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FM leadership and excellent patient environments within acute NHS trusts:

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FM LEADERSHIP AND EXCELLENT PATIENT ENVIRONMENTS WITHIN ACUTE NHS TRUSTS:

ABSTRACT

Purpose

The research investigated the possible common factors in 15 Acute Hospital Trusts in the UK that achieved excellent scores at all their sites in three rounds of national Patient Environment audits.

Design/methodology/approach

A desk based study tested for external factors, organisational commonalities or particular contractual arrangments which the sample might have in common. An ethnographic study examined the behaviours exhibited by 22 managers in 6 of the trusts.

Findings

No external, organisational or contractual commonalities could be identified. The managers concerned all demonstrated 'theory Y' leadership behaviours and in partiular were oberved to be managing overlapping networks of conversations.

Practical implications

The research reveals a behavioural / cultural explanation for the creation of excellent environments. Such an emphasis is not common in FM literature. There is an important question as to why such behaviour is not more common within FM in general or health FM in particular.

Originality/value

The authors are not aware of other studies suggesting a distinctive FM leadership contribution to excellent Patient Environments.

Key words: Patient Environments; Leadership, FM Excellence

1. INTRODUCTION

Most Western healthcare organisations are in the spotlight as they are required to become more effective and efficient to satisfy the demands for good standards of service and the requirements of the financial constraints brought by increasing numbers of people demanding more and improved care. The English National Health Service (NHS) is no exception with growing, growing public, or media, concern that standards are unacceptable. Literature from the United States echoes the events being experienced in healthcare in England when it speaks of changes in demographics increases in users' expectations and competition along with pressure from government that demanded high levels of change. This level of change calls for fundamental change and creation of new value. (Chow, et al. 1998)

In England a political catalyst for change arrived in 2000, when the Government launched the NHS Plan heralded (Department of Health 2000) as:

> *'...the biggest change to healthcare in England since the NHS was formed in 1948* [1]. *The document sets out how increased funding and reform aim to redress geographical inequalities, improve service standards, and extend patient choice.'*

The rhetoric of change in Government policy has been huge with the NHS challenged to realign itself to a new world, relax its hierarchical structures and move away from an internally focused culture and traditional ways of working. Jargon employed includes 'Modernisation', 'not more of the same, just more' and 'working smarter'. The newly formed Foundation Trusts [2] are seeking to exploit their new freedoms in order to be successful within this new world. There is recognition by some within the NHS that radical business process improvement is needed.

After the 2000 White Paper, the Government believed that performance management provided the answer, or at least a political means of demonstrating that the NHS had improved its performance. The result was a series of performance measures that the NHS should meet. Space prevents a full discussion of the merits or otherwise of that policy here. For Facilities Management (FM) there were two immediate targets. The Estates Returns Information Collection (ERIC), requireed some 2000 individual measures, covering items such as the cleaning costs per square metre and total pay costs for directly employed maintenance labour. It is arguable that the focus on cost per unit area actually concealed the existence of a large stock of poor quality, and unneeded space costing perhaps £600M per annum more than was needed (Price and May, 2008).

The research described here focuses on the second target the Patient Environment measures known as the Patient Environment Action Team (PEAT) initiative. In 2000 every NHS Trust was required to prepare detailed action plans to improve their patient environment, focusing on nineteen separate elements that were set by NHS Estates (an agency of the Department of Health (DoH)) in consultation with NHS Trusts. These nineteen elements were deemed to comprise the Patient Environment and included car parking, entrances and reception areas, visitors' and ward toilets, cleanliness, the condition and cleanliness of linen, decoration and maintenance standards and the quality of patient food. Within each Trust, an individual Trust Board member was required to be nominated

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[1] At the time of writing (9 May 2008) another biggest shake up since 1948 has been announced. How many have their been?

