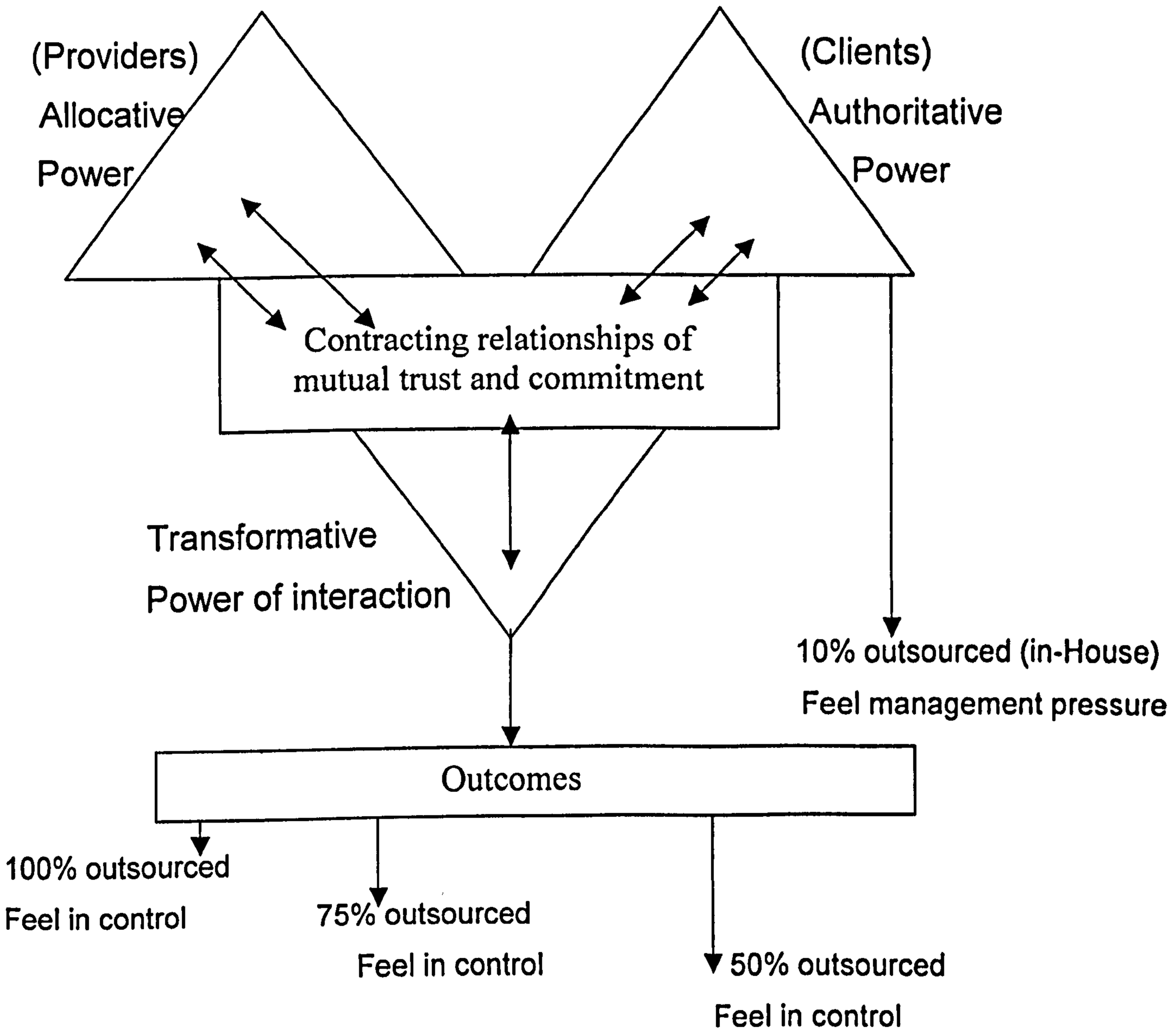
The empirical findings from this study support the conviction of other writers that social research has a broad mandate and no one single lens can be expected to inform all the relevant issues (Stones, 2005; Williamson, 1996). But by using multiple complementary theories many aspects of the subject under study can be illuminated. For example, support services were outsourced in search of cost containment and resource acquisition. These areas involve theories of decision-making for outsourcing (not dealt with in this study since the decision to outsource services was already made for those directly involved), resource acquisition theories for accessing resources and transaction cost economics as a suitable governance structure for economising on total transaction costs.

But resource acquisition theories are criticised for being silent on how to use the acquired resources to build capabilities for comparative advantage. Similarly transaction cost economic is criticised for focusing on economising alone while neglecting the value adding nature of business relationships and alliances. Consequently it is left to interaction model (IMP) to illuminate the study on the value of business relationships while structuration theory puts agents centre stage as knowledgeable and having both authoritative and allocative capacity to make a difference and bring about change and transformation.

The complementary nature of these theories comes to the fore in this study. The result findings validate their combined use and advance the usage of some of them. For instance the results confirm the suitability of resource acquisition theories in a public sector context and show how complementary resources can be combined to build capabilities through skills and knowledge transfer, learning and innovation. Transaction cost economics has sensitised agents towards hybrid arrangements for economising on total transactions and adding value. Similarly, the tenets of interaction model (IMP) have been advanced to add value through business relationships over and above acquiring resources and support through networks and safeguarding of specific investments. Structuration theory has been shown as a valid and appropriate tool for analysing complex data. Its concepts of power and change enabled me understand to explain the underlying structures hidden in the perceptions and voiced experiences of respondents.

Thus this small study has advanced the concepts of structuration theory from a sensitising device of action to a theory of change and liberation.

Figure 6.1 Conceptual Framework of power flows



Theoretical discussion

Power is ubiquitous and no relationship is independent of its subtle effect due to resource asymmetry. The concepts of power are evident in this study. For instance, the support services managers possess the authoritative power to outsource services or keep them in-house. Those in 10% outsourced services chose to keep services in-house. Consequently,

the in-house services managers interviewed complained of management pressure in the use of their budget and staff discipline. There was minimal change in this sector but they had stability and were able to be flexible in controlling costs and quality of services. But in the 50% -100% outsourced services, managers felt they were in control and not under pressure. Although there was visible management, workers had freedom of work movement and were not under pressure. Through interaction these managers were willing to share their authoritative power and combine it with the allocative power of the services providers to realise the transformative capacity for change and liberation. Consequently, there are tangible changes in all three sectors. For example, there are changes in the physical environment at Theresa hospital (100% outsourced) and County hospital (75% outsourced) where services managers in association with the contractors own and manage the facilities in which the hospitals operate from. Thus liberating the erstwhile ancillary workers from manual labour to possessors of built environment fit for the 21st Century. Theresa hospital is also liberated from budgetary deficits and the dictates of Strategic Health Commissioners through foundation status. Consequently, the findings of this study suggest that the ideological change of NHS managers being able to operate like their commercial counterparts in the use of human and financial resources can be realised.

The image and reputation of support services and facilities management have been enhanced. In the outsourced services, ancillary staff have been trained and equipped with skills and knowledge as professionals in support services. Services managers have also gained insight into commercial ethos, negotiation and conflict management to add value to their institutions and are enabled to compete with other health service professionals. There is a "revolution" in healthcare facilities design and accomplishment seen at Theresa and County hospitals. These new buildings have helped to transform the local landscape and mobilised community spirit as currency for support and legitimacy for their local hospitals. Furthermore, the re-distribution of power symbols in new offices, car parks and work areas has resulted in altered perceptions of power differentials benefiting services providers, support services managers and their workforce more than the dominant medical teams. The association of services providers with the health service enhances their reputation. Thus both the support services managers now with improved image, professionalism and profile, their commercial services providers and FM providers of new built environments can all bask in each other's reputation for competitive advantage.

These successes have led to the extension of outsourcing to other areas in the health service. These are clinical imaging, non-emergency ambulance services, sterile services patient appliances and information technology. Outsourcing in the health services is also expected to continue for the foreseeable future. Thus this small study validates the use of outsourcing in resource acquisition in a public sector like the health service and advances the concepts of allocative power from investments as a liberating device.

Furthermore innovation by the services providers in food and services has added value to patient offerings for better services to the satisfaction of support services managers and their patients. There is creativity and innovation in new built environment and real estate management. Consequently the findings of this thesis adds to the scarce literature on FM and estate management as catalytic agents of change, using their resources and expertise to enable some trusts extend their outsourcing objectives, while extending the scale and scope of their services. This has liberated workers and their managers from aging and decaying facilities into better work environments. Thus the benefits of services outsourcing is shown to go beyond value for money and professionalism of ancillary staff to include innovation in food and services and real estate management for comparative advantage.

This thesis can be said to answer the call of Alexander and Young (1996), to show the value of outsourcing. There is perceived value. For example, in the outsourced services, the uncertainty of support services provision is reduced. The streamlined and more skilled staff, provide a smaller, more flexible and manageable workforce for task accomplishment. There is perceived change in the outsourced services from blame culture to teamwork. The complementary assets of clients and services providers make innovation possible while the investments of the services providers enhance the flexibility of trusts to meet changing business needs in support services and free up assets for other use. Services outsourcing also enables managers to focus on their core activities where they can add more value and so become more efficient. Thus this project builds on other studies that confirm significant cost savings in capital projects and business operations (Harland, Knight and Lamming, 2005; Jiang, Frazier and Prater, 2006, Linder et al., 2002).

However services outsourcing has also produced some unintended outcomes in ancillary staff de-skilling, redundancies, exit to better jobs and possible dependence or domination of support services by commercial providers through control of information services and loss of in-house competence in support services. But the job mobility of some contract

workers and the incentive to work anywhere they have contracts, have mitigated the hardship or human misery that would have ensued. For example, some trained ancillary workers have gone on to do other jobs in the trusts while deskilled cooks are redeployed in contractor kitchens cooking the meals they chill! Most of those displaced by streamlining of staff have also been re-deployed and absorbed elsewhere.

There is a perception of hollowing out and creeping privatisation of the health service as the central Government acts as an M-form holding company overseeing private vendors supply and deliver services to healthcare organisations through extended outsourcing. Thus services outsourcing has been beneficial but with some unintended consequences.

6.3 Implications for further research

The issues raised by this exploratory project suggest the need for further research to investigate and validate some of these findings. A list of suggested areas is given below

1. Because the findings of this study are context specific and reflect the personal experiences and perceptions of those directly involved, further investigations of the risks, benefit and impact of hotel services outsourcing in different hospital settings but within the health service is needed to complement this study

2. Investigation of services outsourcing using a mixed model approach, comparing in-house and outsourced services, as in this study would also complement this project.

3. Studies on the consequences of support services outsourcing extended to the private health sector and perhaps compared with those from the NHS as documented here will provide a more holistic picture of this interesting exercise.

4. The evolving role of outsourcing in the health services needs studies in clinical outsourcing to complement what has emerged from support services outsourcing and thus present an overall picture and model of health services outsourcing.

5. Theresa hospital has been enabled to attain foundation hospital status during this study. But other NHS trusts—Featherstone and Karena hospitals are now poised to go the same way. Studies in how these foundation hospitals fare in the coming years will be interesting since there is no policy at present on the likely event of their bankruptcy or failure.

6. The extension of private-public partnerships through the PFI is an interesting initiative. However studies will be needed to investigate the impact of this millstone on the precarious finances of NHS trusts now enjoying new facilities made possible by PFI funding.

7. The prediction that the health service is probably in the throes of being "hollowed out and privatised" will be worth watching in the years to come. Further research is needed to confirm or refute the prediction

8. Investigation into the impact of ancillary staff training in other outsourced support services is needed to quantify the level of job mobility within and beyond NHS trusts

6.4 Managerial applications

The findings of this project confirm the value of relationships and partnerships as powerful avenues to achieving change in hotel services that benefit patients, services managers and the workforce. Consequently, support services managers need to maintain good relationships with all stakeholders, internal and external, as valuable resources for change.

The maintenance of internal and external goodwill amongst stakeholders confers needed legitimacy and ownership for decisions, actions and their outcomes. Hence services managers should also nurture the goodwill of all stakeholders to maintain social legitimacy that supports and sustains their organisation.

Services managers need to be aware of the importance of constant, clear and timely communication. Also early conflict resolution is beneficial for success in contractual relationship management since working together in harmony has been shown here to add value beyond the negative effects from conflicts of interest that can breed antagonism and undermine organisational effectiveness.

Services providers have trained and developed ancillary workforce and their managers in the know-how of support services and some of this knowledge has been stored in routines, procedures and technology. But whether this knowledge can be translated into the know-why of lasting learning and knowledge transfer will be up to the support services' managers and their workforce to decide.

Managers should be aware that subordinates can and do rise above manual tasks given the opportunity and access to knowledge as resource. Consequently workers should be treated with dignity if not respect in whatever capacity they choose to work.

Managers should recognise that a trained and supported workforce becomes motivated, dedicated and loyal to organisational ethos and can be more productive than a controlled and constantly blamed or criticised one. Furthermore visible management was shown to be key to improved performance. Therefore managers who preach improvement in productivity and services should perhaps learn to walk the talk!

On the issue of innovation or continuous improvement, idea generators, from whatever level of the workforce they come, need champions to apply their ideas, boundary spanners or gatekeepers to disseminate ideas and supportive mentors to provide the resources for development before innovation can occur. Consequently, services managers need to welcome ideas from different levels of the workforce and provide the needed conducive environment to nurture and bring them to fruition if improvements and innovation are to continue in support services of the future.

This research demonstrates the role and power of resources (investments) in the transformation of individuals, departments, organisations and their local communities. Managers should recognise the importance of workforce development as investment to equip them with skills and provide the necessary equipment to carry out their duties.

Managers need to recognise the ubiquity of power within organisations and the perceived change in power differentials due to hotel services outsourcing. While some services managers may have the authoritative power to make decisions, others can exercise the power *not* to implement such decisions. Consequently managers need to take cognisance of the delicate balance of power and dependence as a continuous balancing act and respect the holders of other forms of power and influence (economic, social, information) that can aid organisational effectiveness beyond authoritative power.

Lastly, as the whirlwind of change gusts through NHS trusts and their support services, perceptions of power may change. Consequently, those in dominant coalitions today, may find themselves reallocated or redeployed into areas devoid of influence hence services

managers should treat all concerned with equity and fairness knowing that tomorrow is an ill wind that can bring change and upheaval in positions and status.

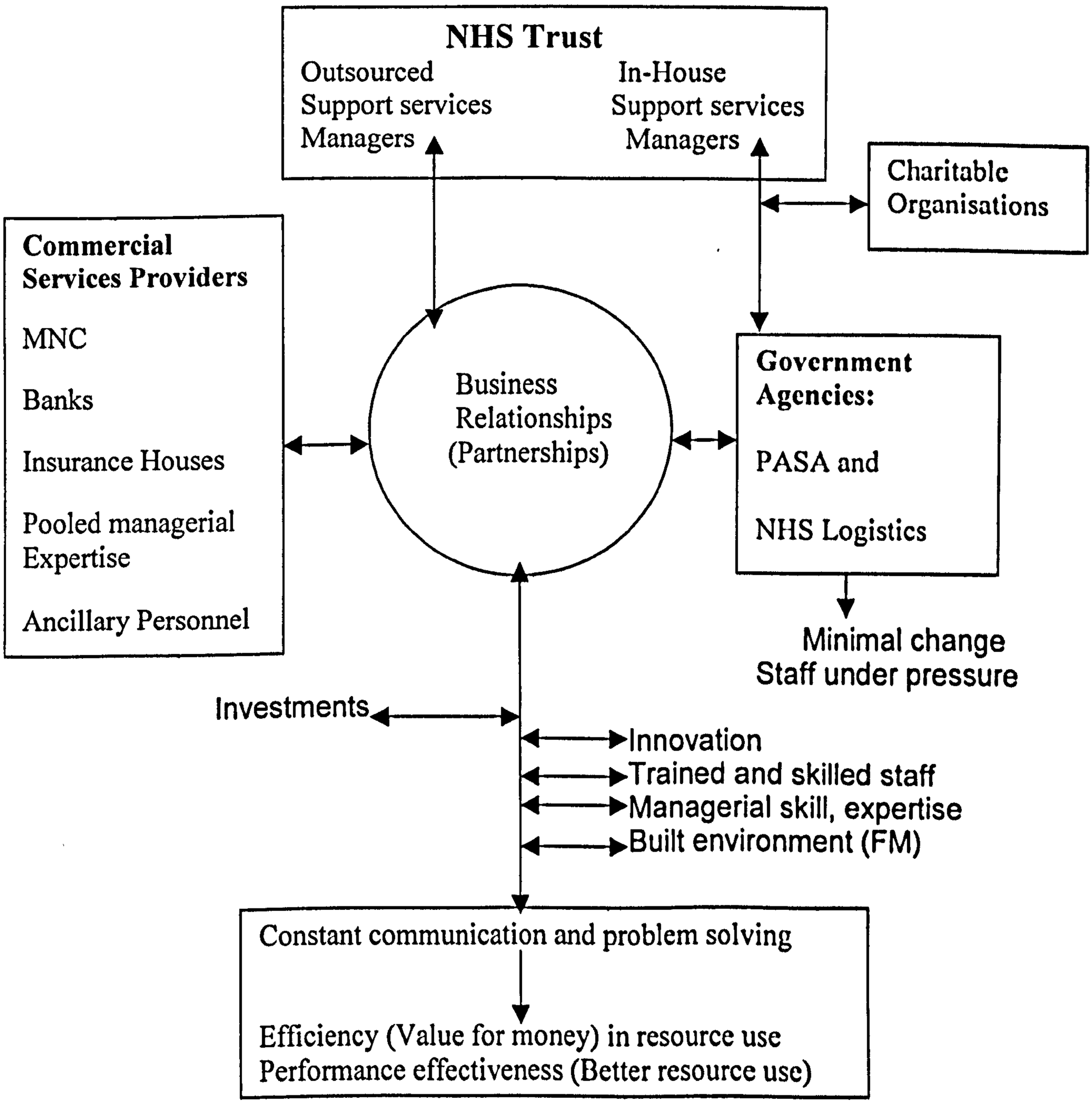
6.5 Concluding remarks

The ideology that a public sector organisation, charged with the social service of providing healthcare funded by the public purse, can function like a commercial organisation, without the incentives to focus on profit maximisation is a contradiction in terms. Besides, support services and provider managers regard this commercial mandate as a contradiction but were determined and became committed to make it work for mutual benefits. Out of this contradiction this project set out to find out how those directly involved in hotel services outsourcing relationships structure their experiences. In the process other questions arose. For example, observers note that 30-50% of outsourcing ventures between commercial firms fail for reasons ranging from lack of well-defined focus to unrealised expectations, divergent motives or dissatisfaction with outcomes (Davis, 2004; IPD, 1998; Moore, 2007). Can services outsourcing succeed to the satisfaction of all concerned in a local context? Secondly, many professionals other than support services managers control the decision-making agenda and resource allocation in the NHS. Can a private-public outsourcing relationship work amidst priority setting and dominant professional group interest? Thirdly can theories developed with data gathered from commercial sector be applicable to a public sector organisation with its political timetable, in a social services context?

The jury is in and the verdict is out. Those directly involved in hotel services outsourcing structure their experiences in terms of their local context of operation and content of their daily work experience. Consequently, many projects seem to proffer different findings due to differences in locales and the lived experiences or perceptions of those involved in their study. The ideology of social organisations working as commercial firms without the same incentives is a contradiction. But out of this contradiction, client and provider managers used their agential capacity for action to overcome the contradiction and make outsourcing mutually beneficial. What is more, services outsourcing has been extended in the NHS trusts investigated and all the services providers are still in place at the time of writing. Outsourcing of support services has been shown to work and be extended despite priority setting and other professional agendas in the health services studied. Multiple theories from other sectors have enabled me unravel the mountains of data and analysed them.

The result findings here suggest that outsourcing has benefited most of the trusts studied as seen in the "bundle of benefits" gained and have also informed other areas of the public services (civil service and public utilities) leading to the rethinking of Government funding alone in public sector organisations. Thus data generated here have helped to completely answer the research question posed while the effects of hotel services outsourcing is reverberating beyond the confines of the trusts studied and the health services in general.