[2] Information on Foundation Trusts available at: www.dh.gov.uk/ Policy And Guidance/ Organisational Policy/Secondary Care/ NHS Foundation Trusts/ fs /en

to take responsibility for the patient environment and for the implementation of these action plans. The Patient Environment was generally seen to be the responsibility of the FM team. In order to ensure that progress was made by each Trust Patient Environment Action Teams were established to assess hospitals. The inspection teams, which are what they are in reality, usually consisted of a mixture of skills, for example, nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates managers. They also include patients, patient representatives and members of the public. Under the programme every inpatient healthcare facility in England with ten beds or more was assessed annually for standards of cleanliness and food. Prior to 2004 each hospital was awarded a colour to denote a Good (Green), Acceptable (Amber) or Poor (Red) performance. The approach was changed in 2004, with hospitals being rated as Excellent, Good, Acceptable, Poor or Unacceptable. In additionextra elements of assessment were introduced, includingprivacy and dignity; segregation of men and women in sleeping areas and toilets/bathrooms. A self-assessment programme was introduced, for hospitals that achieved a score of 'Good' in 2003. External validators were involved in undertaking random visits to those hospitals which self-assessed: seeking to verify that self-assessments were appropriately conducted and scored consistently.

The research was designed to investigate why, given this framework, some Trusts appeared to have achieved significant and sustained quality in their Patient Environments whereas others had not. There were two phases to the work, a desk based review of the sample population and ethnographic field work with Facilities Managers (FMs) in an identified sample of trusts who delivered consistantly high standards of Patient Environment. For reasons of space we cover the former in more detail. Our primary aim is to demonstrate that the explanations were intrinsic not extrinsic; that is they lie in the culture and behaviour of the FMs and or the Trusts concerned rather than external factors.

2. DESK BASED RESEARCH

2.1 Selection Criterion

The criteria used to establish the research group were:

- An acute Trust in England offering non specialist services;
- The achievement of green PEAT scores at all sites from 2001 to 2003;
- The achievement of good or excellent PEAT scores at all sites for 2004.

The acute sector is the sector within the NHS that most people recognise as an entity. It provides either elective or emergency secondary care in a hospital setting. It is the sector where the impact of the Patient Environment upon the health of the patient is gaining recognition, and the importance of that impact is starting to be understood (Miller and May, 2007). The acute sector performance reports attract much public and political attention.

Since the introduction of the Scottish Regional Government and Welsh Assembly much interpretation and implementation of policy for health has been devolved. The research was restricted to Trusts in England in order to eliminate the potential variation introduced by this. Again to eliminate potential variation specialist trusts were excluded from the sample. Many are better resourced for their size (Price and May, 2008) which, taken with

a focus on particular groups of patients, might influence local decisions on the Patient Environment.

There were a number of reasons for using the PEAT results when setting the criteria:

- They were clear standards for each element of the patient environment. These standards were set by the DoH (originally by NHS Estates and more latterly by the National Patient Safety Agency), and were drawn up in consultation with NHS Trusts.
- The standards dealt with all elements of the patient environment and did not recognize differences in roles and reporting structures. For example they include areas of nursing responsibilities, did not focus only on the built environment, and include the services that form the immediate patient environment, such as linen and food.
- There were clear and objective scoring mechanisms, although these may not be perfect. It is worth noting that there was a lack of belief in the objectivity in the scoring mechanism as Trusts were given 24 hours warning of the inspection visit and 'targeted' cleaning and maintenance could take place; another example of Goodhart's Law (Pidd, 2005; Price and Clark, 2008). When the external inspection was superceded by internal inspection the responsibility for objectivity passed to the Trust and efforts were made by most Trusts to try to ensure this, by the inclusion of non-Trust members such as volunteers in the inspections.
- Audit teams were made up from a number of people from different backgrounds (for example, FM managers, estates managers, infection control nurses, executive directors and non-executive directors, etc.) and these people could be from other organisations within and without the NHS.
- External audits and verification visits took place.
- Patient representatives were included.
- Information was routinely reported to Trust Boards.
- Scores were calculated by a third party, NHS Estates or the National Patient Safety Agency, giving a sense of objectivity.
- The scores used for the research were published on the DoH Web Site, and available to the general public.
- Scores against the standard were available from the inception of the initiative up to the commencement of the field research and thus proved consistency in delivery over time.