Figure 6. 2 Framework of outsourcing outcomes in selected NHS trust



Key:

Lines of interaction

Bibliography:

Akbar, Hammad (2003), Knowledge levels and their transformation: towards the integration of knowledge creation and individual learning, Journal of Management Studies, vol. 40, no. 8, p.1997-2021

Akgűn, Ali, John Byrne and Halit Keskin (2007), Organisational intelligence, Journal of Organisational Change Management, vol. 20, no. 3, p. 272-289

Alexander, Keith, Brian Atkins, Jan Brochner and Tore Haugen (2004), Facilities Management: innovation and performance, London, Spon Press

Alexander, Keith (2003), A strategy for facilities management, Facilities, vol. 21, no. 11/12, p. 269-274

Alexander, Keith (1996), Facilities Management: theory and practice, London, Spon Press

Alexander, Marcus and David Young (1996), Outsourcing: where is the value? Long Range Planning, vol. 29, no. 5, p. 728-730

Alford, Robert (1975), Healthcare Policies, Chicago, University of Chicago Press

Alford, Robert (1975), Healthcare Politics: ideological and interest group barriers to reform, London, University of Chicago Press

Allen, David E. (1982), Annual reviews or no annual reviews: The balance of power between the DHSS and Health Authorities, British Medical Journal, vol. 285, 28 August, p. 665-667

Althussers, Louis (1977), Ideology and the state ideology apparatus: in Lenin and Philosophy and Other Essays, London, New Left books

Althussers, Louis (1969), For Max, London, Allen Lane

Amaratunga, Dilanthi and David Baldry (2002), Performance measurement in facilities management and its relationships with management theory and motivation, Facilities, vol.20, no. 10, p.327-336

Ames, Charles and James Hlavacek (1990), Vital truths about managing your costs, Harvard Business Review, January-February, p. 140-147

Amit, Raffi and Paul Schoemaker (1993), Strategic assets and organisational rent, Strategic Management Journal, vol. 14, no.1, p.33-46

Anderson, James and Kenneth Goodman (2002), Ethics and IT: A case-based approach to a healthcare system in transition, New York, Springer

Anderson, James and James A. Narus, (1999), Business Market Management: understanding, creating and delivering value, Upper Saddle River, New Jersey, Prentice-Hall,

Anderson, James, Håkan Håkansson, Jan Johanson (1994), Dyadic business relationships within a business network context, Journal of Marketing, vol. 58, p. 1-15

Anderson, Erin and Barton Weitz (1992), The use of pledges to build and sustain commitment in distribution channels, Journal of Marketing Research, vol. 29, February, p. 18-34

Anderson, James and James A. Narus (1990), A model of distributor firm and manufacturer firm working partnership, Journal of Marketing, vol.54, p. 42-58

Anderson, James and James A. Narus (1984), A model of distributor's perspective of distributor- manufacturer working relationships, Journal of Marketing, vol.48, p. 62-74

Anderson, Erin and Barton Weitz (1983), Make or buy decisions: vertical integration and marketing productivity, Sloan Management Review, vol. 27, Spring, p. 3-19

Annual Plan (2006/07), The North West London Hospitals NHS Trusts, London, Northwick Park,

Annual Plan (2003), The North West London Hospitals NHS Trusts, London, Northwick Park,

Appleby, John (2007), What has Blair ever done for the NHS? British Journal of Management, vol.13, no.5, p. 146

Appleby, John (2002), One third of Treasury targets unmet, Health Service Journal, 18 April, p.4

Appleby, John and Sean Boyle (2000), Blair's billions: where will he find the money for the NHS? British Medical Journal, vol. 320, 25 March, p. 865-867

Appleby, John and Andrew Thomas (2000), Measuring performance in the NHS: What really matters? British Medical Journal, 27 May, vol.320, p. 1464-1467

Araujo, Luis, Anna Dubois and Lars-Erik Gadde (2003), The multiple boundaries of the firm, Journal of Management Studies, vol. 40, no.5, p. 1255-1277

Araujo, Luis, Anna Dubois and Lars-Erik Gadde (1999), Managing interfaces with suppliers, in Ford, David (2002), Understanding Business Marketing and Purchasing 3rd. ed. London, Thomson Learning

Archer, Margaret (2000), For structure: its reality, properties and powers: a reply to Anthony King, The Sociological Review, (Editorial), p. 465-472

Argyle, Michael (1991), Cooperation: The basis of sociability, London, Routledge

Argyres, Nicholas (1996), Evidence on the role of firm capabilities in vertical integration decisions, Strategic Management Journal, vol.17, p.129-150

Argyris, Chris (1994), Good communication that blocks learning, Harvard Business Review, July-August, p.77-85

Argyris, Chris (1962), Understanding Organisational Behaviour, Homewood, Illinois, Dorsey

Arie, Sophie (2005), Labour Party will continue use of private contractors in the NHS, British Medical Journal, vol. 331, 8 October, p. 797

Arminas, David (2001), Authority gives NHS trusts a £5m Christmas present, Supply Management News, 4 July, p. 12

Asanuma, B. (1989), Manufacturer-supplier relationships in Japan and the Concept of relation-specific skill, Journal of Japanese and International Economics, vol. 3, p. 1-30

Atherton, Jayne (2005), Sick nurses cause the NHS £470m a year, Metro, Monday 27June, p. 12

Atkin, Brian and Adrian Brook (2000), Total Facilities Management, 2nd ed., London, Blackwell Publishing

Atum, Rifat and Martin McKee (2005), Is the Private Finance Initiative (PFI) dead? British Medical Journal, vol. 331, 8 October, p. 792-793

Audit Commission (1987) Competitive Tendering for Support services in the NHS, London, HMSO

Austin, Diana (2002), The buck stops here, Health Service Journal, 20 June, p. 32

Axelsson, Björn and Geoffrey Easton (1992) Industrial Networks: A new view of reality, London, Routledge

Bachmann, Reinhard (2001), Trust, power and control in trans-organisational relations, Organisation Studies, vol. 22, no.2, p. 337-365

Bachrach, Peter and Morton S. Baratz (1970), Power and Poverty: Theory and practice, London, Oxford University Press

Bachrach, Peter and Morton S. Baratz (1962), Two faces of power, American Political Science Review, vol. 56, p. 947-952

Bailey, Mike (2006), Panel to tackle PbR gaming, Health Service Journal, 9 March, p. 12

Barbalet, J.M (1987), Power, structural resources and agency, Perspectives in Social Theory, vol. 8, p. 1-24

Barber, Bernard (1983), The Logic and Limits of Trust, New Brunswick, New Jersey, Rutgers University Press

Barker, James (1993), Tightening the iron cage: Concertive control in self-managing teams, Administrative Science Quarterly, vol. 38, p. 408-437

Barley, Stephen and Gideon Kunda (2001), Bringing work back in, Organisation Science, vol. 12, no. 1, p. 76-95

Barley, Stephen (1990), The alignment of technology and structure through roles and networks, Administrative Science Quarterly, vol. 35, p. 61-103

Barley, Stephen R. and Pamela S. Tolbert (1997), Institutionalization and structuration: Studying the links between action and institution, Organisation Studies, vol. 18, no. 1, p. 93-117

Barnard, Chester (1938), The Functions of The Executive, Cambridge, Massachusetts, Harvard University press

Barney, Jay B., Mike Wright and David Ketchen (2001), The resource-based view of the firm: ten years after 1991, Journal of Management, vol. 27, p. 625 -641

Barney, Jay B. (1999), How a firm's capabilities affects boundary decisions, Sloan Management Review, vol. 40, no.3, p. 137-147

Barney, Jay B. (1997), Gaining and Sustaining Competitive Advantage, Reading, Massachusetts, Addison-Wesley

Barney, Jay B. and Mark Hansen (1994), Trustworthiness as a source of competitive advantage, Strategic Management Journal, Winter issue, vol. 15, p.175-216

Barney, Jay B. (1991a), Resource-based theories of competitive advantage: a ten-year retrospective on the resource-based view, Journal of Management, vol. 27, p. 643-650

Barney, Jay B. (1991b), Firm resources and sustained competitive advantage, Journal of Management, vol. 17, no.1, p. 99-120

Barney, Jay B. (1986), Strategic factor markets: expectations, luck and business strategy, Management Science, vol. 32, p. 1231-1241

Barrar, Peter, Douglas Wood, Julian Jones and Marco Vedovato (2002), The efficiency of accounting service provision, Business Process Management Journal, vol. 8, no.3, p. 195-217

Barringer, Bruce R. and Jeffrey S. Harrison (2000), Walking the tight rope: creating value through inter-organisational relationships, Journal of Management, vol. 26, no. 3, p. 367-403

Barthélemy, Jérôme and Bertrand Quélin (2006), Complexity of outsourcing contracts and ex post transaction costs: an empirical investigation, Journal of Management Studies, vol. 43, no. 8, p. 1775-1797

Barthélemy, Jérôme (2001), The hidden costs of IT outsourcing, MIT Sloan Management Review, Spring, p. 60-69

Bartlett, Christopher and Sumantra Ghoshal (1998), Managing Across Borders, 2nd edn. London, Hutchinson

Bartlett, Christopher and Sumantra Ghoshal (1992), What is a global manager? Harvard Business Review, September-October, p.124-132

Beattie, Jason (2005), £100m crisis hits all London hospitals, Evening Standard, 7 March, Monday, p.1

Beddow, A.J and D.R Cohen (2001), Marginal; contracting in the NHS: results of a preliminary survey, Health Services Management Research, 14, p.104-109

Becker, Franklin and Fritz Steele (1995), Workplace by Design, San Francisco, Jossey-Bass

Becker, Gary Stanley (1993), Human Capital: a theoretical and empirical analysis with special reference to education, Chicago, University of Chicago Press

Becker, Gary Stanley (1964), Human Capital, Chicago, University of Chicago Press

Beer, Michael, A. Russell Eisenstat and Bert Spector (1990), Why change programs don't produce change, Harvard Business Review, November-December, p. 158-166

Bélanger, Jaques (1999), Best HR practice and multinational company, Human Resource Management Journal, vol.9, no.3, p.53-70

Belfield, Gary (2007), Face up to a public-private future, Health Service Journal, 25 January, p. 32

Bellamy, Elizabeth (2000), Essex to tender service, Supply Management, January 27, p.9-10

Bendix Reinhard (1957), A study of managerial ideologies, Economic Developments and Cultural Change, vol. 5, p. 118-128

Bendix Reinhard (1956), Work and Authority in Industry: Ideologies of management in the course of industrialisation, New York, John Wiley (also by Harper Row)

Benington, John (2005), Public service reforms await big idea, Public Servant, Issue 32, 29 July, p. 3

Benson, Kenneth (1977), Organisations: A dialectic view, Administrative Science Quarterly vol, 22, p. 1-21

Bergen, Mark; Shantanu Dutta and Orville C. Walker (1992), Agency relationships in Marketing: a review of the implications and applications of agency and related theories, Journal of Marketing, vol. 56, July, p. 1-24

Berger, Peter and Luckman, Thomas (1966), The Social Construction of Reality, London: Penguin.

Berle, Adolph and Gardiner C. Means (1932), The Modern Corporation and Private Property, New York, Macmillan

Berry, Leonard and A. Parasuraman (1991), Marketing Services, New York, Free Press

Best, Gordon (1989), Exciting journey into the unknown, Health Service Journal, vol.99, no. 5137, 9 February, p.166

Bhaskar, Roy (1989), Reclaiming Reality, London, Verso

Bhaskar, Roy (1986), Scientific Realism and Human Emancipation, London, Verso

Bhaskar, Roy (1978), A Realist Theory of Science, 2nd ed., Brighton, Harvester press

Bichard, Michael (2005), Civil service weakness hampers reform, Public Servant, Issue 32, 29 July, p. 3

Biggs, David and Stephen Swailes (2006), Relations, commitment and satisfaction in agency workers and permanent workers, Employee Relations, vol. 28, no.2, p.130-143

Blair, Tony (2005), Blair backs foundation hospitals and PFI schemes, BBC news, accessed 18/4/05 @ www.news.bbc.co.uk/1/hi/health

Blau, Peter and R.A. Schoenherr (1973), New forms of power, in Graeme Salaman and Kenneth Thompson edn., People and Organisations, London, Longmans, p.13-24

Blau, Peter (1974), On the Nature of Organisations, London, John Wiley and Sons

Blau, Peter (1968), The hierarchy of authority in organisations, American Journal of Sociology, vol. 73, no. 4, p. 453-468

Blau, Peter (1964), Exchange and Power in Social Life, New York, John Wiley and Sons

Blau, Peter (1956), Bureaucracy in Modern Society, New York, Random House

Blauner, Robert (1964), Alienation and Freedom, Chicago, Chicago University Press

Blauner, Robert (1960), Work satisfaction and industrial trends in modern society, in Galenson W. and Seymour. Martin Lipset edn., Labour and Trade Unionism: An interdisciplinary reader, New York, Wiley, p. 339-360

Bleeke, Joel and David Ernst (1991), The way to win in cross-border alliances, Harvard Business Review, November-December, p.127-135

Blois, Keith (2002), Business to business exchange: A rich descriptive apparatus derived from MacNeil's and Menger's analysis, Journal of Management Studies, vol. 39, no. 4, January, p. 523-551

Blois, Keith (1998), Don't all firms have relationships? In Ford (2002) Understanding Business Marketing and Purchasing 3rd ed., United Kingdom, Thomson Learning, p. 95-106

Blois, Keith (1997), Are business-to-business relationships inherently unstable? Journal of Marketing Management, vol. 13, p. 367-382

Bloomfield Brian and Rod Coombs (1992), Information technology, control and power: the centralisation and decentralisation debate revisited, Journal of Management Studies vol. 29, no. 4, p. 459-484

Blumberg, Boris F. (2001), Cooperation contracts between embedded firms, Organisation Studies, vol. 22, no. 5, p. 825-852

Bowen, Frances and Kate Blackmon (2003), Spirals of silence: the dynamic effects of diversity on organisational voice, Journal of Management Studies, vol. 40, no. 6, p. 1393-1413

Bosanquet, Nick and Henry de Zoete (2006), NHS Reform, Reform, Autumn, p. 8-9, www.reform.co.uk (accessed 19/12/07)

Boulding, Kenneth (1990), Three faces of power, London, Sage

Boyne, George A. (2002), Public and private management: what's the difference? Journal of Management Studies, vol. 39, No.1 January pp. 97-122

Bradley, Anusha (2005), The ups and downs of relationships, Supply Management, 20 October, p. 15

Bradshaw, Ben (2008) LIFT awards 2008, Health Service Journal, Souvenir supplement, 15 March (also p.12)

Braverman, Harry (1974), Labour and Monopoly Capital: The degradation of work in the Twentieth Century, New York, Monthly Review Press

Brennan, Ross and Peter W. Turnbull (1999), Adaptive behaviour in buyer-supplier relationships, In Ford (2002) Understanding Business Marketing and Purchasing 3rd ed., United Kingdom, Thomson Learning, p. 360-375

Brewer, John (1970), Organisational patterns of supervision: Study of de-bureaucratization of authority relations in two business organisations, in Grusky and Miller edn., The Sociology of Organisations: Basic studies, New York, The Free Press, p. 341-347

Britnell, Mark (2005), Is the IT programme there to change the NHS or just provide an IT infrastructure for the health service to use as it sees fit?, Health Service Journal, 25 August, p. 15

Brown, Richard Harvey (1978), Bureaucracy as Praxis: toward a political Phenomenology of formal organisations, Administrative Science Quarterly, vol. 23, p.365-382

Bruce, Margaret and Birgit Jenaker (1998), Management of Design Alliances: Sustaining competitive advantage, Wiley, Chichester

Bryant, Christopher G and David Jary (1991), Giddens Theory of Structuration: A critical appreciation, London, Routledge

Buck, Tobias (2005), Microsoft is warned on antitrust deadline, Financial Times, Tuesday, 24, p. 21

Burawoy, Michael (1985), The Politics of Production, London, Verso

Burawoy, Michael (1979), Manufacturing Consent: Changes in labour process under monopoly capitalism, London, The University of Chicago Press

Burns Tom and Stalker G. (1961), The Management of Innovation, London, Tavistock

Burrell, Gibson and Gareth Morgan (1979), Sociological Paradigms and Organisational Analysis, Aldershot, England, Ashgate Publishing

Butler, Judith (1997), The Psychic Life of Power: Theories in subjection, California, Stanford University Press

Cabinet Office (1998), NHS Procurement Review, London,

Cabinet Office (1996), Competing for quality policy review: an efficiency unit survey, London, HMSO

Callinicos, A. (1985), Anthony Giddens: A contemporary critique, Theory and Society, vol. 12, no. 2, p.133-166

Calman, Kenneth Lord (1994), The profession of medicine, British Medical Journal, vol. 309, p. 1140-1143

Campbell, John (1995), Outsourcing in maintenance management, Journal of Quality in Maintenance Engineering, vol. 1, no. 3, p. 18-24

Cannon, Joseph P. and Homburg, Christian (2001), Buyer-supplier relationships and customer firm costs, Journal of Marketing, vol.65, p.29-43

Cappelli, Peter (2000), A market-driven approach to retaining talent, Harvard Business Review, January-February, p. 103-111

Carlisle, Daloni (2007), Talking up the NHS, Health Service Journal, 8 February, p. 23

Carlisle, Daloni (2006) How to steer clear of PbR gaming, Health Service Journal, 2 March, p. 22

Carlisle, Daloni (2002a), Hidden foundations, Health Service Journal, 27 June, p. 13

Carlisle, Daloni (2002b), US health giant plans to run fast-track clinic in Britain, Health Service Journal, p. 4

Carter, Neil, Rudolf Klein and Patricia Day (1992), How Organisations Measure Success; The use of performance indicators in government, London, Routledge

Cartwight, Dorwin (1959), Studies in Social Power, The University of Michigan, Ann Arbor

Cassell, Catherine and Gillian Symon (1994), Qualitative Methods in Organisational Research: A practical guide, London, Sage

Cassell, Philip (1993), The Giddens' Reader, London, Macmillan

Caulkin Simon (2007), Outsourcing slowdown, World business Live, World Business, p. 13

Chanal, Valérie (2004), Innovation management and organisational learning: a discursive approach, European Journal of Innovation Management, vol. 7, no. 1, p. 56-64

Chandler, Alfred D. Jr. (1992), What is a firm – historical perspective, European Economic Review, vol. 36, no.2-3, p.483-492

Chandler, Alfred D. Jr. (1990), Scale and Scope: The dynamics of industrial competition, Cambridge, Massachusetts, Harvard University Press

Chandler, Alfred D. Jr. (1962), strategy and structure: Chapters in the history of Industrial Enterprise, Cambridge Massachusetts, MIT Press

Chapman, James; Jenny Hope and Emily Cook (2006), Hewitt crisis call as NHS faces £1bn debt, Daily Mail, Thursday 26 January, p.6

Checkland, Peter and Sue Holwell (1998), Information, Systems and Information Systems: Making sense of the field, Chichester, John Wiley and sons

Child, John; David Faulkner and Robert Pitkethly (2000), Foreign direct investment in the UK 1985-1994: The impact on domestic management practice, Journal of Management Studies, vol. 37, no. 1, p. 141-166

Child, John (1997), Strategic choice in the analysis of action, structure, organisations and environment: retrospect and prospect, Organisation Studies, vol. 18, no. 1, p. 43-76

Child, John and Chris Smith (1987), The context and process of organisational transformation- Cadbury Limited in its sector, Journal of Management Studies, vol. 24, no. 6, p. 565-593

Child, John (1972), Organisational structure, environment and performance: the role of strategic choice, Sociology, vol. 6, p.1-22

Christensen, Clayton M, Anthony Scott and Erika Roth (2004), Seeing What's Next, Boston, Massachusetts, Harvard Business school Press

Christopher, M. and Juttner, U. (1998), Developing strategic partnerships in the supply chain, proceedings of the 2nd. Worldwide Research Symposium on Purchasing and Supply Management, April 1-3, ISPERA and CRISPS, London, pp. 88-107, sited in Ford (2002), Understanding Business Marketing and Purchasing, 3rd.edn, United Kingdom, Thomson Learning

Clark, Ed (2004), Power, action and constraint in strategic management: explaining enterprise restructuring in the Czech Republic, Organisation Studies, vol. 25, no. 4, p. 607-627

Clark, Ed and Anna Soulsby (1995), Transforming former state enterprises in the Czech Republic, Organisation Studies, vol. 16, no. 2, p. 215-242

Clark, Jon, Celia Modgil and Sohan Modgil (1990), Anthony Giddens: Consensus and controversy, London, Falmer Press

Clarke, Tone (2004), Partnership bid to save the NHS £220m over 10 years, Jobs4Nurses, November, 30-January 10, issue 13, p. 1

Clarke, K and T. Fujimoto (1991), Product development performance: strategy, organisation and management in the world auto industry, Cambridge, Massachusetts, Harvard Business School Press, sited in Ford (2002), Understanding Business Marketing and Purchasing, 3rd.edn, United Kingdom, Thomson Learning

Clarke, Kenneth (1989), Clarke on the review, Nursing Times, vol. 85, 8 February p. 20

Cleaver, Harry (1979), Reading "Capital" Politically, Brighton, Sussex, Harvester press

Clegg, Stewart R. (1998), Foucault, power and organisations, in Alan McKinlay and Ken Starkey ed. Foucault, Management and Organisation Theory, London, Sage

Clegg, Stewart R. (1989), Frameworks of Power, London, Sage publication

Clegg, Stewart R. and David Dunkerley (1980), Organisation, Class and Control, London, Routledge and Kegan Paul

Clegg, Steward R. (1979), The Theory of Power and Organisation, London, Routledge and Keegan

Clegg, Stewart R. (1975), Organisation and control, Administrative Science Quarterly, vol. 26, p. 545-562

Clews, Graham (2005), PFI hospital criticised but refinancing offers hope, Health Service Journal, 17 February, p. 12

Coase, Ronald. H (1937), The nature of the firm, in Readings in Price Theory, G Stigler and Kenneth Boulding edn., Chicago Irwin, p. 331-351

Cohen, Westley and Daniel Levinthal (1990), Absorptive capacity: A new perspective on learning and innovation, Administrative Science Quarterly, vol. 35, no.1, p.128-152

Cohen, Ira J. (1989), Structuration theory: Anthony Giddens and The Constitution of Social Life, London, Macmillan

Collies, Jim (2001), Level 5 leadership, Harvard Business Review, January, p.67-76

Collies, David J. and Cynthia Montgomery (1997), Corporate Strategy: Resources and scope of the firm, London, Irwin

Collies, David J and Cynthia A. Montgomery (1995), Competing on Resources, Harvard Business Review, July-August, p. 118-128

Collies, David J. (1991), A resource board analysis of global competition, Strategic Management Journal, vol. 12, no.1, p. 49-68

Collins (2003) Dictionary and Thesaurus, 2nd ed. Paperback, London, Harper Collins Publishers

Collinson, Simon and David Wilson (2006), Inertia in Japanese organisations: knowledge management routines and failure to innovate, Organisation Studies, vol. 27, no. 9, p. 1359-1387

Comte, Auguste (1853), The Positive Philosophy of Auguste Comte (translated by H. Martineau), London, Trubner and Co.

Conner, Kathleen (1991), A historical comparison of resource-based theory and five schools of though within industrial organisation economics: Do we have a new theory of the firm? Journal of Management, vol. 17, March, p.121-154

Cook, Robin (1989), A private hospital by any other name, Guardian Newspaper, 30 January,

Cook, Karen. S and Richard M. Emerson, (1978) Power, equity and commitment in exchange networks, American Sociological Review, vol. 43 (October), p. 721-739

Cooke, Fang Lee, Jill Earnshaw, Mick Marchington and Jill Rubery (2004), For better and for worse: transfer of undertakings and the reshaping of employment relations, The International Journal of Human Resource Management, vol. 15, no. 2, p. 276-294

Coulter, Mary (2005), Strategic Management in Action, 3rd. ed., New Jersey, Prentice Hall

Courpasson, David (2000), Managerial strategies of domination, power in soft bureaucracies, Organisation Studies, vol. 21, no. 1, p. 141-161

Courtney, Hugh, Jane Kirkland and Patrick Viguerie (1997), Strategy under uncertainty, Harvard Business Review, November-December, p. 67-79

Cowper, Andy (2007), The NHS Blair years, British Journal of Healthcare Management, vol. 13, no. 5, p. 144

Craft, Naomi (1994), Secrecy in the NHS, British Medical Journal, Vol. 309, December, p. 1640

Craib, Ian (1992), Giddens, London, Routledge

Cresswell, John W. (2003), Research Design, 2nd ed. London, Sage Publication

Crisp, Nigel (2005), Choice menus will serve up more private sector options, Health Service Journal, 17 March, p.5

Crisp, Nigel (2005a), Fledgling foundations get development help, Health Service Journal, 17 March, p.7

Crook, Ed and James Blitz (2004), Brown pledges to save £20bn to spend on public services, Financial Times, Thursday, 18 March, p.1

Cross John (1995), IT Outsourcing: British Petroleum's competitive approach, Harvard Business Review, May-June p.94-102

Crouch David (2005), Outside influence, Nursing Times, 22 March, vol. 101, no. 12, p.24

Crozier, Michel (1964), The Bureaucratic Phenomenon, London, Tavistock

Crump, Bernard (2005), New kid on the block, Health Services Journal, supplement, 29 September, p.1-9

Currie Wendy and Bob Galliers (1999), Rethinking Management Information Systems, Oxford university press, Oxford, New York

Cyart, Richard and James March (1963), A Behavioural Theory of The Firm, Englewood Cliffs, New Jersey, Prentice Hall

Czarniawska, Barbara (1992), Exploring Complex Organisations: A cultural perspective, Newbury Park, California, Sage Publication

Dale, Reidar (2000), Organisations and Development: Strategies, structures and processes, London, Sage Publications

Dalton, Melville (1959), Men Who Manage: Fusion of feeling and theory in administration, New York, Wiley.