Some NHS FMs argued that the standards and their use had fallen into disrepute over the period they have been in use, favouring the more affluent or the smaller trusts and that scoring mechanisms have become politicised. However there was a general consensus that this was a national system of standards and scoring, indeed the *only* national system at the time that was recognised and understood within the NHS and was therefore the appropriate system to use.

2,2 Selection of the sample

A list of acute Trusts in England was obtained from the NHS UK website in 2005. All acute Trusts offering non-specialist acute services were then extracted. The nature of the Trust was established firstly by the name of the Trust and then checked against the Trust's web site and Binley's Directory of NHS Management (2004/05) to establish what services were delivered. From this information an initial list of 183 acute non-specialist Trusts was identified. The initial list was then searched for Trusts that had the highest (green) PEAT scores for all their hospital sites for the first and second inspection in 2001 (April and September) and then again in 2002 and 2003. The search reduced the sample to only 21 Trusts.

In 2004, the PEAT scoring methodology changed from a traffic light system of red, amber and green, to a poor, average, good and excellent score. The published results for this year were checked to see which of the 21 Trusts had excellent scores at all their hospital sites. (This study does not examine fluctuations in standards; it looks those at those Trusts that have consistently achieved high standards). Only one Trust met this criterion: a sample felt to be too small a study to be meaningful. The criteria were therefore widened to include both 'good' and 'excellent' scores in 2004. The change was appropriate as the DoH accepts an 'excellent' or a 'good' score as an acceptable standard for the patient environment when awarding the star rating to a Trust. 16 Trusts met the new criteria.

Each Trust in the group was issued a personal identification number and name in order to ensure anonymity, thus facilitating any sensitive discussions that may take place during the course of the research and protecting any confidential information given. The names chosen were those of celebrity chefs.

2.3 Desk Study of the Trusts Within the Research Group

It is an intuitively logical hypothesis to suggest that a number of external influences might offer an FM department an advantage in providing a successful Patient Environment. Indeed, although the desk research had been undertaken before the conversations with the FMs in the research group, they later called attention to the question of these influences, claiming that they were helped by a certain factor, perhaps the size of the Trust, the affluence of the population or the situation of the hospital.

Each Trust was examined against information published on the National Statistics website, NHS websites, Binley's Directory and other such published public information in order to understand any advantages that the Trust characteristics might offer to FMs. This included:

- the type of Trust
- the size of the Trust
- the number of hospital sites in the Trust
- the age of the Trust
- geographical spread

And in a trust's catchment area:

- the population size and density
- the age profile of the population
- economic activity
- the affluence profile of the population

- the health profile of the population.

2.4 Organisational factors

Potential variation due to the type of trust was eliminated by restricting the research group to acute Trusts that offered non-specialist acute services.

Two arguments, both later raised in interviews, were possible in relation to **trust size**. A large trust may have more resources or more skills to bring to bear on the Patient Environment, than a smaller trust. Alternatively, it may be possible for a smaller trust to achieve more ownership and teamwork across the organisation because of its size.

Using the listing published by the NHS Commission, each Trust in the group was designated as large, medium or small. The total number of beds was then arrived at by using the Trusts' websites and Binley's Directory of NHS Management.An additional indicator of the size of the business used was the annual income of each Trust for the year 2004/05 (Binley's Directory of NHS Management & Trust Annual Reports). These three measures give a good indication of the size of each Trust within the group.

The results (Table 1) show the group is spread across the large, medium and small categories, with bed numbers between 354 and 1,192, and incomes between £52M and £202M. The spread suggests that size is not a deciding factor when considering the consistent delivery of high standards of Patient Environment by this particular group of Trusts.

A Trust with only one hospital to maintain might have been able to achieve higher standards than Trusts where resource and attention is spread across more than one site. Conversely, a Trust with more than one hospital may have had more opportunity to use the resources flexibly or more efficiently and therefore had an advantage over Trusts with single sites. Again Table 1 does not support the argument. Whilst there are a number of single site Trusts – 11 out of 16 – the remaining 5 Trusts have between 2 and 5 hospitals per Trust. At the time of the research this distribution was typical of the NHS as a whole.