Das, T.K and Bing-Sheng Teng (2001), Trust, control and risk in strategic alliances: An integrated framework, Organisation Studies, vol. 22, no. 2, p. 251-283

Das, T.K and Bing-Sheng Teng (2000), A resource-based theory of strategic alliances, Journal of Management, vol. 26, no.1, p. 31-61

Das, T.K and Bing-Sheng Teng (1998), Resource and risk management in the strategic alliance making process, Journal of Management, vol. 24, p. 21-42

Davis, Paul (2004), What's this India business? :Offshoring outsourcing and the global services revolution, London, Nicholas Brealey

Davis, Gerald, F. (1991), Agents without principles?: The spread of poison pill through the inter-corporate network, Administrative Science Quarterly, vol. 36, p. 583-613

Dawson, Sandra (1990), Analysing Organisations, 3rd edn., London, Macmillan

Day, Michael (2007), NHS has not reaped benefits from refinancing of PFI schemes, British Medical Journal, vol. 334, p. 19

Day, Michael (2006), UK Government accused of privatising the NHS, British Medical Journal, vol. 333, 8 July, p. 61

DeCesare, Pamela T. (2003), Dynamic duo: maximizing the potential of partnerships, Design Management Journal, p.15-19

De Cork, Christian and Tudor Rickards (1995), A rejoinder to and reply from Weaver and Gioia, Organisation Studies, vol. 16, no. 4, p. 699-705

Deetz, Stanley (2000), Discursive formations, strategized subordination and self-surveillance, in Alan McKinlay and Ken Starkey edn., Foucault, Management and Organisation Theory, London, Sage Publication

Deffenbaugh, John L. (1998), Healthcare pact to replace contracting, Health Services Management Research, vol.10, p. 266 -274

Demos (2002), Fines added to toxic incentives, Health Service Journal, 23 May, p.5

Denzin, Norman K (1989), The Research Act: A theoretical introduction to sociological methods, 3rd. ed., Englewood Cliffs, New Jersey, Prentice Hall

Department of Health (2005a), A short guide to NHS foundation trusts, London

Department of Health (2005) Office of the deputy Prime Minister, Local Government finance, www.local.dtlr.gov.uk/pfi/intro accessed 18/4/05

Department of Health (2003), Summary of the NHS Private Finance Initiative standard form project (The contract), Department of Health, August

Department of Health (2002), A guide to NHS foundation status, London, HMSO

Department of Health (2000), The NHS Plan, HMSO, London

Department of Health (1997), The New NHS, London, Executive News, p. 5.

Department of Health (1997), The New NHS: Modern and Dependable, London, HMSO

Department of Health (1989), NHS Review working papers, London, HMSO

Department of Health (1989a), Working for patients, Cmmd. 555, London, HMSO

DHSS (1983), Competitive tendering in the provision of domestic catering and laundry services, HC 83, vol.18, London, DHSS (Department of Health and Social Security)

DHSS (1972), Management arrangements for the reorganised NHS, London, HMSO

Dierickx, Ingemar and Karel Cool (1989) Asset stock accumulation and sustainability of competitive advantage Management Science, vol. 35, no. 12, p. 1504 -1511

DiMaggio, Paul J. and Walter W. Powell (1991), Introduction in The New Institutionalism in Organisational Analysis, Walter W. Powell and Paul DiMaggio (ed.) p. 1-40, Chicago, University of Chicago press

DiMaggio, Paul J. and Walter W. Powell (1983), Institutional Isomorphism, In Derek Pugh (1997), Organisation Theory, 4th ed. London, Penguin Books

Dix, Ann (2002), Consumerism agenda adds to hospital building fears, Health Service Journal, 18 April, p. 4

Dix, Ann (2002a), Castles in the air, Health Service Journal, 18 April, p. 33-41

Dixon, Nancy M. (2000), Common Knowledge: How companies thrive by sharing what they know, Boston, Massachusetts, Harvard Business School press

Dixon, Jennifer (2000a), Modernising the NHS: performance and productivity, British Medical Journal, 27 May, vol. 320, p. 1462-1464

Dobson, Roger (2006), NHS is told to save £2.2bn by being more efficient, British Medical Journal, vol. 333, 28 October, p. 873

Donnelly, Laura (2006), £800m deficit forecast triggered DoH pressure, Health Service Journal, 2 March, p. 7

Donnelly, Laura (2002), Purchasing power goes to waste, Health Service Journal, 16 May, p. 10

Dopson, S and R. Stewart (1990), What is happening to middle management? British Journal of Management, vol. 1, p. 3-16

Douglas, Thomas J. and Joel A. Ryman (2003), Understanding competitive advantage in the general hospital industry: evaluating strategic competencies, Strategic Management Journal, vol.24, p. 333 -347

Doz, Yves L and Gary Hamel (1998), Alliance Advantage: The art of creating value through partnering, Boston Massachusetts, Harvard Business School Press

Drucker, Peter E. (2004), What makes an effective executive, Harvard Business Review, June, p. 59-63

Drucker, Peter E. (1998), The discipline of innovation, Harvard Business Review Classic, November-December, p. 149-157

Drucker, Peter E. (1992), The new society of organisations, Harvard Business Review, September-October, p. 95-104

Drucker, Peter E. (1974), Management: Tasks, responsibilities and practices, New York, Harper and Row

Dubois, Anna (1998), Organising Industrial Activities Across Firm Boundaries, London, Routledge

Dunne, Lauren (2006), Medical staff in protest over job cut fears, www.icHarrow.co.uk, Thursday, June 29, p. 7

Durand, Rodolphe and Vincente Vargas (2003), Ownership, organisation and private firms' efficient use of resources, Strategic Management Journal, vol. 24, p. 667-675

Dwyer, Robert, Paul H. Shurr and Sejo Oh (1987), Developing buyer-seller relationships, Journal of Marketing, vol. 51, April, p. 11-27

Dyer, Jeffery. H and Singh, I. (1998), The relational view: cooperative strategy and sources of inter-organisational competitive advantage, Academy of Management Review, vol. 23, p. 660 -679

Dyer, Jeffery H. (1997), Effective inter-firm collaboration: How firms minimize transaction costs and maximize transaction value, Strategic Management Journal, vol. 18:7, p. 535 -556

Dyer, Jeffery H. (1996), Does governance matter? Keiretsu alliances and asset specificity as sources of Japanese competitive advantage, Organisation Science, vol. 7, no. 6 p. 649 -666

Dyer, Jeffrey H. (1994), Dedicated assets: Japan's manufacturing edge, Harvard Business Review, November-December, p. 174 -178

Dyne, Linn Van, Soon Ang and Isabel Botero (2003), Conceptualising employee silence and employee voice as multidimensional constructs, Journal of Management Studies, vol. 40, no. 6, p. 1359-1392

Eaglesham, Jean (2005), Reforms aim to cut bureaucracy burden, Financial Times, March 17, Thursday, p.11

Easton, Geoffrey (1992), Industrial networks: A review, In Ford, David (2002), Understanding Business Marketing and Purchasing 3rd. ed. London, Thomson Learning

Easton, Geoffrey (1995) Methodology and industrial networks in Kristian Möller and David Wilson (1995), Business Marketing: An interaction perspective, Boston, Massachusetts, Kluwer Academic Publishers, p. 412-492

Easterby-Smith, Mark; Thorpe, Richard and Lowe, Andy (2002), Management Research: An introduction, 2nd ed., London, Sage Publications

Eaton, Lynn (2007), Blair trumpets Labour's investment in NHS, British Medical Journal, vol. 334, 5 May, p. 919

Eccles, Robert G. (1991), The performance measurement manifesto, Harvard Business Review, January-February, p. 131-136

Edwards, Nick and Ian Lloyd (2005), Patients offered pick of any ITC or foundation by 2006, Health Service Journal, 10 March, p. 5

Eldridge, JET and A.D Crombie (1974), A Sociology of Organisations, London, George Allen & Unwin

Elias, Norbert (1978), The Civilising Process, Oxford, Blackwell

Elkeles, R. (1989) The cash register may drown out the sound of the ambulance, Independent, 24 January

Elmuti, Dean (2003), The perceived impact of outsourcing on organisational performance, Mid-American Journal of Business, vol. 18, no. 2, p. 33-37

Elmuti, Dean and Yunus Kathawala (2000), The effects of global outsourcing strategies on participants' attitudes and organisational effectiveness, International Journal of Manpower, vol. 21, no. 2, p. 112-128

Eisenhardt Kathleen and Shona L. Brown (1999), Patching: Restitching business portfolios in dynamic markets, Harvard Business Review, May-June, p.72-82

Eisenhardt, Kathleen M. (1989a), Agency theory: an assessment and review, Academy of Management Review, vol. 14, p. 57-71

Eisenhardt, Kathleen .M (1989), Making fast strategic decisions in high velocity environments, Academy of Management Journal, vol. 32, p. 543-576

Eisenhardt, Kathleen M. (1985), Control: Organisational and economic approaches, Management Science, vol. 31, p. 134-149

Eisingerich, Andreas and Simon Bell (2007), Maintaining customer relationships in high credence services, Journal of Services Marketing, vol. 21, no. 4, p. 253-262

Emerson, Richard M. (1962), Power-dependence relations, American Sociological Review, vol. 27, p. 31-41

Enthoven, Alain (2000), Modernising the NHS: A promising start but fundamental reform is needed, British Medical Journal, vol., 320, p. 1329-1331

Enthoven Alain (1985) Reflections on The Management of The NHS, London, Institute of Health Service Management,

Erez, M and P.C Earley (1993), Culture, Self-identity and Work, New York, Oxford University Press

Eriksson, Per Erik and Albertus Laan (2007), Procurement effects on trust and control in client-contractor relationships, Engineering, Construction and Architectural Management, vol. 14, no., 4, p. 387-399

Eriksson, Per Erik, Michael Dickinson and Malik M. A. Khalfan (2007), The influence of partnering and procurement on subcontractor involvement and innovation, Facilities, vol. 25, no. 5/6, p. 203-214

Eriksson, Per Erik (2006), Procurement and governance management: development of a conceptual procurement model based on different types of control, Management Review, vol. 17, no.1, p. 30-49

Evans, Rebecca (2008), Naylor knighthood tops health honours, Health Service Journal, 10 January, p. 11

Ezzamel, Mahmoud, Hugh Willmott and Frank Worthington (2001), Power, control and resistance in "the factory that time forgot", Journal of Management Studies, vol. 38, no. 8 p. 1053-1079

Fama, Eugene and Michael Jensen (1983), Separation of ownership and control, Journal of Law and Economics, vol. 26, June, p. 301-325

Fama, Eugene (1980), Agency problems and the theory of the firm, Journal of Political Economy, vol. 88, p. 375-390

Farndale, Elaine and Chris Brewster (2005), In search of legitimacy: personnel management associations worldwide, Human Resource Management Journal, vol. 15, no. 3, p. 33-43

Faulkner, David (1995), Strategic Alliances: Cooperating to compete, London, McGraw Hill

Feldman, Martha and Brian Pentland (2003), Reconceptualizing organisational routines as a source of flexibility and change, Administrative Science Quarterly, vol. 48, p. 94-118

Feldman, Martha (2000), organisational routines as a source of continuous change, Organisation Science, vol. 11, p. 611-629

Ferner, Anthony, Phil Almond, Ian Clark, Trevor Colling, Tony Edwards, Len Holden and Michael Muller-Camen (2004), The dynamics of central control and subsidiary autonomy in the management of human resources: a case study evidence from US MNCs in the UK, Organisation Studies, vol. 25, no. 3, p.363 -377

Ferner, Anthony (2000), The underpinnings of "bureaucratic" control systems: HRM in European multinationals, Journal of Management Studies, vol. 37, no. 4, p.521-540

Ferriman, Annabel (2000), Health spending in UK to rise to 7.6% of GDP, British Medical Journal, vol. 320, 1 April, p. 889

Festinger, Leon (1957), A Theory of Cognitive Dissonance, Stanford, California, Stanford, University press

Fidler, John (1981), The British Business Elite: Its attitudes to class, status and power, London, Routledge and Kegan

Field, Frank (1989), Time bomb set to blow apart the NHS, Sunday Times, 19 February

Filkin, Geoffrey (1999), Fresh chance to prove purchasing's key role, Supply Management, 21 January p.10

Fill, Chris and Elke Visser (2000), The outsourcing dilemma: A composite approach to make or buy decision, Management Decision, vol. 38, No.1, p. 43-50

Financial Times (2005), Civil service reforms, Thursday, 17 March, p.32

Fincham, Robin (1992), Perspectives on power: Processual, institutional and internal forms of organisational power, Journal of Management Studies, vol. 29, no. 6, p. 741-758

Finegold, David, Alec Levenson and Mark Van Buren (2005), Access to training and its impact on temporary workers, Human Resource Management, vol. 15, no. 2, p. 66-84

Fischbacher, Moira and A. Francis (1999), Relationships in healthcare commissioning: A case study of Glasgow, in Davis, H.T.O et al ed., Controlling Costs: Strategic issues in healthcare management, Aldershot, Ashgate Publishing

Fischbacher, Moira and M. Francis (1998), Purchaser-Provider Relationships and Innovation: A Case Study of GP Purchasing, Financial Accountability and Management, vol.14, no.4, p. 281-298

Fisher, Mike (1997), Qualitative Computing, London, Ashgate

Flack, Jo-Ann (2002), Making the relationship work for all, Marketing Week, p. 3-15

Flick, Uwe (2002), An Introduction to Qualitative Research 2nd ed., London, Sage

Forbes Magazine (1973), The number's game: the larger the company, the more understanding the accountant? vol. 112, no. 1, July, p. 33-35

Ford, David, Lars-Erik, Håkan Håkansson and Ivan Snehota (2006), The Business Marketing Course: Managing in complex networks, 2nd edn., Chichester, Wiley

Ford, David (2003), Managing Business Relationships, 2nd edn., Chichester, John Wiley

Ford, David (2002) Understanding Business Marketing and Purchasing, 3rd. ed., United Kingdom, Thomson Learning

Ford, David and Mike Siren (2001), First steps in technology strategy in Ford (2002) Understanding Business Marketing and Purchasing, 3rd ed., United kingdom, Thomson Learning pp 376-386

Ford, David and Raymond McDowell (1999), Managing business relationships by analysing the effects and value of different actions, in Ford (2002) Understanding Business Marketing and Purchasing, 3rd ed., United kingdom, Thomson Learning pp. 320-335, (see also Industrial Marketing Management, vol. 28, no.5 p. 429-442)

Ford, David (1980), The development of Buyer-Seller Relationships in Industrial markets, European Journal of Marketing, vol. 14, no.5/6, p. 339-354

Forde, Chris and Gary Slater (2006), The nature and experience of agency working in Britain, Personnel Review, vol. 35, no. 2, p. 141-157

Fraser, Sarah (2002), Three's a crowd, Health Service Journal, 27 June, p. 33

Frankforter, Steven, Shawn Berman and Thomas Jones (2000), Board of directors and shark repellents, Journal of Management Studies, vol. 37, no. 3, p. 321-348

Freeman, Edward (1984), Strategic Management: A stakeholder approach, London, Pitman

French, John and Bertram Raven (1959), The bases of social power, in Dorwin Cartwright edn. (1959), Studies in Social Power, Arbor, The University of Michigan Press

Freund, Julien (1968), The Sociology of Max Weber, Allen Lane, London, Penguin Press

Friedman, Brian, James Hatch and David Walker (1998), Delivering on The Promise: How to attract, manage and retain human capital, London, The Free press

Fry Geoffery (1981), The Administrative Revolution in Whitehall, London, Croom Helm

Foster, Mike (2005), Where IT is at, British Medical Association News, Saturday, February 12, p. 6-7

Foster, Andrew (2004), Goodbye to all that, Health Service Journal, 16 December, Christmas special edn. p. 17

Foucault Michel (1991), Governmentality (in Graham Burchell, Colin Gordon and Peter Miller edn.) The Foucault effect: studies in governmentality, London, Harvester, p. 87-104

Foucault Michel (1984), On power in L.D Kritman edn., Michel Foucault: Politics, philosophy, culture, London, Routledge, p. 96-109

Foucault Michel (1980), Power/Knowledge: Selected interviews and other writings, 1972-1977, Colin Gordon (edn.), Brighton, Harvester Press

Foucault, Michel (1977), Discipline and Punishment: The birth of the prison, Harmondsworth, Penguin

Foucault, Michel (1977), Discipline and Punishment, London, Allen Lane press

Fulton, Lord (1982), Committee on the Civil Service, Report, London, HMSO

French, John, P..R and Bertram Raven (1959), The Basis of Social Power, in Dorwin Cartwright (ed.), Studies in social power, University of Michigan Press

Gadde, Lars-Erik and Snehota, Ivan (2000), Making the most of supplier relations, In Ford, David (2002) Understanding Business Marketing and Purchasing, 3rd. ed., United Kingdom, Thomson Learning, p 438-449

Gainsbury, Sally (2007), Fear DoH could claw back Foundation trust surpluses, Health Service Journal, 20 December, p. 9

Galbraith, Jay (1977), Organisation Design, *Reading, Massachusetts*, Addison-Wesley

Galbraith, Jay (1973), Designing Complex Organisations, Reading, Addison-Wesley

Gallagher, Mike (1998), Evolution of Facilities Management in The Health Care Sector, London, The Chartered Institute of Building

Gallie, Duncan, Alan Felstead and Francis Green (2001), Employer policies and organisational commitment in Britain 1992-97, Journal of Management Studies, vol. 38, no. 8, p. 1081-1100

Gander, Jonathan and Alison Rieple (2004), How relevant is Transaction Cost Economics to Inter-firm relationships in the music industry?, Journal of Cultural Economics, vol.28, p. 57-79

Ganesan, Shanker (1994), Determinants of Long-term orientation in buyer-seller relationships, Journal of Marketing, vol. 58, p. 1-19

Garfinkel, Harold (1967), Studies in Ethnomethodology, Englewood Cliffs, New Jersey, Prentice-Hall

Geertz, Clifford (1964), Ideology as cultural system in David Apter, (edn.) Ideology and Discontent, New York, Free Press

Gershon, Peter (2004), Civil Service to be decimated, Labour Research, July, vol. 93, no. 7, p.12 -13

Ghoshal, Sumantra and Christopher Bartlett (1994), Linking organisational context and managerial action: the dimensions of quality of management, Strategic Management Journal, vol. 15, p. 91-112

Gibbs, Graham (2002), Qualitative Data Analysis: Explanations with Nvivo, Buckingham, Philadelphia, Open University Press,

Giddens, Anthony (2007), Europe in The Global Age, Cambridge, Polity Press

Giddens, Anthony (2006), Sociology, Cambridge, Polity Press

Giddens, Anthony (2002), Runaway World: How globalism is reshaping our lives, London, Polity

Giddens, Anthony (2001), The Global Third Way Debate, Cambridge, Polity Press

Giddens, Anthony (2000), The Third Way and Its Critics, Cambridge, Polity Press

Giddens, Anthony (1994), Living in a post-traditional society in Reflexive Modernization, Ulrich Beck, Anthony Giddens and Scott Lash ed. p. 56-109, Cambridge, Polity

Giddens, Anthony (1991), Modernity and Self-identity, London, Polity Press

Giddens, Anthony (1990), Structuration theory: past, present, future in Giddens Theory of Structuration: A critical appreciation, Christopher Bryant and David Jary (eds.), London, Routledge, p. 201-221

Giddens, Anthony (1984), The Constitution of Society: Outline of the theory of structuration, London, Polity Press

Giddens, Anthony (1982), Profiles and Critiques in Social Theory, London, Macmillan

Giddens, Anthony (1981), A Contemporary Critique of Historical Materialism, vol. 1: Power, property and the state, London, Macmillan

Giddens, Anthony (1979), Central Problems in Social Theory: Action, structure and contradiction in social analysis, London, MacMillan

Giddens, Anthony (1976), New Rules of Sociological Methods: A positive critique of interpretative Sociologies, London, Hutchinson

Giddens, Anthony (1973), The Class Structure of Advanced Societies, London, Hutchinson

Glaser, Barney and Strauss, Anselm (1967), The Discovery of Grounded Theory: Strategies for Qualitative Research, Chicago: Aldine Press.

Goffee, Robert and Gareth Jones (2000), Why should anyone be led by you? Harvard Business Review, September-October, p. 63-70

Goffman, Erving (1969), Where The Action Is, London, Allen lane

Goffman, Erving (1961), Asylums, Garden City New York, Doubleday, London Penguin 1970

Goldman, Mark (2005), Raising standards at the heart of England, Health Director, vol. 4, issue 4, p. 52

Goldsmith, Jeff (1989), A radical prescription for hospitals, Harvard Business Review, May-June, p.104-111

Goodrich, Carter (1975), The Frontiers of Control, London, Pluto Press

Gouldner, Alvin. W (1976), The Dialectic of Ideology and Technology, London, Macmillan

Gouldner, Alvin. W (1955), Patterns of Industrial Bureaucracy, Glencoe, Illinois, Free press

Grace, David (2005), Forced out—for not meeting targets before emergencies, Daily Mail, Tuesday, 4 October, p.43

Granovetter, Mark (1985), Economic action and social structure: the problem of embeddedness, American Journal of Sociology, vol. 3, p. 481-510

Gränroos, Christian (1991), The marketing strategy continuum: A marketing concept for the 1990's, Management Decision, vol. 29, no. 1, p.7-13

Grant, Robert M. and Charles Baden-Fuller (2004), A knowledge accessing theory of strategic alliance, Journal of Management Studies, vol.41, no.1, January, p.61-84

Grant, Robert M. (1996), Towards a knowledge-based theory of the firm, Strategic Management Journal, vol. 17 (Winter Special Issue): p.109-122

Grant, Robert M. (1996), Prospering in dynamically-competitive environment: organisational capability as knowledge integration, Organisation Science, vol. 7, no. 4, p. 375-387

Grant, Robert M. (1991), The Resource-Based Theory of competitive advantage: Implications for strategy formulation, California Management Review, Spring, p. 114-135

Green, David (1989), A step in the right direction, Health Service Journal, vol. 99, no. 5137, 9 February, p. 168

Greenwood, Lynne (2002), Pain in gain, Health Service Journal, 10 October, p. 10

Greenwood, Royston and Robert C. Hinings (1996), Understanding radical organisational change: bringing together the old and the new institutionalism, Academy of Management Review, vol. 21, no, 4, p. 1022-1054

Greenwood, Royston and Robert C. Hinings (1987), Editorial introduction: organisational transformation, Journal of Management Studies, vol. 24, no. 6, p. 561-564

Grey, Chris and Christina Garsten (2001), Trust, control and post-bureaucracy, Organisation Studies, vol. 22, no.2, p.229-250

Griffiths, Ron (1988), Community care: An agenda for action, London, HMSO

Griffiths, Ron (1983), NHS Management inquiry, London, DHSS

Grimshaw, Damian and Marcela Miozzo (2006), Institutional effects on the IT outsourcing market: analysing clients, suppliers and staff transfer in Germany and the UK, Organisation Studies, vol. 27, no. 9, p. 1229-1259

Grönroos, Christian (1997), Value-driven relational marketing: from products to resources and competences, Journal of Marketing, vol. 13, p. 407-419

Grönroos, Christian (1994), Quo Vadis, marketing? towards a relationship marketing paradigm, Journal of Marketing Management, vol.10, p. 347-360

Grönroos, Christian (1991), The marketing strategy continuum: A marketing concept for the 1990's, Management Decision, vol. 29, No. 1, p.7-13

Grönroos, Christian (1990), Service Management and Marketing, Lexington, Massachusetts, Lexington Books.

Grossman, Kenneth (2004), Case study: outsourcing enables American startup to enter Japanese funeral services industry, Strategy and Leadership, vol. 32, no. 6, p.37-41

Guest, E. David (1999), Human resource management, the workers' verdict, Human Resource Management Journal, vol.9, no.3, p. 5-25

Guest, E. David and Zella King (1999), Power, innovation and problem-solving: the personnel manager's three steps to heaven? Human Resource Management Journal, vol.9, no.3, p.401-422

Gulati, Ranjay (1998), Alliances and networks, Strategic Management Journal, vol.19, p. 293 -317

Gulati, Ranjay (1995), Does familiarity breed trust? The implications of repeated ties for contractual choice in alliances, Academy of Management Journal, vol. 38, no.1, p. 85-112

Gummesson, Evert (1994), Making relationship marketing operational, International Journal of Service Industry Management, vol. 5, p. 5-20

Gummesson, Evert (1991), Qualitative Methods in Management Research, Revised edn., Newbury Park, California, Sage.

Haberberg Adrian and Alison Rieple (2001), The Strategic Management of Organisations, England, Prentice-Hall

Habermas, Jürgen (1987), The Philosophical Discourse of Modernity: Twelve lectures, Cambridge Massachusetts, MIT Press

Habermas Jürgen (1971), Toward a Rational Society, London, Heinemann

Hagedoorn, John and Geert Duysters (2002), Learning in dynamic inter-firm networks: The efficiency of multiple contacts, Organisation Studies, vol.23, no.4, p.525 -548

Hailey, Veronica Hope, Elaine Farndale and Catherine Truss (2005), The HR department's role in organisational performance, Human Resource Management Journal, vol.15, no. 3, p.49-66

Håkansson, Håkan and Snehota, Ivan (2000), The IMP Perspective, assets and liabilities of relationships, in Ford, David (2002) Understanding Business Marketing and Purchasing, 3rd. ed. United Kingdom, Thomson Learning

Håkansson, Håkan and Snehota, Ivan (1995), Developing Relationships in Business Networks, London, Routledge

Håkansson, Håkan and Lars-ErikGadde (1992), Supplier relations in professional purchasing, in Ford (2002), Understanding Business Marketing and Purchasing 3rd ed., United Kingdom, Thomson Learning, p. 402-425

Håkansson, Håkan and Ivan Snehota (1990), No business is an island: The network concept of business strategy, in Ford (2002), Understanding Business Marketing and Purchasing 3rd ed., United Kingdom, Thomson Learning, p. 150-161

Håkansson, Håkan (1982), International Marketing and Purchasing of Industrial Goods: An Interaction Approach, New York: Wiley.

Hall, Peter and David Soskice (2001), Varieties of Capitalism: The institutional foundations of comparative advantage, Oxford, Oxford University Press

Hall, Richard (1991), Organisations: Structure, process and outcomes, 5th edn., London, Prentice Hall

Hallen, L, Johanson J, and Seyed-Mohamed, N (1991), Inter-firm adaptation in business relationships, Journal of Marketing, vol. 55, April, p. 29-37

Halligan, Aidan (2002), Lies: that professionals work as a team, Health Service Journal, 30, May, p. 14

Halinen, Aino (1997), Exchange Relationship in Professional Services: A study of relationship development in advertising sector, Finland: Turku School of Economics and Business Administration

Ham, Chris (2005), US and UK healthcare: a special relationship? British Medical Journal, vol. 330, p.597-599

Ham, Chris, N. York, S. Sutch and R. Shaw (2003), Hospital bed utilisation in the NHS: analysis or routine data, British Medical Association, vol. 327, p. 1257-1260

Ham, Chris and A. Coulter (2001), Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices, Journal of Health Services Research and Policy, vol. 6, no. 3, p. 163-169

Ham, Chris (1996), Competition slips away, British Medical Journal 13 January, pp. 70-71

Ham, Chris (1994), Management and Competition in The New NHS, Oxford, Radcliffe Medical Press

Ham, Chris and Ken Judge (1989) Managed Competition: A new approach to healthcare in Britain, London, Kings Fund Institute

Hamel Gary (2000), Leading the Revolution, *Harvard Business Press*, Boston, Massachusetts

Hamel Gary and C.K. Prahalad (1994), Competing for the future, Harvard Business Review, July-August, p. 122-128

Hamel, Gary (1991), Competition for competence and inter-partner learning within international strategic alliances, Strategic Management Journal, vol. 12, p. 83 -103

Hamel, Gary, Yves L. Doz and C.K. Prahalad (1989), Collaborate with your competitors and win, Harvard Business Review, vol. 67, May-June, p. 133 -139

Hamel, Gary and C.K. Prahalad (1989), Strategic intent, Harvard Business Review, vol. 67, May- June, p. 63-76

Hammersley, M. (1992), What's Wrong with Ethnography? London, Routledge

Hampden-Turner, Charles (1991), The boundaries of business: commentaries from the experts, Harvard Business Review, September-October, p.93-96

Handy, Charles (2000), Gods of Management, London, Arrow Books

Handy, Charles (1997), The Hungry Spirit, London, Hutchinson

Handy, Charles (1996), Beyond Certainty, London, Arrow Books

Harding, Mary-Louise (2006), Foster goes as pay bill grows, Health Service Journal, 30 March, p. 7

Harding, Mary-Louise and Daniel Martin (2005), Constitution aims to bring an end to health economy warfare, Health Service Journal, 10, February, p. 5

Harding, Mary-Louise (2005a), A & E targets and PbR hit trusts with financial double whammy, Health Service Journal, 6 January, p. 5

Harding, Mary-Louise (2005b), Auditors sound alarm bells in Surrey and Sussex cash crisis, Health Service Journal,14, April, p. 5

Harding, Richard (2005), The Royal Navy: Innovation and Defence, London, Frank Cass

Harding, Richard (1999), Seapower and Naval Warfare 1650-1830, London, University College London Press, Taylor and Francis Group

Harding, Richard (1995), The Evolution of The Sailing Navy 1509-1815, London, St. Martin's Press

Hardy Cynthia, Nelson Phillips and Thomas, B. Lawrence (2003), Resources, Knowledge and Influence: The organisational effects of inter-organisational collaboration, Journal of Management Studies, vol.40, no.2, March, p.321-347

Harland, Christine, Louise Knight and Richard Lamming (2005), Outsourcing: Assessing the risks and benefits for organisations, sectors and nations, International Journal of Operations and Production Management, vol. 25, no. 9, p. 831-850

Harris Carol (2005), To conquer, don't command, Health Service Journal, 13 January, p. 36

Harrison, Sarah (2006), Battle lines drawn on employment rights as privatisation beckons, Nursing Standard, vol.20, no. 28, March 22, p.14-16

Harrison, Sarah (1995), Clinical autonomy and planned markets: The British case, in Saltman, R and Von Otter, C ed. Implementing Planned Markets in Healthcare, Buckingham, Open University Press

Harrison, Sarah, David Hunter, G. Marnoch and C. Pollitt (1989), General management in the NHS: Before and after the white paper, report no. 2, Leeds, Nuffield Institute

Harzing, Anne-Wil (1999), Managing The Multinationals: An international study of control mechanisms, Cheltenham, Edward Elgar

Hatch, Mary Jo (1997), Organisation Theory, London, Oxford University Press

Hayes, David, James Hunton and Jacqueline Reck (2000), Information systems outsourcing announcements: investigating the impact on the market value of contract-granting firms, Journal of Information Systems, vol. 14, no.2, p. 109-125

Health Service Journal (2006), Media watch, 30 March, p.10

Health Service Journal (2005b), Targets pressure threatens services, 20 January, p. 6

Health Service Journal (2005a), Capital reports worst debt, 3 March, p. 15

Health Emergency (2004a), Bulletin of hands off our NHS, No. 59, Spring

Health Emergency (2004), NHS reforms bring back market chaos! no. 60, p. 1-8

Health Service Journal (2002), Organisational lies dog health professionals, 30 May p.14

Health Service Journal (1989b), In-house teams win most Welsh hospital contracts, vol.99, no. 5136, 2 February p.132

Health Service Journal (1989a), Flawed by fanatics, vol.99, no. 5136, 2 February p.131

Health Service Journal (1989), Working for patients, vol.99, no. 5136, 2 February p.135

Healy Paul M. and Krishna G. Palepu (2003), How the quest for efficiency corroded the market, Harvard Business Review, July, p.76-85

Helfat, Constance E. and Margaret A. Peteraf (2003), The dynamic resource-based view: capability lifecycles, Strategic Management Journal, vol. 24, p. 997-1010

Helfat, Constance E. (2000), The evolution of firm capabilities, Strategic Management Journal, (Editorial) vol.21, p. 955-959

Helfat, Constance E. (1997), Know-how and asset complementarity and dynamic capability accumulation: the case of R&D, Strategic Management Journal, vol. 18, no. 5, p. 339-360

Heide, Jan B. 1994), Inter-organisational *governance in marketing* channels, Journal of Marketing, vol.58, January, p.71- 85

Heide, Jan B. and John George (1992), Do norms matter in marketing relationships? Journal of Marketing, vol. 56, April, p. 32- 44

Heide, Jan B. and John George (1988), The role of dependence balancing in safeguarding Transaction-specific assets in conventional channels, Journal of Marketing, vol. 52, January p. 20-35

Henry, Jane and David Mayle (1991), Managing Innovation and Change, 2nd (edn.), London, Sage Publication

Herbig, Paul A. (1991), Game theory in marketing: Applications, uses, and limits, Journal of Marketing Management, Vol.7, pp. 285-298

Hill, Charles W. and Thomas Jones (1992), Stakeholder—Agency theory, Journal of Management Studies, vol. 29, no. 2, p. 131-154

Hinings C. Robert, John Brown and Royston Greenwood (1991) Change in autonomous professional organisation, Journal of Management Studies, vol. 28, no. 4, p.375-393

Hitt, Michael, Robert Hoskisson, Jeffrey Harrison and Timothy Summers (1994), Human capital and strategic competitiveness in the 1990s, Journal of Management Development, vol.13, no.1, p. 35-46

HMSO, (1970), The reorganisation of Central Government, London, Cmnd, 4506

HM Treasury (1995), Private opportunity, public benefit: programming the PFI, London

Hobbes, Thomas (1965), Leviathan, London, Oxford University Press, first published 1651

Hobbes, Thomas (1958), Leviathan, Indianapolis, Bobbs-Marrill

Hodge Billy J. and William P. Anthony (1991), Organisation Theory: A strategic approach, 4th ed., Massachusetts, Allyn and Bacon

Hoeksma, Jon (2002), DoH Battles for £5bn to spend on IT, Health Service Journal, 30 May, p. 4

Hofstede, Geert (1998), Attitudes, values and organisational culture: dis-entangling the concept, Organisation Studies, vol. 19, no. 3, p. 477-492

Hofstede, Geert (1991), Cultures and Organisations, Maidenhead, McGraw-Hill

Hofstede, Geert (1980), Cultures, Consequences: Internal differences in work-related values, Beverly Hills, Sage

Holiday, Ian (1995), The NHS Transformed, Manchester, United Kingdom, Baseline Books

Hope-Hailey, Veronica, Elaine Farndale and Catherine Truss (2005), The HR department's role in organisational performance, Human Resource Management Journal, vol. 15, no. 3, p. 49-66

Hosking, Sarah and Liz Haggard (1999), Healing The Hospital Environment, London, Spon

House of Commons (2003), Public Accounts -Twenty-Eight Report on PFI, 9 June, Public Accounts Committee Publications

Huber, George (1999), Facilitating project team learning and contribution to organisational knowledge, Creativity and Innovation Management, vol. 8, no. 2, p. 70-76

Huber, Richard L. (1993), How Continental bank outsourced its crown jewels, Harvard Business Review, January- February, p. 121-129

Huff, Ann S. (1997), A current and future agenda for cognitive research in organisations, Journal of Management Studies, vol. 34, no. 6, November, p. 947-952

Hundley, Greg and Carol Jacobson (1998), The effects of the Keiretsu on the export performance of Japanese companies: help or hindrance? Strategic Management Journal, vol. 19, p. 927-937

Hunt, Shelby and Robert Morgan (1996), The resource advantage theory of competition: dynamics, path dependencies and evolutionary, Journal of Marketing, vol. 60, no. 4, p. 107-115

Hunt, Shelby and Robert Morgan (1995), The comparative advantage theory of competition, Journal of Marketing, vol. 59, April, p.1-15

Hunter, David (2003), Foundation hospitals: back to the future, (Editorial), Public Money and Management, vol. 23, no. 4, p. 211-213

Hunter, David (2002), Coming up for air: NHS hollowed out? Health Service Journal, 16 May, p. 20

Hunter, David (1980), Coping with Uncertainty, Chichester, Research Studies Press

Ilozor, Ben, Peter Love and Graham Treloar (2002), The impact of work settings on organisational performance measures in built facilities, Facilities, vol. 20, no.1/2, p. 61-68

Innovation (2002), Innovationinspiration magazine, Spring issue

Institute of Personnel and Development (1998), The IPD Guide on Outsourcing, London

Jacoby, Ryan and Diego Rodriguez (2007), Innovation, growth and getting to where you want to go, Design Management Review, Winter, p. 10-15

Jacoby, Sanford (1997), Modern Manors: Welfare capitalism since the new deal, Princeton, New Jersey, Princeton University press

Jackson, Barbara Bund (1985), Build customer relationships that last, Harvard Business Review, November-December, p. 120-127

Jamali, D., G. Khoury and H. Sahyoun (2006), From bureaucratic organisations to learning organisations, The Learning Organisation, vol. 13, no. 4, p. 337-352

Jarillo, J. Carlos (1988), On strategic networks, Strategic Management Journal, vol. 9, p. 31- 41

Jarrold, Ken (2002), Goodbye to all that, Health Service Journal, 19, December, p. 15

Jaques Elliott (1990), In praise of hierarchy, Harvard Business Review, January-February, p. 127-133

Jennings, Dick (2005), Agents of change, Supply Management, 3 November, p. 22

Jennings David (2002), Strategic sourcing: Benefits, problems and a contextual model, Management Decision, vol.40, no. 1, p.26-34

Jiang, Bin, Gregory Frazier and Edmund Prater (2006), Outsourcing effects on firm's operational performance: An emprircal study, International Journal of Operations and Production Management, vol. 26, no 12, p.1280-1300

Jiang, Bin and Amer Qureshi (2006), Research on outsourcing results: current literature and future opportunities, Management Decision, vol. 44, no. 1, p. 44-55

Johnson, James (2005), Labour's capacity plan ignore the long term, British Medical Association News, Saturday February 12, p. 10-11

Jolly Adam (2003), Innovation: Harnessing creativity for business growth, London, Kogan Page

Jones, Oswald (2000), Innovation management as a post-modern phenomenon: the outsourcing of pharmaceutical R&D, British Journal of Management, vol. 11, no. 4, p. 341-356

Jones, Oliver (2000c), Facilities management: future opportunities, scope and impact, Facilities, vol. 18, no. ¾, p. 133-137

Jones, Judy (2000b), The private finance initiative: spinning out the defence, British Medical Journal, vol. 320, 27 May, P. 1460-1461

Jones, Judy (2000a), The secret life of the NHS, British Medical Journal, vol. 320, 27 May, p. 1457-1459

Joshua-Amadi, Mabel (2003), Recruitment and Retention: A Study in Motivation Nursing Management, vol. 9, no. 9, p 14-19.

Joshua-Amadi, Mabel (2002), Recruitment and Retention: A Study in Motivation Nursing Management, vol. 9, no. 8, p17- 21.

Kaletsky, Anatole (2008), Budget 2008: Income and expenditure 2008-09, The Times, Thursday, 13, p. 2

Kanter, Rosabeth Moss (1994), Collaborative advantage: the art of alliances, Harvard Business Review, July-August, p. 96-108

Kanter, Rosabeth Moss (1989a), The new managerial work, Harvard Business Review, November-December, p. 85-92

Kanter, Rosabeth Moss (1989), When giants learn to dance, London, Simon and Schuster

Kanter, Rosabeth Moss (1987) The attack on pay, Harvard Business Review, March-April, p. 62-67

Kanter, Rosabeth Moss (1983), The Change Masters: Corporate entrepreneurs at work, London, Unwin

Kanter, Rosabeth Moss (1979) Power failure in management circuits in Derek S. Pugh (1997) Organisation Theory, 4th ed., London, Penguin, p.319-338

Karöf Bengt (1993), Strategic Precision: Efficiency, Chichester, John Wiley and Sons

Kaspersen, Lars Bo (2000), Anthony Giddens, Oxford, UK, Blackwell Publishers (European edn. published 1995)

Key, Peter, Bob Dearden and Brian Lind (1994), Private lessons: perspectives on purchasing, Health Services Journal, January 27, p. 27-29

Khanna, Tarun, Ranjay Gulati and Nitin Nohria (1998), The dynamics of learning alliances: Competition, cooperation and relative scope, Strategic Management Journal, vol. 19, p. 193 -210

Khanna, Tarun (1995), Racing behaviour: Technological evolution in the high-end computer industry, Research Policy, vol. 4, p. 933 -958

Khilji, Shaista and Xiaoyun Wang (2006), Intended and Implemented HRM: The missing linchpin in strategic HRM research, International Journal of Human Resource Management, vol. 17, issue 7, p. 1171-1184

Khong, Kok (2005), The perceived impact of successful outsourcing on customer services management, Supply Chain Management, vol. 10, no. 5, p. 402-411

Kingsfund (2005), Private concern, Health Director, vol.4, Issue 4, p.42-43

Klein, Rudolf (2001), The New Politics of The National Health Service, 4th ed., London, Prentice Hall

Klein, Rudolf (1997), Learning from others: shall the last be first? Journal of Health Politics, Policy and Law, vol. 22, p. 1267-1278

Klein, Rudolf (1995), The New Politics of The National Health Service, 3th edn., London, Prentice Hall

Klein, Rudolf (1991), Risks and benefits of comparative studies: notes from another shore, Milbank Quarterly, vol. 69, p. 275-291

Klein, Rudolf and Patricia Day (1989), NHS Review: The broad picture, British Medical Journal, vol. 298, 11 February, p. 339 -340

Kleinaltenkamp, Michael and Michael Ehret (2006), The value added by specific investments: a framework for managing relationships in the context of value networks, Journal of Business and Industrial Marketing, vol. 21, no. 2, p. 65-71

Kleiner, Art (2003), Are you in the crowd? Harvard Business Review, July, p.86-92

Kleiner, Art and George Roth (1997), How to make experience your company's best teacher, Harvard Business Review, September-October, p. 172-177

Kmietowicz, Zosia (2006), Poor leadership is blamed for financial problems in the NHS, British Medical Journal, vol. 333, 15 July, p. 115

Knight, Daniel (2004), How to grow no matter what, Strategy & Leadership, vol. 32, no.6, p. 4-10

Kotler, Peter (1980), Principles of Marketing, Englewood Cliffs, New Jersey, Prentice-Hall

Kotler, Peter (1992), It's Time for total marketing, Business Week, Advance Executive Brief, vol. 2

Krackhardt, David and Jeffrey R. Hanson (1993), Informal networks: The company behind the chart, Harvard Business Review, July-August, p. 104-111

Labour Research (2005a), Has Warwick saved the link? vol.94, no.1, p.9-13

Labour Research (2005b), Fairer deal for contract staff, vol. 94, no. 2, February, p. 17-18

Labour Research (2005c), Choice and jobs challenge for public services, vol.94, no.5, May, p.11-13

Labour Research (2005d) Outsourcing- does it work? vol. 94, no. 8 August, p.17-18

Labour Research (2004), Civil service to be decimated, vol. 93, no. 7, p. 12-13

Lacity, Mary and Rudy Hirscheim (1999), I.T outsourcing: What problems are we trying to solve? In Wendy L. Currie and Bob Galliers, "Rethinking Management Information Systems", Chapter 14, New York, Oxford University Press

Lacity, Mary C and Leslie P. Willcocks (1997), Information systems sourcing: examining the privatisation option in USA public administration, Information Systems Journal, vol. 77, p. 85-108

Lacity, Mary and Rudy Hirschheim (1995), Beyond the Information Systems Outsourcing Bandwagon, John Wiley & Sons, New York

Lacity, Mary C., Leslie P. Willcocks and David F. Feeny (1995), IT Outsourcing: Maximize flexibility and control, Harvard Business Review, May-June, p. 84-93