The possible influence of organisational changes was also considered. The majority (13 out of 15), of the group received Trust status between 1991 and 1994 and remained the same entity for the period 2001 to 2004. Two, Whitingstall (founded in 1998) and Oliver (in 2000) had been subject to merger or reorganisation since the inception of NHS Trusts. Another policy change since the inception of NHS Trusts is the formation of Primary Care Trusts. These organisations often resulted in combined Acute and Community Trusts giving away certain parts of their business so that the Acute Trust became more focussed on the acute needs of the population with Community services provided by Primary Care. This is true of Smith, and meant that although the Trust did not become a new organisation, it has been through considerable structural changes. The FMs from Smith subsequently asserted that downsizing had contributed to its success. Others asserted the benefits of stability. All that can be said from this evidence is that it is possible for success to be delivered even when organisational identity is being challenged and Smith's history shows that success can be maintained during a period of significant organisational change. So, whilst stability might assist in the delivery of high standards of Patient Environment, Oliver, Whittingstall and Smith show that high standards can still be delivered during periods of change.

The group did not show any unique organisational arrangement for FM services. It included both old and new sites, some with all FM services outsourced under PFI, some with all services in house and some a hybrid of in house and outsourced FM services.

Some of the trusts had adopted a Facilities Directorate model. Others had retained traditionally separate responsibility for estates and hotel services / catering.

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

Table 1 Size designation, number of hospitals, bed numbers and annual turnover of Trusts in the research group, ranked by bed numbers *Oliver turnover figures only available for year 2003/04

2.5 Geographical Spread

There was a feeling among Facilities Managers in the NHS that PEAT was very political, and that there may be an element of 'one in each area' to satisfy the political agenda. Work identifying the group does not support the assertion. There are no Trusts in the group from either the London or North East Regions disproving the political spread theory. However, in further considering this point of viewwe questioned whether the opposite was true; were there areas of the country where successful Trusts predominated? To understand whether the group members were evenly spread around England, or predominately grouped in one area, the Trusts were allocated to the regions of England as defined by the National Statistics Office (Census 2001). As can be seen in Table 2 while a group of 5 Trusts fall into the South West of England and 3 Trusts appear in the West Midlands group with the remainder are spread across the other regions. These numbers must however be considered against the total number of acute Trusts in each region (NHS UK 2006) in which light they do not seem exceptional. For example, although there are 5 successful Trusts in the South West there are 39 Trusts in the region: more than any other region in England. There is no evidence of significant groupings of Trusts delivering high standards of Patient Environment in certain regions nor of a politically orchestrated spread of such Trusts across England.

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

Table 2 Geographical spread of Trusts within the research group

2.6 The Population

It was important to understand the population that the group served. It may be that a certain size or profile of population resulted in a successful Patient Environment. For example, if the population were more affluent (and therefore healthier), they may have made less use of the hospital, and consequently the Patient Environment suffered less wear and tear? Maybe providing good environments in inner city hospitals serving a more densely populated area was more difficult? Maybe older populations used their hospitals more and were more demanding of better standards because they were more reliant on services?

A Trust will predominantly draw its patients from a catchment area determined by the purchasing patterns of the Primary Care Trusts (PCT's), who mainly buy non specialist acute services from their local Trust. Therefore it was possible to identify each PCT and thus the Trust catchment area by using the NHS website 'NHS in England' which allowed a search by Strategic Health Authority (SHA). The major purchasing PCT's for each Trust were then identified by selecting maps on the NHS website and cross referring to the PCTs' websites. The methodology does not allow for seasonal migrations such as holidaymakers and migrant workers but established the population profile for each catchment area in terms of:

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

Table 3 shows the size of the population within the catchment area of each Trust. It shows populations from 146,000 people to1,861,000. Thus the figures show no correlation between the size of the population and the success in standards of Patient Environment demonstrated by the group members.

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

Table 3 The population numbers and density of Trusts within the research group
*other hospitals outside the research group share the same catchment area

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

Thus we see that the group contained a wide spectrum of sparse, dense and combined populations, deriving from catchment areas comprising of rural, town or inner-city locations. There is no evidence that a certain type of location offers group members an advantage in delivering high standards of Patient Environment. Again, the later interviews with the FMs showed that they believed their particular geography could contribute to their success.

2.6 The Age of the Population

An older population may access health care services more frequently than a younger one. Conversely, younger populations may access a different spectrum of health care services, for example, maternity services or paediatric care. Either factor could have affected the FMs' ability to provide high standards of Patient Environment.

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

Table 4 Mean and Median Age of Trusts within the research group

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

Whilst it would appear (Table 4) that a number of the Trusts were serving a population that were a little older than the mean and median for England, there are Trusts that had populations with age means and medians that are the same or below the England figures.

The age of the population may have a slight impact on the group. Equally the correlation may be non causational.

2.7 The Affluence of the Population

Higher levels of affluence are known to result in lifestyles that in turn bring better health. This might have resulted in less call for health services and thus less demand on local hospitals. Less demand could have extrapolated to the standard of Patient Environment in that less use would result in standards being more easily and cheaply maintained. A more affluent society may also have an expectation of higher standards of Patient Environment.

The Approximated Social Grade UV50 (National Census 2001) was used as an indicator for affluence in order to understand the Socio Economic Classing of the catchment areas from which the group were taking their patients. All people aged over 16 within each PCT catchment area were divided into the following categories:

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

The information was grouped according to Trust catchment areas (Table 5) and compared with national averages.

Table 5 shows that the population for each Trust has a different socio-economic profile. Whilst these figures are interesting, and provided more background on the profile of the catchment area of the Trusts, they do not suggest a consistent theme of affluence or deprivation, if socio-economic class is accepted as a indicator of these states.

2.8 Economic Activity

It is well accepted within the NHS that employment brings better health. We therefore examined the employment rate of the populations under consideration. Unfortunately there was insufficient data shown for Employment Rate (percentage of population employed) against PCT area. In the absence of this data, we used the data relating to Economic Activity UV28 (National Census 2001). Table 6 shows the usual resident population aged 16 to 74 who were economically active. All people who were working in the week before the Census are described as economically active as are people who were not working but were looking for work and were available to start work within 2 weeks. Full-time students who are economically active are also included. Those classed as economically inactive are:

- Retired;
- Student (excludes those students who were working or in some other way were economically active);
- Looking after family/ home;
- Permanently sick/disabled;
- A person who is looking for work but is not available to start work within 2 weeks; and
- Other.

Trust	PCT	All People (16 +)	AB		C1		C2		D		E	
		Apr01	Apr01	%	Apr01	%	Apr01	%	Apr01	%	Apr01	%
	England	*38,393,304*	*8,520,649*	*22.19*	*11,410,569*	*29.72*	*5,780,577*	*15.06*	*6,538,308*	*17.03*	*6,143,201*	*16.00*
Garcia	PCT 1	125,685	22,588	17.97	37,817	30.09	24,308	19.34	20,138	16.02	20,834	16.58
	PCT 2	126,066	19,154	15.19	37,789	29.98	24,376	19.34	22,283	17.68	22,464	17.82
	PCT 3	148,731	25,207	16.95	46,572	31.31	26,401	17.75	25,373	17.06	25,178	16.93
	Total	**400,482**	**66,949**	**16.72**	**122,178**	**30.51**	**75,085**	**18.75**	**67,794**	**16.93**	**68,476**	**17.10**
Rosengarten	PCT 1	95,549	18,405	19.26	33,339	34.89	14,200	14.86	13,290	13.91	16,315	17.08
	PCT 2	102,213	21,544	21.08	33,104	32.39	14,446	14.13	18,167	17.77	14,952	14.63
	PCT 3	73,046	13,503	18.49	22,003	30.12	14,909	20.41	11,481	15.72	11,150	15.26
	Total	**270,808**	**53,452**	**19.74**	**88,446**	**32.66**	**43,555**	**16.08**	**42,938**	**15.86**	**42,417**	**15.66**
Blumenthal	PCT 1	66,608	14,514	21.79	21,218	31.86	11,451	17.19	9,096	13.66	10,329	15.51
	PCT 2	105,251	20,656	19.63	34,127	32.42	17,513	16.64	15,776	14.99	17,179	16.32
	PCT 3	121,433	27,309	22.49	41,343	34.05	16,377	13.49	14,762	12.16	21,642	17.82
	Total	**293,292**	**62,479**	**21.30**	**96,688**	**32.97**	**45,341**	**15.46**	**39,634**	**13.51**	**49,150**	**16.76**
Slater	**Total**	**142,682**	**31,532**	**22.10**	**47,263**	**33.12**	**22,348**	**15.66**	**19,831**	**13.90**	**21,708**	**15.21**
Rhodes	PCT 1	157,909	18,814	11.91	41,045	25.99	26,469	16.76	37,247	23.59	34,334	21.74
	PCT 2	172,937	20,424	11.81	36,610	21.17	24,691	14.28	48,482	28.03	42,730	24.71
	PCT 3	124,677	29,379	23.56	39,140	31.39	17,494	14.03	18,769	15.05	19,895	15.96
	PCT4	67,636	8,704	12.87	16,544	24.46	11,446	16.92	16,652	24.62	14,290	21.13
	PCT 5	156,376	42,608	27.25	48,356	30.92	20,149	12.88	22,361	14.30	22,902	14.65
	PCT 6	276,328	55,822	20.20	76,256	27.60	38,426	13.91	53,427	19.33	52,397	18.96