Lai, Joseph and Francis Yik (2007), Monitoring building operation and maintenance contracts, Facilities, vol. 25, no. 5/6, p. 238-251

Laing, Angus; Fishbacher, Moira; Hogg, Gillian; Smith, Anne (2002), Managing and Marketing Health Services, Cornwall United Kingdom, Thomson

Laing, Angus and Seonaidh Cotton (1996), Purchasing healthcare services: information sources and decision criteria, Journal of Marketing Management, vol.12, p.719-734

Lam Alice (2000), Tacit knowledge, organisational learning and societal institutions: an integrated framework, Organisation Studies, vol.21, no.3, p.487-513

Lancet (1989) Curtains up on the NHS Review, 4 February, p. 247-249

Lane, Nikala (2000), The management implications of women's employment disadvantage in a female-dominated profession: a study of NHS nursing, Journal of Management Studies, vol. 37, no. 5, p. 705-731

Lane, Christel and Reinhard Bachmann (1996), The social constitution of trust: Supplier relations in Britain and Germany, Organisation Studies, vol. 17, no. 3, p. 365-395

Lansbury, Russell and Marian Baird (2004), Researching HRM and employment relations in a global context: choosing appropriate methodologies, International Journal of Human Resource Management, vol. 15, no. 3, p. 429-432

Lawrence, S., M. Alam, D. Northcott and T. Lowe (1997), Accounting systems and systems of accountability in the New Zealand health sector, Accounting, Auditing and Accountability Journal, vol. 10, no. 5, p. 665-683

Lawrence Jeremy (1988), Silencing the NHS, New Statesman and Society, 10 June p.14-15

Lawrence, Paul and Jay Lorsch (1967), Organisation and Environment, Cambridge, Massachusetts, Harvard University Press

Layder, Derek (1997), Modern Social Theory, London, University College London Press

Layder, Derek (1987), Key issues in structuration theory: some critical remarks, Current Perspectives in Social Theory, vol. 8, p. 25-46

Leathard, Audrey (1990) Health Care Provision, London, Chapman and Hall

Leavitt, Harold J. (2003) Why hierarchies thrive, Harvard Business Review, March, p.97-102

Leavy, Brian (2004), Outsourcing strategies: opportunities and risks, Strategy and Leadership, vol. 32, no. 6, p. 20-25

Lee, Kenneth and Anne Mills (1982), Policy-making and Planning in The Health Sector, London, Croom Helm

Legge, Karen (1995), Human Resource Management: Rhetorics and realities, Basingstoke, Macmillan

Le Grand, Julian (2006), Sixty years on, how Bevan's vision is bearing up, Health Service Journal, 27 April, p. 20

Leonard-Barton, Dorothy (1992), Core capabilities and core rigidities: a paradox in managing new product development, Strategic Management Journal, Summer issue, vol. 13, p.111-125

Lev, Baruch (2004), Sharpening the intangible edge, Harvard Business Review, June, p. 109-116

Levitt, Ruth, Andrew Wall and John Appleby (1999), *The Reorganised National Health Service,* 6th edn. Cheltenham, United Kingdom, Stanley Thornes

Levitt, Ruth, Andrew Wall and John Appleby (1995), The Reorganised National Health Service, 5th ed., London, Chapman and Hall

Levitt, Theodore (1965), Marketing myopia, Harvard Business Review, September-October, vol. 43, p. 26-44

Lewis, Richard (2005), Strong foundations? Health Director, vol.4, Issue 4, p. 40-41

Lewis, Ira and Jim Suchan (2003), Structuration theory: its potential impact on logistics research, International Journal of Physical Distribution and Logistics Management, vol. 33, no. 4, p. 296-315

Lin, Chad, Graham Pervan and Donald McDermid (2007), Issues and recommendations in evaluating and managing the benefits of public sector IS/IT outsourcing, Information Technology and People, vol. 20, no. 2, p. 161-183

Linder, Jane, Martin Cole and Alvin Jacobson (2002), Business transformation through outsourcing, Strategy and Leadership, vol. 30, no. 4, p. 23-28

Little, William (2005), Charities ready to play with the big boys but says "let's play fair", Health Service Journal, 27 January, p. 14

Littler, Craig and Peter Innes (2004), The paradox of managerial downsizing, Organisation Studies, vol. 25, no. 7, p. 1159-1184

Littler, Craig, Retha Wiesner and Richard Dunford (2003), The dynamics of de-layering: changing management structure in three countries, Journal of Management Studies, vol. 40, p. 225-256

Lloyd, Ian (2006), More redundancies to follow 5,000, says chiefs, Health Service Journal, 30 March, p.6

Lloyd, Ian (2005a), Trusts wary of 472 stealth targets, Health Service Journal, 17 February, p. 6

Lloyd, Ian (2005b), Staff attitude under fire, Health Service Journal, 24 February, p. 7

Llewellyn, Sue (2001), Two-way windows: Clinicians as medical managers, Organisation Studies, vol.22, no. 4, p.593-623

Lorsch, Jay (1995), Empowering the board, Harvard Business Review, January-February, p. 107-117

Louis, Meryl (1980), Surprise and sensemaking: what newcomers experience in entering unfamiliar organisational settings, Administrative Science Quarterly, vol. 25, p. 226-251

Lukes, Steven (2005), Power: A radical review, Basingstoke, Palgrave, Macmillan

Lukes, Steven (1977), Power in structure: Essays in Social Theory, London, Macmillan

Lukes, Steven (1974), Power: A radical view, London, Macmillan

Machiavelli, Niccolo (1958), The Prince, London, Everyman

Machiavelli, Niccolo (1940), The Prince and The Discourses, New York, Random House

Macniel, Ian R. (1980), The New Social Contracts: An inquiry into modern contractual relations, New Haven, Yale University Press

Macniel, Ian R. (1978), Contracts adjustments of long-term economic relations under classical, neoclassical and relational contract law, North Western University Law Review, vol. 72, no. 6, p. 854 -905

Makadok, Richard (2001), Toward a synthesis of the resource-based and dynamic-capability views of rent creation, Strategic Management Journal, vol.22, p. 387-401

Maitlis, Sally (2004), Taking it from the top: how CEOs influence (and fail to influence) their board, Organisation Studies, vol. 25, no. 8, p. 1275-1311

Manning, Peter (1982), Organisational work: structuration of environment, British Journal of Sociology, vol. 33, p.118-134

March, James (1981), Footnotes to organisational change, Administrative Science Quarterly, vol. 26, p. 563-577

March, James .G and Johan .P Olsen (1989), Rediscovering Institutions: The organisational basis of politics, New York, Free Press

March, James and Herbert Simon (1958), Organisations, New York, Wiley

Martin, Daniel (2006), We won't split the job, claims minister, Health Service Journal, 9 March, p. 8-9

Martin, Daniel and Ian Lloyd (2005), NHS is £500m in red, Health Service Journal, 6 January, p. 7

Martin, Roderick (1977), Sociology of Power, London, Routledge and Kegan Paul

Marx, Karl (1990), Capital: A critique of political economy, vol. 1, London, Penguin books

Marx, Karl and Friedrich Engels (1968), Selected Works, vol. 1, London, Lawrence and Wishart

Marx, Karl (1909), Capital: A critique of political economy, vol. 3, Chicago, Charles H. Keer and company

Mattausch, John (2003), Chance and societal change, The Sociological Review, editorial board, p. 506-527

Mattsson, Lars-Gunnar (1997), Relationship Marketing and the markets-as-networks approach, Journal of Marketing Management, vol. 13, p 447-461

Mattsson, Lars-Gunnar (1988), Interaction Strategies: A network approach, Working paper

Maxwell, Joseph (1996), Qualitative Research Design: An interactive approach, Thousand Oaks California, Sage

May, Daryl and Louise Suckley (2005), Ward housekeepers in mental health environment, Facilities, vol. 23, no. 13/14, p. 608-620

Maynard, Alan (2005), Trusts have little power to force doctors to take part in audits, Health Service Journal, 10 March, p.15

Maynard, Alan (2002), Popping out all over: 40% of antibiotics used in the NHS are inappropriate, Health Service Journal, 5 December, p.18

Maynard, Alan (1989), Carrots to blend with choice cuts, Guardian, 30 January

Maynard, Alan (1989), Budget holding and how it will affect GPs' usual work practices, Pulse, vol.49, no.8, 25 February, p. 65

McCarthy, Ian and Angela Anagnostou (2004), The impact of outsourcing on the transaction costs and boundaries of manufacturing, International Journal of Production Economics, vol. 88, no. 1, p. 61-71

McClelland, David and David Burnham (1995), Power is the great motivator, Harvard Business Review, January- February, p. 126-138

McGauran, Ann (2002), Devil in the details, Health Service Journal, 9 May, p. 13

McGregor, Wes and Danny Shien-Shin Then (1999), FM and The Business of Space, London, Arnold

McLellan, Alistair (2005), Crisp offers vision of PCT's banded together for contract efficiency, Health Service Journal, 17 March, p.6

McKinlay, Alan and Ken Starkey (2000), Foucault, Management and Organisation Theory, London, Sage

McMillan, Charles (1974), The Problem of Organisations, Unit 2, Milton Keynes, The Open University Press

McNay, Lois (1994), Foucault: A critical introduction, Oxford, Polity Press

McNulty, Terry and Ewan Ferlie (2004), Process transformation: Limitations to radical organisational change within public service organisations, Organisation Studies, vol. 25, no. 8, p. 1389-1412

McNulty, Terry and Ewan Ferlie (2002), Reengineering Healthcare: The complexities of organisational transformation, Oxford, Oxford University Press

Mechanic David (1962), Sources of power of lower participants in complex organisations, Administrative Science Quarterly, vol. 7, no. 3, December, p. 349-364

Miles, Mathew and Micheal Huberman (1994), Qualitative Data Analysis: A sourcebook of new methods, Beverly Hills, California, Sage Publications.

Milliken, Frances, Elizabeth Morrison and Patricia Hewlin (2003), An exploratory study of employee silence: issues that employees don't communicate upward and why, Journal of Management Studies, vol. 40, no. 6, p. 1454-1476

Mintzberg Henry (1990), The manager's job: folklore and fact, Harvard Business Review, March-April, p.163-176

Mintzberg, Henry (1983), Power In and Around Organisations, Englewood Cliffs, NJ, Prentice Hall

Mintzberg Henry (1973), The Nature of Managerial Work, New York, Harper and Row

Mitton, Craig and Cam Donaldson (2003), Resource allocation in healthcare: health economics and beyond, Health Care Analysis, vol.11, no. 3, p. 245-257

Mizruchi Mark and David Bunting (1981), Influence in corporate networks: an examination of four measures, Administrative Science Quarterly, vol. 26, p. 475-489

Möller, Kristian and David Wilson (1995), Business Marketing: An interaction, perspective, Boston, Massachusetts, Kluwer Academic Publishers,

Momme, Jesper and Hans-Henrik Hvolby (2002), An outsourcing framework: action research in the heavy industry sector, European Journal of Purchasing and Supply Management, vol.8, no.4, p. 185-196

Mooney, Helen (2005a), Evercare says pilots would do better with own staff, Health Service Journal, 10 February, p. 7

Mooney, Helen (2005b), ACAD eyes new markets, Health Service Journal, 24 February, p. 5

Mooney, Helen (2005c), Monitor would do things differently today, Health Service Journal, 10 March, p.18

Moore, Alison (2007), In or out: contractors braced for a domestic over clean, Health Service Journal, 1 February, p. 14

Moore, John (1992), British privatisation—taking capitalism to the people, Harvard Business Review, January-February, p.115-124

Moorcroft, Ray (2005), Manager: business news update, Advanced Institute of Management, October-November, p.11-22

Morgan, Gill (2006), The human tragedy, Health Service Journal, 30 March p.6

Morgan, Gill (2002), Central grip will pass, says Crisp, Health Service Journal, 30 May, p. 15

Morgan, Robert M. and Shelby Hunt (1994), The commitment-Trust theory of relationship marketing, Journal of Marketing, vol. 58, p. 20-38

Morita, Akio (1992), Partnering for competitiveness: the role of Japanese business, Harvard Business Review, May-June, p.76-83

Morrison, Elizabeth Wolfe and Frances Milliken (2003), Speaking up, remaining silent, Journal of Management Studies, vol. 40, no. 6, p.1453-1458

Moschandreas, Maria (2000), Business Economics, 2nd edn., London, Thomson learning

Moyes, Bill (2005), Monitor relaxes borrowing limits, Health Service Journal, 31 March, p.7

Mueller, Frank, John Sillince, Charles Harvey and Chris Howorth (2003), A rounded picture is what we need: rhetorical strategies, arguments and the negotiation of change in a UK hospital trust, Organisation Studies, vol., 25, no. 1, p. 75-93

Mueller, Frank and John Purcell (1992), The Europeanisation of manufacturing and the decentralisation of collective bargaining, International Journal of Human Resource Management, vol. 3, p. 15-34

Munck, Bill (2001), Changing a culture of face time, Harvard Business Review, November, p.125-132

Navaretti, Giorgio B. and Anthony Venables (2005), Multinational: heroes or villains of the global economy, Centrepiece, The magazine of the centre for economic performance, vol.10, issue1, Spring, p.2-7

Nelson, Margaret-Mary (2004), The emergence of supply chain management as a strategic facilities management tool, in Facilities Management, London, Spon

Nelson, Richard R. and Sidney Winter (1982), An Evolutionary Theory of Economic Change, Harvard University Press, Cambridge, Massachusetts

Newbold, David (2005), Foundation trusts: economics in the postmodern hospital, Journal of Nursing Management, vol. 13, p. 439-447

NHS Executive (1999), The new NHS-Reference costs London, HMSO

NHS Procurement Review, (1998), London, Cabinet Office

Nichols, Nancy A. (1993), From complacency to competitiveness, Harvard Business Review, September-October, p. 163-171

Niven, Karen, Stephen Reeves, Becci Newton, Sue O'Hara, John Lawson (2005), Findings from qualitative research with health service professionals: DWP research report 225: the potential for certification of incapacity for work by non-medical healthcare professionals, Department of Works and Pensions, www.dwp.gov.uk/asd5/ (accessed 19/12/07)

Nordin, Fredrik (2006), Outsourcing services in turbulent contexts, Leadership and Organisation Development Journal, vol. 27, no. 4, p. 296-315

Nutt, Paul C. (2000), Decision-making success in public, private and third sector organisations: finding sector dependent best practice, Journal of Management Studies, vol. 37, no. 1, p. 77-107

Nutt, Bev and Peter McLennan (2000), Facilities Management, Oxford, Blackwell Science

O'Hara, Suzanne, Trix Webber and Steve Reeve (1996), Action Learning in management education, Education and Training, vol. 38, no. 8, p. 16-21

Ohmae, Kenichi (1995), Putting global logic first, Harvard Business Review, January-February, p.119-125

Ohmae, Kenichi (1990), The Borderless World: Power and strategy in the interlinked economy, London, Collins

Ohmae, Kenichi (1989), Managing in a borderless world, Harvard Business Review, vol. 67, May-June, p. 152-161

Okoroh, M., P. Gombera and B. Ilozor (2002), Managing FM (support services): business risks in the healthcare sector, Facilities, vol. 20, no. 1/2, p. 41-51

Oliver, Ralph (2003), Supporting contracts, Investors Chronicle, 24 October p. 44

Ollman, Bertell (1976), Alienation, London, Cambridge University Press

Organisation for Economic Cooperation and Development (2003), Health at a glance, Paris, OECD

Orlikowski, W. (1988), computer technology in organisations: some critical notes in Knights D. and Willmott H. (ed.) New Technology and The Labour Process, London, Macmillan, p. 20-49

Osarenkhoe, Aihie and Az-Eddine Bennani (2007), An exploratory study of implementation of customer relationship management strategy, Business Process Management Journal, vol. 13, no. 1, p. 139-64

Osborne, Stephen and Kerry Brown (2005), Managing Change and Innovation in Public Service Organisations, London, Routledge

Ostrom, Amy and Dawn Iacobucci (1995), Consumer trade-offs and the evaluation of services, Journal of Marketing, vol. 59, January, p. 17-28

Ouchi, William G. (1980), Markets, bureaucracies and clans, Administrative Science Quarterly, vol. 25, p. 129-145

Ouchi, William G. (1979), A conceptual framework for the design of organisational control mechanisms, Management Science, vol.25, p. 833-848

Ouchi, William G. (1977), The relationship between organisational structure and organisational control, Administrative Science Quarterly, vol. 22, p. 95-113

Øvretveit, John (1995), Purchasing for Health, Buckingham, Philadelphia, Open University Press

Owen, David (1989), Unhealthy prescription for the NHS, Daily Telegraph, 31, January

Packer, Kerry (1988), The golden rule, Australian Morning Herald, 30 July, p. 32

Park Royal Partnership (2006), Regeneration: A tour of Park Royal's new healing city, July-August-September issue

Parke, Arvind (1993), Strategic alliance structuring: A game theoretic and transaction cost examination of inter-firm cooperation, Academy of Management Journal, vol. 36, no. 4., p. 794-829

Parris, Mathew (2004), Jobs cut to remove waste—84,000, Jobs lost—0, The Times, Tuesday, 13 July, p. 20

PASA (1998), NHS Procurement review, Cabinet Office, London

Payne, Trevor (2000), Facilities Management, Oxford, Chandos Publishing

Peisch, Richard (1995), When outsourcing goes awry, Harvard Business Review, May-June, pp. 24-37

Penrose, Edith (1996), The Theory of The Growth of The Firm, Oxford, Basil Blackwell

Penrose, Edith (1959), The Theory of The Growth of The Firm, Oxford, Basil Blackwell

Perrow, Charles (1986), Complex Organisations: A critical essay, 3rd edn. New York, McGraw-Hill

Perrow, Charles (1981), Markets, Hierarchy and Hegemony: A critique of Chandler and Williamson, In Perspectives of Organisation Design and Behaviour, New York, Wiley inter-science

Perrow, Charles (1974), Perspectives on Organisations, unit 15, Milton Keynes, The Open University Press

Perrow, Charles (1972), The Radical Attack on Business: A critical analysis, New York, Harcourt Brace Jovanovich

Perryman-Starkey, Martha, Patrick Asuboteng Rivers and George Munchus (1999), The effects of organisational structure on hospital performance, Health Services Management Research, vol. 12, p.232-245

Pesämaa, Ossi and Joseph Hair (2007), More than friendship is required: an empirical test of cooperative firm strategies, Management Decision, vol. 45, no. 3, p. 602-615

Persaud, Raj (2005), Mind games, Health Service Journal, 13 January, p. 36

Petchey, R (1986), The Griffith's reorganisation of the NHS: Fowler-ism by stealth? Critical Social Policy, vol. 17, p. 87-101

Peteraf, Margaret and Mark E. Bergen (2003), Scanning dynamic competitive landscape: A market- based and resource-based framework, Strategic Management Journal, vol.24, p. 1027-1041

Peteraf, Margaret A. (1993), The cornerstones of competitive advantage: A resource-based view, Strategic Management Journal, vol. 14, p. 179-192

Peters, Tom (1992), Liberation management, New York, Alfred Knopf

Peters, Tom (1988), Thriving on Chaos, New York, Knopf

Peters, Tom and Robert Waterman (1982), In Search of Excellence: Lessons from America's best run companies, New York, Harper and Row

Peters, Tom (1980), Management systems: the language of organisational character and competence, Organisational Dynamics, p. 3-26

Pettigrew, Andrew and Evelyn Fenton (2000), The Innovating Organisation, London, Sage

Pettigrew, Andrew (1992), The character and significance of strategy, research and process, Strategic Management Journal, Winter Special Issue, vol. 13, p. 5-16

Pettigrew, Andrew, Ewan Ferlie and Lorna Mckee (1992), Shaping Strategic Change, London, Sage Publications

Pettigrew, Andrew and R. Whipp (1991), Managing Change for Competitive Success, Oxford, Basil Blackwell

Pettigrew, Andrew (1987), Context and action in the transformation of the firm, Journal of Management Studies, vol. 26, no. 6, p. 649-670

Pettigrew, Andrew (1985), The Awakening Giant: continuity and change in Imperial Chemical Industries (ICI), Oxford, Blackwell

Pettigrew, Andrew (1973), The Politics of Organisational Decision-making, London, Tavistock

Pfeffer, Jeffrey (1998), Six dangerous myths about pay, Harvard Business Review, May-June, p.109-119

Pfeffer, Jeffrey (1996), When it comes to "best practice," why do smart organisations occasionally do dumb things? Organisational Dynamics, Summer, p. 33-44

Pfeffer, Jeffrey (1995), Producing sustainable competitive advantage through the effective management of people, Academy of Management Executive, vol.9, no. 1, p. 55-69

Pfeffer, Jeffrey (1994a), Competitive Advantage Through People: Unleashing the power of the workforce, Boston, USA, Harvard School Press

Pfeffer, Jeffrey (1994), Managing With Power, Boston, Massachusetts, Harvard Business School Press

Pfeffer, Jeffrey (1981), Power in Organisations, Cambridge Massachusetts, Ballinger Publishing

Pfeffer, Jeffrey and Gerald R. Salanick (1978), The External Control of Organisations A Resource Dependence Perspective, New York, Harper and Row

Pfeffer, Jeffrey and Gerald R. Salancik, (1978), The Design and Management of Externally Controlled Organisations, In Derek Pugh, (1997), Organisation Theory, 4th ed. London, Penguin Books

Pfeffer, Jeffrey, Gerald R. Salancik and Huseyin Leblebici (1976), The effect of uncertainty on the use of social influence in organisational decision-making, Administrative Science Quarterly, vol. 21, p. 227-244

Phillips, Estelle and Pugh, Derek (2002), How to Get a PhD, 3rd ed., London: Open University Press.