	PCT 7	196,286	29,491	15.02	47,434	24.17	38,027	19.37	42,624	21.72	38,710	19.72
	PCT 8	126,839	31,991	25.22	36,727	28.96	20,520	16.18	20,901	16.48	16,700	13.17
	PCT 9	142,413	26,384	18.53	37,498	26.33	26,662	18.72	30,241	21.23	21,628	15.19
	Total	**1,421,401**	**263,617**	**18.55**	**379,610**	**26.71**	**223,884**	**15.75**	**290,704**	**20.45**	**263,586**	**18.54**
Harriott	PCT 1	78,695	13,698	17.41	20,552	26.12	13,328	16.94	16,150	20.52	14,967	19.02
	PCT 2	134,933	23,937	17.74	34,284	25.41	24,242	17.97	26,968	19.99	25,502	18.90
	Total	**213,628**	**37,635**	**17.62**	**54,836**	**25.67**	**37,570**	**17.59**	**43,118**	**20.18**	**40,469**	**18.94**
Bourdin	PCT 1	114,948	29,310	25.50	34,831	30.30	16,562	14.41	18,264	15.89	15,981	13.90
	PCT 2	181,085	49,150	27.14	54,722	30.22	29,370	16.22	25,085	13.85	22,758	12.57
	Total	**296,033**	**78,460**	**26.50**	**89,553**	**30.25**	**45,932**	**15.52**	**43,349**	**14.64**	**38,739**	**13.09**
Ramsay	PCT 1	72,102	9,548	13.24	20,638	28.62	13,302	18.45	14,473	20.07	14,141	19.61
	PCT 2	79,893	13,227	16.56	23,774	29.76	14,140	17.70	12,653	15.84	16,099	20.15
	PCT 3	96,572	15,529	16.08	27,109	28.07	18,119	18.76	17,082	17.69	18,733	19.40
	Total	**248,567**	**38,304**	**15.41**	**71,521**	**28.77**	**45,561**	**18.33**	**44,208**	**17.79**	**48,973**	**19.70**
	PCT 1	121,191	35,316	29.14	35,441	29.24	15,272	12.60	16,979	14.01	18,183	15.00
	PCT 2	63,890	12,924	20.23	16,999	26.61	10,160	15.90	12,984	20.32	10,823	16.94
Stein	**Total**	**185,081**	**48,240**	**26.06**	**52,440**	**28.33**	**25,432**	**13.74**	**29,963**	**16.19**	**29,006**	**15.67**
Whitingstall	**Total**	**240,404**	**47,975**	**19.96**	**71,454**	**29.72**	**40,632**	**16.90**	**41,675**	**17.34**	**38,668**	**16.08**
Smith	**Total**	**159,792**	**42,832**	**26.80**	**50,663**	**31.71**	**24,271**	**15.19**	**20,720**	**12.97**	**21,306**	**13.33**
Oliver	**Total**	**174,446**	**35,796**	**20.52**	**52,535**	**30.12**	**29,718**	**17.04**	**29,936**	**17.16**	**26,461**	**15.17**