Pichault, Francois (1995), The management of politics in technologically related organisational change, Organisation Studies, vol. 16, no. 3, p. 449-476

Pleasants, Nigel (1999), Wittgenstein and The Idea of Critical Social Theory: Critique of Giddens, London, Routledge

Plumridge, Noel (2005), Extending payment by results carries the potential for drifting into the primeval swamp, Health Service Journal, 31 March, p. 15

Polanyi, Michael (1983), The Tacit Dimension, Gloucester, Peter Smith

Polanyi, Michael (1962), Personal Knowledge: Towards a post critical philosophy, New York, Harper Torchbooks

Polanyi, Michael (1958), Personal Knowledge, London, Routledge and Kegan Paul

Pollitt, Christopher (1990), Managerial-ism and The Public Service, Oxford, Blackwell

Pollock, Allyson, M. Dunnigan, D. Gaffney, D. Price and J. Shaoul (1999), The private finance initiative: planning the new NHS downsizing for the 21st century, British Medical Journal, vol. 319, p. 179-184

Popper, Karl (1972), Objective Knowledge: An evolutionary approach, Oxford Clarendon Press

Porter, Michael E. (1996), What is strategy, Harvard Business Review, November-December, p. 61-76

Porter, Michael E. (1995), The competitive advantage of the inner city, Harvard Business Review, May-June, p.55-71

Porter, Michael E. (1990), The competitive advantage of nations, Harvard Business Review, March April, p. 73-93

Porter, Michael E. (1987), From competitive advantage to corporate strategy, Harvard Business Review, May-June, p. 43-59

Porter, Michael E. (1980), Competitive Strategy, New York, Free Press

Porter, Theodore Michael. (1995), Trust in Numbers: The pursuit of objectivity in science and public life, Princeton, Princeton University press

Porter, Theodore Michael (1991), Towards a dynamic theory of strategy, Strategic Management Journal, vol. 12 (Winter special issue), p. 95-117

Portillo, Michael (1998), The Bevan legacy: a sacred NHS, Nursing Management, vol. 5, no. 7, p. 32-36

Powell, Thomas C. (2001), Competitive Advantage: Logical and philosophical considerations Strategic Management Journal, vol. 22, p 875-888,

Powell, Enoch (1966), Medicine and Politics, London, Pitman Medical

Power, Damien and Moosa Sharafali and Vikram Bhakoo (2007), Adding value through outsourcing, Management Research News, vol. 30, no. 3, p. 228-235

Power, Mark, Carlo Bonifazi and Kevin Desouza (2004), The ten outsourcing traps to avoid, Journal of Business Strategy, vol. 25, no. 2, p. 37-42

Prahalad, C.K and Gary Hamel (1990), The core competence of the corporation, Harvard Business Review, May-June, pp.79-91

Prahalad, C.K and Yves Doz (1981), An approach to strategic control in Multinational corporations, Sloan Management Review, vol. 22, no. 4, p. 5-13

Preston, Simon (2004), Lost in migration: offshore need not mean outsourced, Strategy and Leadership, vol. 32, no. 6, p. 32-36

Pugh, Derek, S. (1997), Organisation Theory, 4th. (edn.) London, Penguin Books

Punch, Keith (2000), Developing Effective Research Proposal, London, Sage.

Purcell, John (1999), Best practice and best fit: chimera or cul-de-sac? Human Resource Management Journal, vol.9, no.3, p.26-41

Quilgars, Debora (2000), Low intensity support services: A Systematic Review of Effectiveness, Bristol, United Kingdom, Polity press

Quinn, James Brian (1999), strategic outsourcing: leveraging knowledge capabilities, Sloan, Management Review, vol. 40, no. 4, p. 9-21

Quinn, James Brian, Philip Anderson and Sydney Finkelstein (1996), Managing professional intellect: making the most of the best, Harvard Business Review, March-April, p.71-80

Quinn, James Brian; Thomas Doorley and Penny C. Paquette (1990), Beyond products: Services-based strategy, Harvard Business Review, March-April, p. 58-67

Quinn, James Brian (1980), Strategies for Change: Logical incremental-ism, Homewood, Illinois, Irwin

Ralph, Oliver (2003), Supporting contracts, Investor's Chronicle, October, 24, p. 44

Ranson, Stewart, Bob Hinings and Royston Greenwood (1980), The structuring of organisational structures, Administrative Science Quarterly, March, vol.25, p 1-17

Reagans, Ray and Bill McEvily (2003), Network structure and knowledge transfer: The effects of cohesion and range, Administrative Science Quarterly, vol. 48, p. 240-267

Reed, John (2005), Elite partnerships and political mix: a step away from crony capitalism, Financial Times, Tuesday 24 May, p. 6

Reed, Michael I. (2001) Organisation, trust and control: A realist analysis, Organisation Studies, vol.22, no.2, p.201-228

Reed, Michael (1997), In praise of duality and dualism: Rethinking agency and structure in organisational analysis, Organisation Studies, vol.18, no.1, p.21-42

Reed, Michael (1996), Expert power and control in late modernity: An empirical review and theoretical synthesis, Organisation Studies, vol.17, no.4, p. 573-597

Reed, Michael (1984), Management as a social practice, Journal of Management Studies, vol. 21, no. 3, p. 273-285

Reeve Steve and Hatter Warren (2004a), Beyond contracts: What makes a PPP successful? NLGN, network@ngln.org.uk, (unable to access 16/1/08)

Reeve Steve and Hatter Warren (2004), Good breeding gets results, Municipal Journal, 2 December, p. 12

Reeves, Colin (1999), Economics of PFI in the NHS, British Medical Journal, vol. 319, p. 191

Rehfeld, John (1990), What working for a Japanese company taught me, Harvard Business Review, November-December, p. 167-176

Restell, Jon (2008), On valuing all the front line, Health Service Journal, 27 March, p. 15

Ring, Peter Smith and Andrew Van de Ven (1994), Developmental processes of cooperative inter-organisational relationships, Academy of Management Review, vol. 19, pp. 90-118

Riley, Patricia (1983), A structurationist account of political culture, Administrative Science Quarterly, vol. 28, p. 414-437

Robinson, J.C (2001), The end of managed care, Journal of American Medical Association, vol. 285, p. 2622-2628

Robinson Ray (1996), The Impact of the NHS Reforms 1991-1995: A review of research evidence, Journal of Public Health Medicine, vol. 18, no. 3, p. 337-342

Robinson, Ray and Julian Le Grande (ed.) (1994), Evaluating the NHS Reforms, London, Kings Institute

Robinson Ray (1989), New healthcare market, British Medical Journal, vol. 298, 18 February, p. 437-439

Robinson Ray (1988), Efficiency and the NHS: A case for internal markets, London, Institute of Economic Affairs Unit

Robinson, Ray (1984) Privatisation and The Welfare State, London, Allen and Unwin

Rock, Stuart (1999), Outsourcing IT: CBI Business Guide, Caspian Publishing, London

Rodney, William and Paul Gallimore (2002), Risk assessment in PFI schemes for primary healthcare, Facilities, vol. 20, no. 1/2, p. 52-60

Rogers, Alisdair and Steven Vertovec (1995), The Urban Context, Ethnicity, Social Networks and Situational Analysis, Oxford, United Kingdom, Berg Publishers

Ronchetto, John R., Michael D. Hunt and Peter H. Reingen (1989), Embedded influence patterns in organisational buying systems, Journal of Marketing, vol. 53, October, p. 51-62

Roome, Nigel and Frank Wijen (2005), Stakeholder power and organisational learning in corporate environmental management, Organisation Studies, vol. 27, no.2, p. 235-263

Russell, Bertrand (1938), Power: A new social analysis, London, George Allen and Unwin

Salaman, Graeme and Kenneth Thompson (1973), People and Organisations, London, Longmans

Salonen, Anssi (2004), Managing outsourced support services: observations from case study, Facilities, vol. 22, no. 11/12, p. 317-322

Sahlman, William (1990), Why same people shouldn't serve on public boards, Harvard Business Review, May –June, p. 28-34

Santry, Charlotte (2008), Acquisitions need to be more attractive says takeover chief, Health Service Journal, 12, June, p. 7

Savery Lawson (1996), The congruence between the importance of job satisfaction and the perceived level of achievement, Journal of Management Development, vol. 15, no. 6, p. 18-27

Schein, Edgar H (2004), Organisational Culture and Leadership, 3rd. (ed.) San Francisco, California, Jossey-Bass

Schein, Edgar H (1996), Three cultures of management: the key to organisational learning, Sloan Management Review, (Fall), p. 9-20

Schein, Edgar H (1985), Organisational Culture and Leadership, San Francisco, Jossey Boss

Schuler, Randall and Vandra L. Huber (1990), Personnel and Human Resource Management, 4th ed., New York, West Publishing Company

Schutz, Alfred (1967), The Phenomenology of The Social World, Evanston, Illinois, North-western University press

Schoemaker, Paul J. (1993), Strategic decisions in organisations: rational and behavioural views, Journal of Management Studies, vol. 30, no. 1, p.114-129

Schumpeter, Joseph A. (1950), Capitalism, Socialism and Democracy, New York, Harper and Row

Scott, Richard (1995), Institutions and Organisations, Thousand Oaks, Sage

Scull, Andrew T. (1979), Museums of Madness, Middlesex, England, Penguin books

Seltzer, Kimberly and Tom Bentley (1999), The Creative Age: Knowledge and skills for the new economy, London, Demos

Selznick, Philip (1965), TVA and the grass roots, New York, Harper and Row (1st 1949)

Senge, Peter M. (1999), The Dance of Change, New York, Doubleday

Senge, Peter M. (1990), The Fifth Discipline, The art and practice of the learning organisation, London, Century Business

Strategic Health Authority (2003), Annual Review: North West London, NHS

Shapiro, Benson P. (1994), Shared Purchasing and Collaborative Commissioning Within the NHS, Birmingham, United Kingdom, NAHAT

Shapiro, Carl (1989), The theory of business strategy, RAND Journal of Economics, vol. 20, no. 1, p. 125-137

Sheard, Sally (1994), Gagging public health doctors, British Medical Journal, vol. 309, 17 December, p. 1643

Sheth, Jagdish and Arun Sharma (1997), Supplier relationships: emerging issues and challenges, Industrial Marketing Management , vol.26, p. 91-100

Shenkar, Oded (1996), The firm as a total institution: reflections on the Chinese State Enterprise, Organisation Studies, vol. 17, no. 6, p. 885-907

Sherwell, John (2005), New tools for libraries bring chapter of innovation, Research Information Special, p. 10

Sheu, Chwen, Rebecca Yen and B. Chae (2006), Determinants of supplier-retailer collaboration: evidence from an international study, International Journal of Operations and Production Management, vol. 26, no.1, p. 24-49

Shifrin, Tash (2005a), Foundation directors held to account but ever so gently, Health Service Journal, 13 January, p. 14

Shifrin, Tash (2005), Cleaners heckle minister, Health Service Journal, 3 February, p. 11

Shifrin, Tash (2002a), "Scapegoat" prepares, Health Service Journal, 12 December, p. 6

Shifrin, Tash (2002b), Private sector will take outpatient role, Health Service Journal, 27 June, p. 4

Silverman, David (2000), Doing Qualitative Research: A practical handbook, London, Sage

Simon, Herbert (1991), Bounded rationality and organisational learning, Organisation Science, vol. 2, no. 1, p. 125-134

Simon, Herbert (1957), Administrative Behaviour, 2nd. edn., New York, Free Press (3rd.1976)

Sims, Paul (2005), Operations are cancelled as NHS trusts tries to save £17m, Evening Standard, Wednesday, 31 August, p.11

Slipman, Sue (2006), Foundation trust network calls for overhaul, Health Service Journal, 2 March, p. 6

Sloman, John (2000), Economics, 4th ed. London, Prentice Hall

Smith, Paul (2002), Trust admits ancillary staff pay claim is fight for justice, Health Service Journal, 7 June, p. 7

Smith, Paul (2002a), Tied in knots, Health Service Journal, 28 November, p. 10

Smith, Carole (2000), The Sovereign state v Foucault: Law and disciplinary power, The Sociological Review, editorial board

Smy Janis (2005), A century of care, Nursing Times, vol. 101, no. 41, p. 16-18

Smyth, Hedley (2005), Procurement push and marketing pull in supply chain management: The conceptual contribution of relationship marketing as a driver in project financial performance, Journal of Financial and Management of Property and Construction, vol. 10, no. 1, p. 33-44

Social Services Committee (1988), Resourcing the NHS: Short-term issues, Vol.1, London, HMSO

Stake, Robert (1998), Case Studies, In Denzin and Lincoln (1998), Strategies of Qualitative Inquiry, Thousand Oaks, CA: Sage.

Starbuck, William (1992), Learning by knowledge-intensive firms, Journal of Management Studies, vol.29, no. 6, p. 713-740

Stacey, Ralph D. (2000), The Challenge of Complexity, 3rd. edn., London, Prentice-Hall

Stanworth, Philip and Anthony Giddens (1974), Elites and Power in British Society, London, Oxford University press

Stengel, James, Andrea Dixon and Chris Allen (2003), Listening begins at home, Harvard Business Review, November, Best Practice, p. 106-116

Stephenson, Paul (2002a), Fraud-buster jailed for mileage fiddle, Health Service Journal, 7 November, p. 4

Stephenson, Paul (2002b), Foreign firms in PPP discussions, Health Service Journal, 16 May, p. 8-9

Stones, Rob (2005), Structuration Theory, Basingstoke, Hampshire, Palgrave, MacMillan

Storey, John and Graeme Salaman (2005), Managers of Innovation, Oxford, Blackwell

Storey, John (1985), Management control as a bridging concept, Journal of Management Studies, vol. 22, no. 3, p. 269-291

Strong, Philip and Jane Robinson (1990), The NHS Under New Management, Milton Keyes, Open University Press

Stuart, Toby E. (2000), Inter-organisational alliances and the performance of firms: A study of growth and innovation rates in a high-technology industry, Strategic Management Journal, Vol.21, pp. 791-811

Strauss, Anselm L. (1987), Qualitative Analysis for Social Scientists, Cambridge, Cambridge University Press

Stephen, Harrison and Christopher Pollitt (1994), Controlling Health Professionals, Buckingham, Open University Press

Sumetzberger, Walter (2004), Managing human resources in a multinational context, Journal of European Industrial Training, vol. 29, no. 8, p. 663-674

Sussex, Jon and Maria Goddard (2002), Flexible friends, Health Service Journal, 23 May, p. 28

Sveiby, Erik (1997), The New Organisational Wealth: Managing and measuring knowledge- based assets, San Francisco, Berrett-Koehler Publishers Inc.

Svensson, Göran (2002), The Measurement and Evaluation of Mutual Dependence in Specific Dyadic Business Relationships, Journal of Business and Industrial Marketing, vol. 17, no.1, p. 56 -74

Taylor, Laurie and Stanley Cohen (1976), Escape Attempts, London, Allen Lane

Taylor, Frederick W. (1911), The Principles of Scientific Management, New York, Harper

Teece, David J. Gary Pisano and Amy Shuen (1997), Dynamic capabilities and strategic management, Strategic Management Journal, vol.18: 7, pp. 509-533

Teisberg, Elizabeth Olmsted, Michael E. Porter and Gregory B. Brown (1994), Making competition in healthcare work, Harvard Business Review, July-August, p.131-141

The New NHS, (1997), Modern and dependable, London, HMSO

The Health Service (1983), Cooperation between the NHS and the private sector at district level, 3, June

The NHS before 1957, London, HMSO

Thilabaut, John W. and Harold H Kelley (1959), The Social Psychology of Groups, New York, John Wiley and Sons

Thibodeau, R and E. Aronson (1992), Taking a closer look: Reasserting the role of self-concept in dissonance theory, Personality and Social Psychology Bulletin, vol. 18, p. 591-602

Thomas, David (1985), Clean out the cleaners, New Society, 14 March pp. 414

Thompson, James D. (1967), Organisations in Action, New York, McGraw-Hill

Thompson, Kenneth (1974), The Problem of Organisations: Open University social science course, Unit 1, The Open University Press, Milton Keynes

Thorne, Marie L. (1997), Being a clinical director: First among equals or just a go-between, Health Services Management Research, vol. 10, p. 205 -215

Thornton, Stephen (1999), The Pocket Guide to The NHS, 2nd edn., Birmingham, NHS Confederation

Timmins, Nick (2007), Farewell to dodging and weaving, British Medical Journal, vol. 334, 28 April, p.877

Timmins, Nick (2007a), Hospital trusts to be free of rules, Financial Times, March, 28, p.2

Timmins, Nicholas and Jimmy Burns (2005), Oversight agencies to be reduced from eleven to four, Financial Times, Thursday, March 17, p. 11

Torrington, Derek; Laura Hall and Stephen Taylor (2005), Human Resource Management, 6th edn., Essex England, Prentice Hall

Torrington, Derek; Laura Hall and Stephen Taylor (2002), Human Resource Management, 5th ed., London, Prentice-Hall

Trice, Harrison and Janice Beyer (1993), The Cultures of Work Organisations, Englewood Cliffs, New Jersey, Prentice-Hall

Truss, Catherine (2001), Complexities and controversies in linking HRM with organisational outcomes, Journal of Management Studies, vol. 38, no. 8, p. 1121-1149

Tsang, Eric W.K (2000), Transaction cost and resource-based explanations of joint ventures: A comparison and synthesis, Organisational Studies, vol., 21, no. 1, p. 215-241

Turner, J.H (1987) Toward a sociological theory of motivation, American Sociological Review, vol. 52, p. 15-27

Turrill, Tony (1993), Change and Innovation: A challenge for the NHS, London, Institute of Health Services management

Tyler, Katherine and Edmund Stanley (2002), Marketing over-the-counter equity derivative: The role of relationships, International Journal of Bank Marketing, vol.20, no. 2, p. 67-75

Tyler, Katherine (1996), Exchange relationships in financial services: marketing equities to institutions, International Journal of Bank Marketing, vol. 14, no. 2, p. 50-63

Tyson, Shaun (1999) How HR knowledge contributes to organisational performance, Human Resource Management Journal, vol.9, no.3, p.42-52

Tyson, Shaun (1995), Human Resource Strategy: Towards a general theory of HRM, London, Pitman

Uhlenbruck, Klaus, E. Klaus Meyer and Michael A. Hitt (2003), Organisational transformation in transition economies: resource-based and organisational learning perspectives, Journal of Management Studies, vol. 40, no. 2, p. 257-282

Ulrich, Dave and Norm Smallwood (2004), Capitalising on capabilities, Harvard Business Review, Spotlight, June, p. 108

Ulrich, Dave (1997), Human Resource Champions, Boston, Harvard University Press

Uzzi, Brian (1997), Social structure and competition in inter-firm networks: the paradox of embeddedness, Administrative Science Quarterly, vol. 42, no. 1, p. 35-67

Van de Vliert, Evert and Gerben Van der Vegt (2004), Women and wages worldwide: how the national proportion of working women brings underpayment into the organisation, Organisation Studies, vol. 25, no. 6, p.969-986

Van Maanen, John (1988), Tales of The Field: On Writing Ethnography, Chicago: University of Chicago Press.

Van Maanen, John (1983), (ed.) Qualitative Methodology, Beverly Hills, California, Sage

Venables, Tony (2005), Multinational: heros or villains of the global economy, Centrepiece, The magazine of the centre for economic performance, vol.10, issue1, Spring, p.2-7

Venkatesan, Ravi (1992), Strategic sourcing: to make or not to make, Harvard Business Review, November-December, p. 98-107

Ventovuori, Tomi, Tero Lehtonen, Anssi Saonen and Suvi Nenonen (2007), A review and classification of academic research in facilities management, Facilities, vol. 25, no. 5/6, p. 227-237

Vize, Richard (2008), Premises buy-back and anti-private brigade, Health Service Journal, Editorial, 6 March, p. 3

Von Hippel, Eric (1998), The Sources of Innovation, Oxford, Oxford University Press

Vondle, David P. (1989), Services Management Systems, New York, McGraw-Hill

Waddington, David (1987), The Ansell Brewery Dispute, Aldershot, Gower

Wallas, Graham (1926), The Art of Thought, New York, Harcourt Brace

Walker, Anna (2005), Targets are a mixed blessings, Public Servant, issue 2, 29 July, p.2

Watson, Rory (2006), Health spending rising faster than GDP in most rich counties, British Medical Journal, vol. 333, 8 July, p. 60

Walton, Thomas (2007), Design connections, Design Management Review, Winter, p. 6-9

Walton, Tony (1982), The Individual and Society: Social science course, unit 31, Milton Keyes, Open University Press

Ward, Seamus (2002), The next generation, Health Service Journal, 18 April, p. 39

Warner, Lord (2005), Minister: don't pass the buck, Health Service Journal, 20 January, p. 13

Warwick Agreement (2005), Has Warwick saved the link between Labour Party and the unions? Labour Research, vol. 94, no. 1, January, p. 9

Watson, Tony J. (2001), In Search of Management: Culture, chaos and control in managerial work, London, Thomson-Learning

Watson, Tony (1994), In Search of Management: Culture, chaos and control in managerial work, London: Routledge.

Weaver, Gary and Dennis Gioia (1994), Paradigms lost: incommensurability versus structuration inquiry, Organisation Theory, vol. 15, no. 4, p. 565-590

Webb, Lisa and Justin Laborde (2005), Crafting successful outsourcing vendor/client relationship, Business Process Management Journal, vol. 11, no. 5, p. 437-443

Weber, Max (1978), The Protestant Ethic and The Spirit of Capitalism, New York, Basic Books (1930, London, Allen and Unwin)

Weber, Max (1962), Basic Concepts in Sociology, London, Peter Owen

Weber, Max (1947), The Theory of Social and Economic Organisation, (edited by A. H. Henderson and T. Parsons, Glencoe, Illinois, Free Press (first published 1924)

Weber, Max (1952), The Protestant Ethic and Spirit of Capitalism, New York, Scibners

Webster, Philip (2004), Can we count on your figures?: 100, 000 civil service jobs to go, The Times, Tuesday, 13 July, p.1

Webster, Charles (1988), The Health Service Since The War: Problems of healthcare, Vol.1,

Weicks, Karl E. (1995) Sense-making in Organisations, London, Sage publications

Weicks, Karl E. (1989), Theory construction as disciplined imagination, Academy of Management Review, vol. 14, p.516-531

Weick, Karl E. (1979), The Social Psychology of Organising, Reading, Massachusetts, Addison-Wesley

Weightman, Jane (1996), Managing People in The Health Service, London, Institute of Personnel & Development (IPD)

Weitz Ely and Yehouda Shenhav (2000), A longitudinal analysis of technical and organisational uncertainty in management theory, Organisation Studies, vol. 21, no. 1, p. 243-265

Weitz, Barton A. (1981), Effectiveness in sales interactions: A contingency framework, Journal of Marketing, Winter, p.85-103

Wernerfelt, Birger (1995), The resource-based view of the firm: ten years after, Strategic Management Journal, vol. 16, p. 171-174

Wernerfelt, Birger (1989), From Critical resources to corporate strategy, Journal of General Management, vol. 14, p. 4-12

Wernerfelt, Birger (1984), A resource-based view of the firm: Strategic Management Journal, vol. 5, no. 2, p. 171-180

Wessel, David and Walt Bogdanich (1992), Closed markets: laws of economics often don't apply in healthcare fields, Wall Street Journal, 22 January, p. A1

West, Peter (1988), Understanding the NHS: A question of incentives, London, King fund

Westley, Frances (1990), Middle managers and strategy: micro-dynamics of inclusion, Strategic Management Journal, vol. 11, p. 337-351

Westphal, James and Poonam Khanna (2003), Keeping directors in line: social distancing as a control mechanism in the corporate elite, Administrative Science Quarterly, vol. 48, no. 3, p. 361-398

White, Michael (2006), Newspapers love writing about the NHS in crisis, Health Service Journal, 30 March, p.10

White, Michael (2002a), PFI, the phantom menace? The committee begs to differ, Health Service Journal, 23 May, p. 23

White, Michael (2002), Bird's eye view of earnings—and it's a finger lick' disgrace, Health Service Journal, 16 May, p. 21

White, Michael (1993), New ideas dressed up as fine old traditions, Health Service Journal, 24 June p. 22

White Paper (1989) Working for Patients: The Health Service: Caring for the 1990s, CM 555, London, HMSO

Whitney, Ray (1988) National Health Crisis: A modern solution, London, Shepheard-Walwyn

Whittington, Richard (1992), Putting Giddens into action: social systems and managerial agency, Journal of Management Studies, vol. 29, no. 6, p. 693-712

Wiklund, Johan and Dean Shepherd (2003), Aspiring for and achieving growth: the moderating role of resources and opportunities, Journal of Management Studies, vol. 40, no. 8, p.1919-1941

Wilding, Richard and Andrew Humphries (2006), Understanding collaborative supply chain relationships through the application of Williamson organisational failure framework, International Journal of Physical Distribution and Logistics Management, vol. 36, no.4, p. 309-329

Willetts, D. (1989) The NHS remedy – to be taken internally, Guardian, 1 February

Williams, Bernard (2002), Cost Effective Facilities Management, Kent, Building Economics Bureau

Williamson, Oliver E. (1999), Strategy research: governance and competence perspectives, Strategic Management Journal, vol. 20, no.12, p.1087-1108

Williamson, Oliver E. (1996), The Mechanism of Governance, New York, Oxford University Press

Williamson, Oliver E. (1991), Comparative economic organisation: The analysis of discrete structural alternatives, Administrative Science Quarterly, vol. 36, no. 2, p. 269-296

Williamson, Oliver E. (1985), The Economic Institutions of Capitalism, New York, The Free Press

Williamson, Oliver E. (1981), The modern corporation: origins, evolution attributes, Journal of Economic Literature, vol. 19, December, p. 1537-1568

Williamson, Oliver E. (1975), Markets and Hierarchies, New York, The Free Press

Wilmot, Stephen (2004), Foundation trusts and the problem of legitimacy, Healthcare Analysis, vol. 12, no. 2, June, p. 157-169

Willmott, Hugh (1993), Strength is ignorance, slavery is freedom, Managing culture in modern organisations, Journal of Management Studies, vol. 30, no. 4, p. 515-552

Willmott, Hugh (1987), Studying managerial work: A critique and a proposal, Journal of Management Studies, vol. 24, no. 3, p. 249-270

Willmott, Hugh (1981), The structuring of organisational structure: a note, Administrative Science Quarterly, vol. 26, p.470-474

Wilson, Graeme (2005), Brown's inquisition on NHS spending, Daily Mail, Tuesday, 4 October, p.9

Wilson, Graeme (2005), Hospital funding crisis could force wards to be closed, *Daily Mail*, Tuesday 11 October, p.17

Wilson, D. C (1992), The Strategy of Change: Concepts and controversies in the management of change, London, Routledge

Wilson, David and V. Mummalaneni (1986) Bonding and Commitment in Buyer-Seller Relationships: A Primary Conceptualisation, in Kristian Möller and David Wilson (1995), Business Marketing: An Interaction Perspective, Boston, Massachusetts, Kluwer Academic Publishers

Winter, Sidney G. (2003), Understanding dynamic capabilities, Strategic Management Journal, Vol. 24, pp. 991-995

Winter, Sidney G. (1987), Knowledge and competence as strategic assets, in The Competitive Challenge: Strategies for industrial innovation and renewal, David Teece (edn), Cambridge, Massachusetts, Ballinger, p.159-184

Wirrel, (2005) Wirrel Health services: Foundation hospitals, www.wirrelhealth.org.uk/foundation.asp (accessed 18/04/05)

Wirtz, Veronika, Alan Cribb and Nick Barber (2003), Understanding the role of "the hidden curriculum" in resource allocation—the case of the UK NHS, Health Care Analysis, vol.11, no. 4, p. 295 -301

Wood, Stephen (1982), The Degradation of Work? London, Hutchinson

World Health Organisation (2000), The World Health Report 2000, Health systems: improving performance, Geneva, WHO,

Wray-Bliss, Edward (2002), Interpretation—appropriation: Making an example of labour process theory, Organisational Research Methods, vol.5, no. 1, January, p. 81-104

Wrong, Dennis H. (1979), Power: Its forms, bases and uses, Oxford, Blackwell

Xavier, Leflaive (1996), Organisations as structures of domination, Organisation studies, vol.17, p.23-47

Yin, Robert (1994), Case Study Research, Beverly Hills, California, Sage

Yin, Robert (1989), Case Study Research: Design and methods, Newbury Park, Sage

Yin, Robert (1981), The case study crisis: some answers, Administrative Science Quarterly, vol. 26, p. 58-65

Young, Hugo (1989), One of Us, (on Mrs. Thatcher), London, Macmillan

Zajac Edward J. and Cyrus Olsen (1993), From transaction cost to transaction value analysis implications for the study of inter-organisational strategies, Journal of Management Studies, Vol. 30, No. 1, pp. 131-145

Zander, Alvin, Arthur Cohen and Ezra Stotland (1959), Power and the relations among professions, in Dorwin Cartwright (1959) Studies in Social Power, The University of Michigan, Arbor

Zhu, Zhiwei, Kathy Hsu and Joseph Lillie (2001), Outsourcing - a strategic move: the process and the ingredients for success, Management Decision, vol. 39, no. 5, p.373-378

Zolkiewski, Judy (1999), Purchaser/Provider Relationship in UK NHS: A Marketing Perspective, (Doctoral thesis), UMIST.

Zukin, Sharon (1991), Landscapes of Power: from Detroit to Disney world, Berkley, University of California Press

Appendix 1 GUIDE TO INTERVIEW PROTOCOL

1. PERSON SPECIFIC:

Name of interviewee

Gender /Sex /Age

2. JOB SPECIFIC:

Job title

Job specification

Actual work done and perception of role played

How long on job/in NHS

3. ORGANISATION SPECIFIC:

Type of organisation

Specialization (division into specialist roles)

Qualifications

Standardisation (standard rules/practices/procedures)

Formalisation (written down instructions/descriptions)

Centralisation (authority for decision-making)

Configuration (span of control)

4. ORGANISATIONAL CONTEXT: [environment]

Origin/history /ownership (public/private)

Size (number of employees)

Size of annual budget

Charter (number of services offered)

Location (closeness)

Technology (automation and integration with suppliers/customers)

Interdependence (stakeholders—government, suppliers, customers)

5. OUTSOURCED SERVICES:

What services outsourced

Who decided to outsource

Outsourcing process (How)

Portfolio Analysis — Degree of involvement

6. SUPPLIER/BUYER

Search/ Evaluation/Choice/Engagement

Motivation for present supplier

Objectives/expectations

Performance monitoring agreed

Cost /Benefit analysis of supplier portfolio

7. INTERACTION PROCESS

Contract terms/duration

Associations (transactional / relational /social /legal)

Partnerships: Suppliers
Competitors/government
Internal customers (departments/employees)
Customers

Resources exchanged: importance /complexity /alternatives /evaluation

Adaptation (specific) / flexibility in accommodating customer needs

Coordination (terms of the trade)

Perception of degree of dependence

8. NATURE OF INTERACTION

(a) Trust

Communication: Frequency /Mode /Problem type

Shared values (common beliefs, goals, policies, behaviour)

Incentives/rewards

(b) Commitment (contractual/social)

Benefits of interaction

Exit cost

Cost of alternatives

Dependence (investments)

Satisfaction with service

Social bonds formed

Exit clause/reasons

(c) Termination process: dissatisfaction
cost/benefit
dissolution

(d) Performance: set targets to achieve

Monitoring (reactive/proactive)

9. DRIVING FORCE FOR INTERACTION

Market forces (profits)

Creating value / creativity and innovation

Power /Conflict / Cooperation

Commitment / Trust

10. INTERACTION OUTCOME

Cost / Benefits

Expectations fulfilled?

Outsourcing objectives realised?

Value created

11. INTERACTION MANAGEMENT

12. INTERACTION MAINTENANCE

Appendix 1b

Full Interview Transcript—a sample

Interview conducted with a catering manager, I have called Roland (R) from Mediserve International at Karena Hospital NHS trust in March 2004

MJ: Thank you for agreeing to talk to me about the services you provide here. As I promised before, I will not ask your name or any personal details from you but I would like to know what you do here, your position and your job title

Roland: I am a catering manager in hotel services

MJ: how many catering managers are there at this hospital?

Roland: there are four managers here but I am in charge of catering

MJ: what do the other managers do?

Roland: one of them is in charge of domestic services and another for patient services then there is our general manager

MJ: why is it called hotel services?

Roland: why is it called hotel services? That's the name it is given

MJ: but why?

Roland: I don't know why

MJ: okay, I want to know what you think. Why do you think it is called hotel services?

Roland: I haven't got a clue why it is called hotel services

MJ: do you mind telling me the company you work for and why you work for them

Roland: I work for a certain catering company and I like working for them

MJ: Alright, the name of the company does not matter. How long have you worked for them?

Roland: I have worked for them for 13 years on and off

MJ: when you were not working for them where else did you work?

Roland: Oh here and there (telephone interrupts)

MJ: You were telling me where you worked when you were not working for this company

Roland: I was working

MJ: What exactly do you do here for your company?

Roland: we provide hotel services for our clients

MJ: Is this the first tenure here for your company?

Roland: Tenure?

MJ: I mean have you served this hospital before?

Roland: we have been here before

MJ: yes. How long was that for?

Roland: (inaudible)

MJ: so what area of business is your company known for?

Roland: we are into catering, cleaning and all that sort of thing

MJ: do you have porters as well?

Roland: yes we have our porters

MJ: what do they do?

Roland: what do you mean what do they do? They transport patients around the hospital

MJ: what else do they do apart from transporting patients around the hospital?

Roland: Boy. They collect specimens from the wards to the labs and letters and equipments

MJ: Thank you but I do need to know what your views are so I don't get it wrong

Roland: why are you asking all these questions anyway?

MJ: like I said before, I am conducting a private research into support services of which hotel services is a part.

Roland: So you do know what hotel services mean. But what exactly is the research for?

MJ: it is for a personal degree programme

Roland: so you go about asking people all sorts of questions for a personal degree?

MJ: how else will I know what you do here and be able to tell it to my bosses? So do tell me again what area of business is your company into?

Roland: everybody has an idea what a business is

MJ; Yes but why are you here? Some businesses come to make money while...(interrupted)

Roland: there aren't any business that operates to make money

MJ: Good so why is your company here at this hospital at this time?

Roland: I don't know. I wasn't part of the start up contract

MJ: so you came in when the business was up and running?

Roland: when the contract started up, many people did different things but it was all done by outside people from the head office

MJ: so where is your head office?

Roland: why do you ask? It does exist

MJ: But where is it based? In London or the UK?

Roland: we have a head office and people there set up contracts

MJ: so what do you think is the reason this contract was set up?

Roland: The reason why they came here?

MJ: yes why did your company come here?

Roland: we are here to clean the hospital and serve the patients good meals in a clean environment. We also built a restaurant for this hospital

MJ: Very good. How much did that cost your company?

Roland: I am not sure

MJ: But the hospital could have built itself a restaurant

Roland: we have just refurbished it

MJ; why did you refurbish it?

Roland: because it needed refurbishing

MJ: so was it a new restaurant or did you just refurbish an old one?

Roland: Boy, this is tedious. I just told you that we refurbished it because it needed refurbishing and we also built them a new restaurant

MJ: I am sorry that it is tedious but I really do need to know what you make of your presence here

Roland: so what else do you want to know?

MJ: do you have a purchasing manager?

Roland: we haven't got a purchasing manager. The hospital has one but he has nothing to do with what we do here

MJ: do you think I should talk to him for his views?

Roland: Yes why not. We work in partnership with the hospital. We don't have different views we have the same objective

MJ: Good, what does partnership mean and how do you work in partnership?

Roland: it means that we are partners and what they require we deliver

MJ: how else do you work in partnership and what do you deliver?

Roland: we deliver the services they require

MJ: such as?

Roland: They require the hospital environment to be clean so they get good scores and the patients to be fed

MJ: how do you deliver these requirements?

Roland: what do you mean how do we deliver it?

MJ: I mean do you go to the market and buy the food you provide for the patients?

Roland: well we deliver the services they require and we are not talking about fruit and vegetables

MJ: Okay. What are we talking about then? How do you make the food you give the patients?

Roland: how do we make it?

MJ: yes

Roland: it comes in ready cooked and chilled from the company supplier

MJ: so somebody else cooks the food and you negotiate for them to supply it chilled?

Roland: yes

MJ: what sort of food do they supply you?

Roland: the right sort

MJ: what is the right sort for your company? And who else do they supply food to?

Roland: I don't know. The food goes into different countries

MJ: so how do you know that it is the right sort for your clients?

Roland: because that is what the client ordered

MJ: you say that you are partners with the hospital so what links do you have with it?

Roland: the other links we have is to provide the services they require within the catering and domestic services

MJ: so what links do you have with your opposite number in the hospital?

Roland: we talk

MJ: what do you talk about?

Roland: About the business

MJ: Good. What about the business?

Roland: how the business is going

MJ: in what ways do you talk about it?

Roland: just talk, you know talk

MJ: Good. Talk about what? This is like pulling out teeth

Roland: Pulling out teeth? I think you are pulling my tooth

MJ: sorry about that I did not come to pull your tooth but to get your views on what your company does here and as their catering manager, I need to hear it from you

So what is your relationship with your opposite number?

Roland: strictly business

MJ: You do not interact socially?

Roland: No unless there is a special trust do to which we get invited and then only if it is appropriate for us

MJ: so you don't meet socially except by invitation?

Roland: we meet everyday on business, otherwise only if we are invited to social dos

MJ: so which invitations do you consider to be appropriate to attend?

Roland: the ones that are appropriate for us to attend

MJ: how do you monitor what you do here?

Roland: it depends on the service but it is all done on paper

MJ: If there is any variation how do you know about it?

Roland: when we go around with the palm monitor, we know if there is something wrong

MJ: so you use a palm monitor, how does it work?

Roland: yes there is a standard monitor. If there is something wrong it shows up on the monitor

MJ: what if the hospital monitoring is different from yours?

Roland: it is the same procedure so there is no difference. But if there is a problem, we rectify it immediately

MJ: how do you rectify it?

Roland: by e-mail, phone or face to face

MJ: what is your commonest mode of contact?

Roland; it depends on the problem but mostly we use the phone

MJ: what would you say is the gain for your company here? What is the benefit of this contract?

Roland: to give the hospital a good service so they get the right food in a clean environment

We get the satisfaction that the patients are being fed in a clean environment

MJ: Good. What else does your company gain from this contract?

Roland: that is the gain (a visitor interrupts)

MJ: does your company make any profits here?

Roland: I don't know about the company accounts. I just do the day to day running of the catering department. I have no idea of the accounts

MJ: Okay. Do you think that your company makes any profits from this contract?

Roland: well I am pretty sure that they are not losing money here

MJ; Good what about your company's reputation?

Roland: what about it?

MJ: would your company take on a client that is say "dodgy"?

Roland: what is a dodgy client? I have never met one. My company will not get involved with what you call a dodgy client. No

MJ: you haven't?

Roland: No

MJ: how do you provide new products to your clients?

Roland: it certainly has to be agreed first

MJ: Agreed with whom?

Roland: Normally the company works across the board. If we provide service or food in one place and it is good there then it is good for everyone else. But it has to be agreed with the client because they pay for the service

MJ: what is the relationship between the hospital and your company?

Roland: it is fine and on the level. It is a good relationship

MJ: what is the level?

Roland: it is a business relationship and it is good

MJ: what makes it good?

Roland: we supply what the client requires

MJ: what about politics, does it come into the relationship?

Roland: an emphatic NO

MJ: not even underground?

Roland: again NO

MJ: Ok what about decision-making? How do you people make decisions here?

Roland: How do we make decisions?

MJ: Yes for example how did you decide to supply chilled food?

Roland: I didn't know because it was already going on when I arrived. Besides I don't look after the kitchen. Somebody else does that but I know that the client ordered cook-chill so that's what they get.

MJ: what about disagreements or any other major issues who decides what to do?

Roland: there are no disagreements. I mean the only thing that could happen is if there was a major incident, like a bomb or train crash, then we have got the right resources and the right procedures to follow. We use our manuals for everything and it covers most things

MJ: so it is all in the manual?

Roland: yes it is and we follow it to solve anything you call disagreements or major issues

MJ: What about learning? Have you learnt anything from being here?

Roland: Everyday we learn many things

MJ: What have you learnt personally or is it your company that learns?

Roland: we all learn. I think that in every job, everyone is learning everyday, I don't think that there is anyone who does not learn everyday. If we all knew everything then there will be nothing to do or learn

MJ: what do you think is the limit of your company? I mean where is the boundary?

Roland: the sky

MJ: the sky is your limit?

Roland: Yes

MJ: Good but what is the limit around you as a contract firm?

Roland: what do you mean, my limit on earth?

MJ: I mean the limitations of your company as a contractor. For example if your suppliers don't supply the goods, you cannot provide what the client requires

Roland: We have no limits because we have many suppliers

MJ: How many suppliers do you use for this contract?

Roland: I don't know exactly how many but there are a lot of them approved by my company

MJ: do you have any competitors in this contract?

Roland: No we don't compete. We are not in the business to compete

MJ: you don't compete even in the stock exchange?

Roland: No

MJ: so your company is not listed on the stock exchange?

Roland: I did not say that but we don't compete with anyone

MJ: so what is so wonderful about your company that it has no competition?

Roland: everything we do we do wonderfully

MJ: what do you do?

Roland: well in this hospital, as I have told you already about six times,

MJ: Laughs, do tell me again so I don't forget

Roland: we deal with catering, portering and domestic services

MJ: what about your suppliers don't they compete for your custom?

Roland: I don't know. We have many suppliers

MJ: Well your suppliers could be your boundary because if they don't supply, you cannot provide the services

Roland: Yeah but we have no boundaries because we always have procedures in place. I mean we don't just have one supplier. A good supplier cannot just ring up and say we are not serving you no more, goodbye, so supplies will not be an issue, as you call it

MJ: so what will be an issue with your meeting the requirements of the client here?

Roland: Inaudible due to interference

MJ: what is your relationship with your suppliers?

Roland: Just business

MJ: what would you say is the core competence of your company? What are they known for? What sets your company apart from the other hotel services suppliers?

Roland: we are back to the monitoring again. We monitor everything we do so we know

MJ: What role does trust play in your relationship with the hospital and your suppliers?

Roland: what do you mean play

MJ: I mean does trust have any role in your relationships?

Roland: I mean we trust them

MJ: Yes but how exactly does that trust play out on a daily basis?

Roland: trust?

MJ: everyone has an idea what trust means

Roland: it means honesty to me

MJ: Good so give me an example of how you show that you trust your suppliers or your opposite number in the hospital

Roland: well they are our client and we supply them a service. That's it. We thank them for allowing us provide them with the services. They are happy and we are happy with the relationship we have. I can't give you a better example than that

MJ: What does your company do to improve the image or reputation of the hospital?

Roland: The government inspections are successful and the hospital gets a good score so the image of the hospital is improved. We are a part of that

MJ: how do you know that the government inspection was successful?

Roland: Because we scored three and that was the top mark

MJ: Very good. They were satisfied with your work. What about quality what does it mean to you?

Roland: Er, good question. What does it mean to you?

MJ: *Well I am not supplying* anything but you supply quality products and services so how do you measure that quality?

Roland: Yeah but don't you know what quality means?

MJ: it is not what I know that counts but what you, as the supplier, think and say that it means to you. That is what I take to be important to you

Roland: Yeah but what do you think that quality means from your research? What kind of qualities are you trying to get from what I am telling you?

MJ: Well some people tell me that they give quality services so I ask them what they mean by quality so that I can compare what they tell me with what others say

Roland: Then we are back to the standardisation of services again

MJ: Yes. Standard service is not necessarily quality service

Roland: Yes it is. If you have a set standard, which is the right quality for the hospital, then that standard is the quality for that hospital

MJ: who decides the standard service?

Roland: The trust and us agree on it

MJ: You agreed on a set standard?

Roland: yes. We agreed on what they need and that is the standard and the quality for them

MJ: Relax. I am not taking you to task. I only want to make sure that I understand what you mean

Roland: You have got 4 minutes left and I am timing you

MJ: laughs

Roland: after one hour now I cannot wait to get out of here. I have loads of work to do and qualities to achieve

MJ: Very good and I am grateful for your time. Enjoy the interview. It may never happen again. Now what about the mixed cultures you have working for you here?

Roland: We have a multicultural workforce from different backgrounds

MJ: so what about their salaries and entitlements are they the same between the hospital workers and your staff?

Roland: the hospital does not have the same level of staff that we have

MJ: What is the level of your staff?

Roland: they are better workers than we met here

MJ: in what way are they better? Do you have other hotel services workers like porters, working for the hospital?

Roland: No the hospital has no porters apart from our porters

MJ: In some hospitals there are hospital workers and contract workers so we can compare

Roland: Here the hospital has no hotel services workers so there is no comparison. They don't have their own cleaners or caterers for certain

MJ: Okay

Roland: the standard of our workers are slightly higher obviously

MJ: in what way?

Roland: If they had all the standard and quality, why did they engage us to supply them?

MJ: You tell me. That's why we are having this interview to find out why they engaged your company to supply them with the services you provide. What about the food supply, is it also of a higher standard?

Roland: Yes it is actually. The food comes in chilled

MJ: How?

Roland: How do you think they chill the food in the oven or washing machines?

MJ: well some companies have great big freezer-lorries that bring in food supplies

Roland: and where are they kept on site, in lorries?

MJ: You tell me. As the catering manager, you know how your company supplies food to the hospital so you just tell me what you do. How do you resolve conflicts here?

Roland: It depends on what you call conflict

MJ: Well lets say one of your workers disagrees with another one over some issues and one worker slaps the other. How do you deal with such issues?

Roland: we go through the company procedures. They guide everything that we do so that everyone knows that they are fair

MJ: so your company must be a big company with all these procedures. How many staff members do you have here?

Roland: here we have 15

MJ: What is your position amongst them?

Roland: I am the hotel services catering manager as I told you

MJ: Laughs, what does that mean? Is there a director above you?

Roland: Oh Yes I have my bosses

MJ: Are they on site or at the head office?

Roland: On site

MJ: how many people are above you? I want to know how many tiers or levels you have

Roland; Oh boy

MJ: sorry but that will give me an idea of your company structure

Roland: we have the unit business manager and the lead hotel services manager then there is myself and the workers

MJ: so there are four levels on site here?

Roland: No because this is only the managing structure but not who is in charge

MJ: Ok how do you see it, how many levels are there?

Roland: this hasn't stopped (meaning the tape recorder)

MJ: No it lasts for two hours (laughs) and I will specially write yours up as a difficult case

Roland: No I don't mind it but I just wonder what you are trying to gain from all these

MJ: as I told you before, it is for a personal degree course

Roland: In what?

MJ: In support services

Roland: In what field, general management of support services?

MJ: Well I am trying to find out what I can about support services from the people who are actually doing the work like yourself not those who only seem to think and talk about it. I want to find out if the talk matches with what is actually done on the ground or in the field. That is how policies can be changed if what is actually done is found to be different from what is said

Roland: But different policies work for different places, don't they?

MJ: sure. That is why we interview many people to find out their differences and what makes them different. It may be the local culture or the people involved or something else

Roland: Mn

MJ: Not convinced?

Roland: I wonder

MJ: That's why I asked about your relationships with the *hospital and your suppliers* and if your staff interacted with the hospital staff or if there are other hotel services workers apart from your contract workers

Roland: well, I have told you all that

MJ: I am grateful to you. Well I think I leave you alone for now. But can I call you or come to clarify any issues that are not clear?

Roland: Yes you can call me or come by but not for so long. I have standards and qualities to achieve

MJ: laughs. Thank you very much for your time

Roland: That's alright and good luck with the research

Appendix 2 Interviews conducted

Totally (100%) Outsourced NHS trusts

1. Theresa Hospital NHS trust on eight locations transferred to a single location

Roger	Catering manager, Kingsland
Aged 63	3 years with Kingsland, 32 years with NHS at the same post
	Was angry about being sold to contractors and reprimanded for giving interviews and speaking his mind about the woes of the NHS
Dennis	Patient services manager, now with Kingsland
Aged 42	3 years in post but 10 years with NHS, in the same post
	Young and energetic, rose from the purchasing ranks

Two administrative stakeholders (agents C and D) herein called Joanna and Sue, were interviewed during working hours along the corridors but their interviews were not taped

2. Helina Hospital NHS trust

Pauline	Facilities manager
Aged 57	25 years in post, commercial experience opened her very green eyes
	Recommends all NHS managers go through commercial experience
Andrew	General purchasing manager, Interviewed twice. Army trained
Aged 56	8 years in the post, national and NHS experience—valuable contact
Oliver	Purchasing manager for medical supplies
Aged 36	3 years in post, commercial experience, aggressive for profits
Steven	Catering manager, Assure (Premier Group)
Aged 59	4 years at present post but worked for Assure for > 20years

75% outsourced NHS trusts

3. Karena Hospital NHS trust (on two locations)

Morrison	General manager, Facilities and estates (the boss)
Aged 62	40 years in NHS, very experienced, rose from the ranks
	Informative and helpful, was there when outsourcing began
Yusuf	Estates and facilities manager (limited interview)
Aged 52	10 years in the post, has varied commercial experience
Anthony	Purchasing manager, Interviewed X3
Retired at 65	36 years with the NHS at the same post, had seen it all come
	and go, very informative. Was there when outsourcing began
Roland	Catering manager, 13 years with Mediserve International
Aged 30	4 years as catering manager, still rather insecure

Other stakeholders, many from previous studies were spoken to again and again at work

4. Victoria Hospital NHS trust (on two locations)

Lawrence	General manager, Areno
Aged 56	8 years in post now general coordinator for Areno
	Ex-soldier, trained as chef and rose from the ranks
	International experience, very good ambassador for his firm
Peter	Director of estates and facilities (declined to be interviewed)
Margaret	Project manager at County hospital
Aged 58	2 years in post, ex-theatre nurse, got tired of nursing and
	wanted commercial experience within the NHS, informative
Gideon	Catering manager for Areno
Aged 42	8 years in post but worked on other Areno contracts
	Experienced and informative

Stakeholders from domestic services, nurses and security men were interviewed at work

50% outsourced NHS trusts

5. Featherstone Hospital NHS trust (on four locations)

James	Manager, estates and facilities, was interviewed twice
Aged 52	8 years in post, rose from the ranks as a structural engineer
	Has leadership qualities, was informative and constructive
Damien	Catering manager, Assure (Premier Group)
Aged 58	4 years in post, worked 7 years for NHS before transferring to
	Assure. Now will not work for any firm except Assure
	An experienced leader, informative and helpful
Jo	Manager, domestic services, for Assure
Aged 57	4 years in present post, worked at other Assure contracts
	20 years in NHS before transfer. Informative and experienced

Domestic and catering services workers, their trainer and ward manager were interviewed.

6. Reinhard Hospital NHS trust

Sussanah	Manager, estates and facilities
Aged 42	Graduate structural engineer, straight into the NHS
	10 years in NHS posts. No commercial experience
Juan	Catering manager, Assure (Premier Group)
Aged 48	2 years in present post but worked on other Assure contracts
	7 years in the NHS as a young man—said never again!
	Experienced and informative, a good ambassador for Assure

Other stakeholders from domestic, catering and friends of the hospital were interviewed

10% outsourced NHS trusts

7. Charlston Memorial Hospital NHS trust (on three locations)

Stanley	Director of estates and facilities (Projects)
Aged 56	Structural engineer (maintenance) rose from the ranks.
	30 years in NHS posts. No commercial experience

Florence	Director, support services
Aged 56	3 months in post but in NHS for 20 years
	Varied commercial experience, likes to move around
	Informative and experienced, left before she was pushed to go
Agnes	Catering manager (one of eight managers)
Aged 38	2 years in post, poached from a commercial firm
	Experienced and informative
Linda	Domestic services manager, interviewed twice
Aged 58	10 years in post, 9 years commercial experience
	Very experienced in both, informative and helpful

Other stakeholders from nursing and domestic services were also interviewed

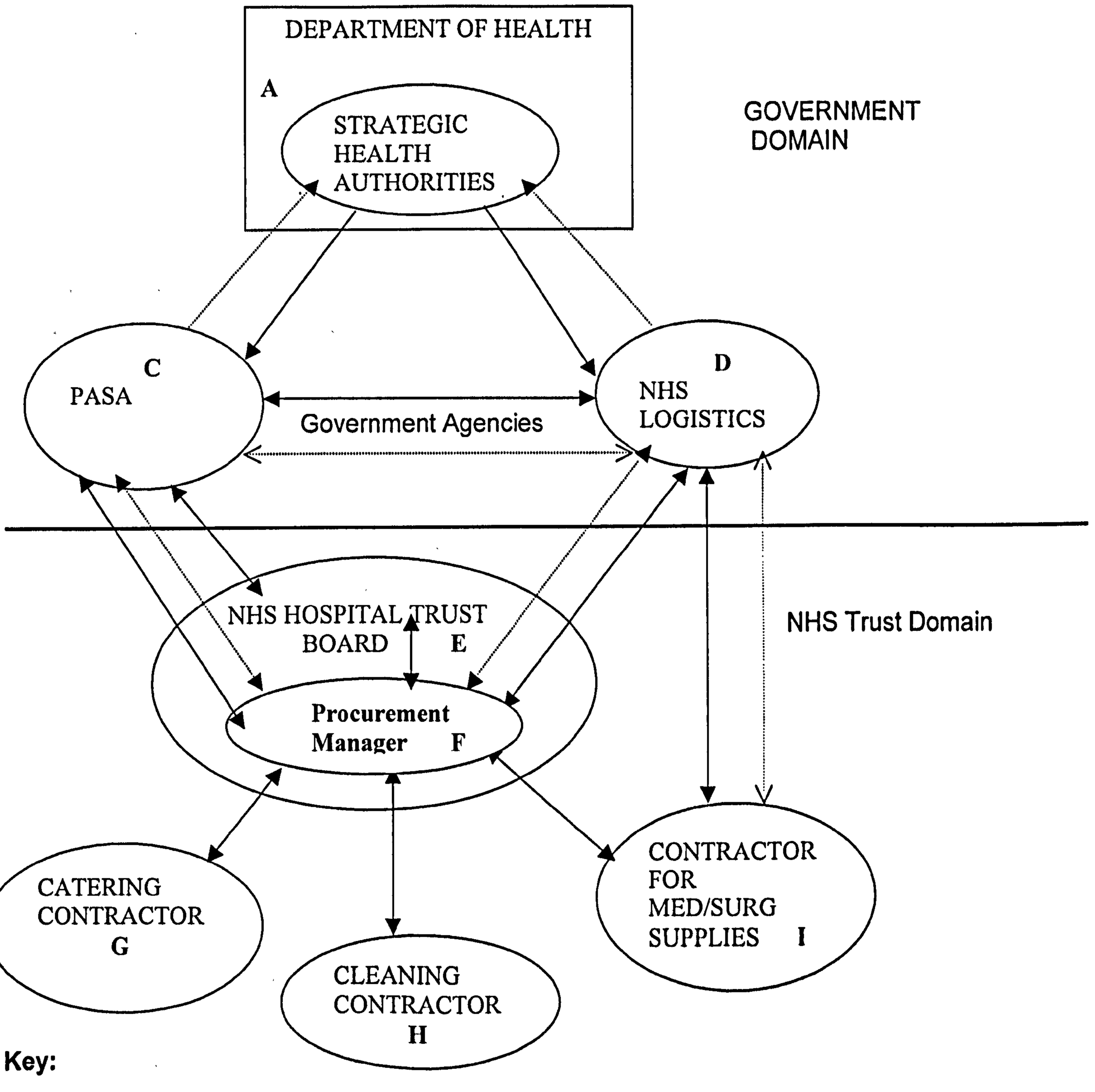
8. Dickson Memorial Hospital NHS trust (on three locations)

Neville	Estates and facilities manager, Interviewed twice
Aged 47	19 years in post
	Engineer by profession but likes NHS maintenance
	Informative and helpful, has no commercial experience
Rhoda	Catering manager recalled from retirement
Aged 64	3 years in present post, worked for 35 years in the NHS
	No commercial experience, very informative and helpful
Albert	Domestic services manager
Aged 48	4 years in post with varied previous commercial experience
	Informative and helpful

Other stakeholders from domestic, catering and portering services were also interviewed

Appendix 3 SYNOPSIS OF ORGANISATIONS INVOLVED

Figure 1 Pattern of NHS Hospital Supply Network



Key:

◄► Lines of Operational Systems and Procedures

..... Feedback lines

A – I Labels

28 strategic health authorities (consortium) govern NHS trusts and primary care trusts

HOTEL SERVICES PROVIDERS (information culled from Annual Reports)

1. Areno—based in the UK, with headquarters in IRELAND

Driving force for the organisation: innovation is the life-blood of our organisation
Innovative products are field-tested for six months before they are transferred to our subsidiaries and client organisations
Cost containment through operational efficiency is now a given for us and help us add *value or return value for money in our offerings* to customers

Areas of interest: defence, leisure, education and healthcare
Number of sites now served in the UK: 2, 3000
Number of staff employed in the UK: 48,000

Service offering: Cost effective solutions to improve the quality of daily life and the comfort of our customers

Relationship guide: Aims for life-long relationships as preferred services supplier

Other interests: ISO 9000 quality standards registered
Aims to provide high quality products and services at fair prices
Undertakes recycling, biodegradation and other environmentally friendly actions to reduce pollution and care for the local community

For NHS trusts served: relentlessly paring funds to invest in cleaning wards and feeding patients as hospitals strive to meet evermore demanding cost-saving targets
Provides 24hours catering service with consistent menu of high quality food in all trusts
Develops branded retail outlets (Diner's Den and Café Locale) to generate streams of revenue for NHS trusts served and to help them balance their budgets

2. Premier Group with headquarters in Surrey

World leading food service company, operating globally in 90 countries
Has 5% global market worth £ 250bn

Driving force of the organisation: Innovative high quality solutions to food and domestic Services

A passion for quality

A can do attitude to business solutions

Teamwork

Lasting business relationships

Areas of interest: Travel, leisure, vending, canteen, hospitality and industry

A favourite hotel services provider in the NHS, involved in (3/8) of the NHS trusts investigated.

3. Kingsland International, based in Berkshire

Driving force for the organisation: continuous improvement in support services.
Applying best practice innovatively developed worldwide to enable clients' businesses run more efficiently

Saves clients time and money, enhances quality of services, adds value to offerings
Driving and managing change through productivity improvements

Areas of interest: power stations, banks, prisons, water supply and facilities design, build, refurbish and manage projects
Change management skills gained through knowledge transfer

Favours long-term business relationships that generate *sustainable revenue streams* in the public and private sectors not interested in mere support services alone

Appendix 4 Foundation Hospitals

The Health and Social Act, 2003, amended 2005 established foundation hospitals as a part of the state Government plan to devolve decision-making and resources hence power away from the centre to professionals at the frontline of healthcare provision—NHS trusts, Primary Care Trusts, local organisations and communities. This would be more responsive to the needs and wishes of the local people (www.doh.gov.uk accessed 18/4/05 and again 7/9/06). Foundation hospitals are to be modelled on co-operative and mutual traditions and hence not for maximizing profits but for maximizing healthcare and will be publicly owned by the health secretary but managed by local boards of governors hence a hybrid system. Their creation is deemed a profound change in the history of the NHS and the way hospital services are provided and managed (DoH, 2002; Morgan, 2006). This change is regarded as the greatest post-war reform to improve health standards and address inequalities. Thus there is a trend to change the health services are provided, which the Government maintains is not a shift in policy, privatisation or hollowing out of the services as observes contend (Day, 2006; Hunter, 2002; Kmietowicz, 2006) but re-organisation (DoH, 2002).

Control

Foundation hospitals are to be controlled and run locally for the benefit of the local community in order to give consumers a wider choice and help to reduce health inequality. They will be freed from central Government control and performance supervision and also management by health authorities. Thus foundation hospitals will be corporations for public benefit and independent legal entities with unique governance structures as self-standing and self-governing organisations free to determine their own future.

Investments

They will have the freedom to invest their own money, keep any surpluses made from sale of land and assets and borrow from both the public and private sectors for their future. Their borrowing capacity will only be limited by their cash flows of up to 40% of their income hence affordability (Moyes, 2005). They can hire and fire their own staff, set conditions of service and wages above national and local agreements or offer performance related pay. Put simply, foundation hospitals will be able to enjoy considerable autonomy, freed from direct management of the Health Minister, the Department of Health and Strategic Health Authority but accountable to the state through the independent regulator, or Monitor, whose powers exceed those of the Health Secretaries. The framework for foundation hospitals was finally launched on 1 April 2004.

Ownership

A Board of Governors representing the interests of patients, local community, hospital key stakeholders, local businesses, universities, Local Authority and Primary Care Trusts will run foundation hospitals and set their strategic direction and manage their affairs.

Technically, the Health Secretary will own foundation hospitals for the nation.

The aim is to create a more efficient dynamic and responsive healthcare that taps into local talent and entrepreneurship while maintaining national standards and quality of treatment to safeguard public interest in what the Health Secretary, Alan Milburn, calls a change of organisation but not a shift in ideology (www.doh.gov.uk, accessed 18/4/2005).

Who can apply?

Only hospitals that have performed consistently well by achieving three star-ratings will be allowed to apply. Thus foundation hospitals will be centres of excellence with high clinical standards, top quality leadership, sound financial management, a good level of patient responsiveness and clear evidence of staff and local community support.

Some NHS trust like Wirral that qualify for foundation status can decline from applying due to the untold distraction such work-up to application and subsequent maintenance of the elite position gained can cause to NHS trusts already burdened with more immediate concerns like performance targets, financial deficits and waiting lists (Wirrel, 2005).

Opposition to foundation hospitals (culled from frequently asked questions)

Opponents argue that foundation hospitals will reward elite hospitals and create a two-tier system because foundation and failing hospitals will be competing for staff and funding and they fear that foundation hospitals will have an edge over other hospitals through better staff incentives and profitability of private financial providers. Furthermore, funding for healthcare will follow patients who are more likely to opt for treatment at foundation hospitals than what obtains locally. Also the elite nature of foundation hospitals, they argue will attract investors and ultimately lead to the privatisation of the health service.

Others argue that the scope to generate and keep financial surpluses may lead to inward-looking NHS organisations that ignore innovation in primary and community care hospitals, where more patients are treated long-term than in acute hospitals (Austin, 2002).

Furthermore foundation hospitals will contract out services to private contractors, allowing them to gain from scarce NHS resources. The Government has rebutted these claims and

maintains that eventually all NHS trusts will be expected to become foundation hospital by 2008 (www.doh.gov.uk)

Observers comment that there is no insolvency regime from the Department of Health regarding foundation hospitals (Slipman, 2006). Consequently any borrowing from the private banks will be seen as risky and so cost more not less. But others see foundation status as access to capital, opportunity to perform better given a new focus and to develop financial skills and the entrepreneur awareness of healthcare as a viable business option (Carlisle, 2002a; Crisp, 2005a and 2005b).

Many maintain that foundation status is a route to privatisation of healthcare as indeed all NHS trusts can subcontract services, but foundation hospitals with their sound financial standing will attract private investors allowing shareholders to profit from scare national resources (Clews, 2005; McGauran, 2002; Smith, 2002). Furthermore, elite foundation hospitals will only treat profitable cases leaving chronic patient care to failing some hospitals (Smith, 2002a). However directors of foundation hospitals claim that it has been a chance to regenerate their local community, become financially sound and develop local services according to local need not national standards (Goldman, 2005; Lewis, 2005).

Others argue that local control and accountability are pies in the sky since locals may be naïve in the running of large complex hospitals hence can be hoodwinked by the multiple vested interests of medical consultants and other dominant groups. Besides many warring stakeholders may leave hospital managers in strong positions to carry out their own plans unencumbered, making light of local accountability (Shifrin, 2005a; Smith, 2002a). For example in the case of Bradford hospital, local stakeholders wanted their chief executive David Jackson and the chairman, John Ryan to stay but the regulator, "Monitor" sacked them anyway because they failed to ensure effective financial planning, stewardship and control through value for money strategies. So where was the local control? Besides, there is no official mechanism or precedent for accountability in foundation hospitals. Thus foundation hospitals are new hybrid structures that the Government seems to be still shaping into form. But whatever the argument, foundation hospitals will remain within the health service for the moment and cannot be sold by law.

Appendix 5 Private finance Initiative (PFI)

Private Finance Initiative (PFI) [(www.local.dtlr.gov.uk/pfi/intro) accessed 18/4/2005]

The private finance initiative was set up in 1992 by the Conservative Government as a public-private partnership to aid Local Governments gain access to improved capital assets such as new buildings, roads, plants and vehicles without public funds (DoH, 2003). This was later expended to include design, build, finance and manage capital assets while transferring all risk involved in the procurement and operation of such facilities to the private sector with appropriate incentives for a more efficient and effective performance. These incentives include long-term contracts with regular streams of payments, genuine risk transfer to ensure best value in total FM, freedom of imagination and innovation in providing facilities with flexible usage and a share in the performance related rewards. Consequently, the public sector does not own or buy the assets or facilities but pays for the use of asset and services provided for them over an extended period usually over thirty years. This is to enable private providers recover investments with handsome profits.

The Labour Government improved and extended the remit of services providers to include PFI to NHS trusts. This has allowed some NHS trusts build facilities fit for the 21st. Century without having to fund it. Furthermore these NHS trusts in total FM bear no risks and only pay for leasing the facilities with the attendant maintenance and services provided.
The value for money in such contracts, stems from contractors building projects to higher standards, delivering them on time without over-runs or additional costs and maintaining them in good conditions to allow continuous healthcare provision without interruptions.

Critiques of PFI

Many state that the case for PFI in a publicly funded health service is "fatally flawed". The reasons proffered range from the shrinking of hospital capacity at a time when demand for beds is rising, the over estimation of the inefficiencies of public sector procurement that necessitated the invitation of the private sector to help with investment finance and the lack of clarity on the level of risk transferred to the private sector (Jones, 2000b; Pollock, et al., 1999). Consequently, observers note that the PFI exercise is fraught with irreconcilable difficulties that will be made manifest in the future and saddle the health service with debts.

Others argue that the PFI has saved NHS trusts huge amounts under the watchful eyes of the National Audit Office (NAO) to prevent private investors making windfall profits and were designed for the economic use of scarce resources (Clews, 2005; Reeves, 1999).

Some of these difficulties stem from the inexperience of public sector managers in commercial discipline and the time needed to negotiate the learning curve of wheeling and dealing in contract negotiations, risk assessment in projects and relationship management (House of Commons, 2003; Machiavelli, 1940; Macniel, 1980). But they are learning and many are aware of the difficulties and are taking steps to address and correct them.

However for some observers, the PFI schemes offer the NHS value for money in an open competitive environment, which allows both the private and public organisations to retain their independence while working together as partners (White, 1993; and 2002a).
Besides PFI brought improvements and the "wow" factor to hospital buildings and added private sector innovation in design and facilities management to them (Dix, 2002a; Ward, 2002). Private sector creativity and innovation they argue manifest as improvements in good working conditions for hospital staff and more space and privacy for patients, hence the buildings are healing environments for patients, staff and communities, making positive contributions to local neighbourhoods (Dix, 2002a; Reeves, 1999). Furthermore, hospitals can now bundle several projects and get them done cheaper, better and more attractively through PFI schemes than ever before. Thus PFI schemes are beneficial to NHS trusts.

Some commentators say that the PFI schemes are value for money because there is no initial capital outlay with no risks to the health services involved and their long leases are incentives for facilities management and maintenance of high standards (Clews, 2005). However some agree that the cost benefit analysis of PFI schemes are difficult to gauge due to the inflexibility of making changes to building projects and since the facilities are built to last for thirty years instead of the normal NHS lifespan of sixty years (Atun and McKee, 2005; Day, 2007; Kingsfund, 2005). But whatever the arguments the Government maintains that commentators should be more concerned with the quality of health facilities that are built on cost rather than who builds, maintains or manages them (Blair, 2005).