Williams	PCT 1	100,363	17,619	17.56	26,489	26.39	21,441	21.36	19,617	19.55	15,197	15.14
	PCT 2	87,703	18,804	21.44	23,725	27.05	16,181	18.45	15,450	17.62	13,543	15.44
	PCT 3	156,563	41,541	26.53	46,976	30.00	22,639	14.46	22,303	14.25	23,104	14.76
	Total	**344,629**	**77,964**	**22.62**	**97,190**	**28.20**	**60,261**	**17.49**	**57,370**	**16.65**	**51,844**	**15.04**
Lawson	**Total**	**116,203**	**18,227**	**15.69**	**35,268**	**30.35**	**23,226**	**19.99**	**20,497**	**17.64**	**18,985**	**16.34**
Carrier	PCT 1	87,703	18,804	21.44	23,725	27.05	16,181	18.45	15,450	17.62	13,543	15.44
	PCT 2	156,563	41,541	26.53	46,976	30.00	22,639	14.46	22,303	14.25	23,104	14.76
	Total	**244,266**	**60,345**	**24.70**	**70,701**	**28.94**	**38,820**	**15.89**	**37,753**	**15.46**	**36,647**	**15.00**

Table 5 Socio economic class groupings of Trusts within the research group

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

Table 6 Economic activity in the catchments of Trusts within the research group

The results show a spread of economic activity between the Trusts, with 5 out of the 14 Trusts being above the percentage figure for England. Again, there is no evidence of consistency, hence no support for economic activity in the catchment areas impacting on the Patient Environment standards of the group.

2.8 The Health of the Population

General Health UV20 (National Census 2001) showed the usual resident population by a self-assessment of their general health over the 12 months before the Census. Limiting Long Term Illness UV22 (National Census 2001) gives a self assessment of whether or not a person had a limiting long-term illness, health problem or disability which limited their daily activities or the work they could do, including problems that are due to old age. It was possible that populations who did not feel they enjoyed good health and consequently had greater dependency on their local hospitals in turn created a demand for higher standards. However, they may have also caused greater wear and tear on the Patient Environment by their more frequent use, thus creating a situation whereby the Trust found it more challenging to deliver high standards of Patient Environment.

Table 7 shows a spread around the percentage figure for England. Again perceived ill health can be dismissed as a shared external influence on the group.

2.9 Conclusions of the desk top study

The study was a high level investigation of the main external influences and Trust characteristics that might influence the Trusts and their FMs. It found no evidence that would warrant further and deeper investigation and indicated that external influences and Trust characteristics were not creating advantages for the FMs that would have assisted them in delivering high standards of Patient Environment.

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

Table 7 Health of the population of Trusts within the research group

The possibility of extremes making the environment more difficult to sustain has not been excluded. It is possible, for example, the conditions that may occur in London (such as density, diversity, staff competition) which explain the absence of any London Trust from the sample. Equally in parts of London and elsewher extreme affluence (bringing with it challenges such as staff competition) might affect a Trust.

Otherwise there was nothing common to the group to obviously distinguish them from a random set of Trusts other than their ability to achieve a high level of PEAT score on a consistent basis.

Given this lack of external influences and Trust characteristics, the question remains as to why the FMs within the research group have consistently delivered high standards of Patient Environment over the period of the research. Was it a factor of their leadership and or the culture of particular Trusts? Was the FM service well managed? That became the question for the second phase of the research, a detailed ethomethodological study in the Trusts who agreed to partcipate from within the group. We can only summarise that study here for reasons of space.

3. ETHNOGRAPHIC RESEARCH

An extensive literature review revealed the FM literature largely ignored leadership, and the 'softer' aspects of management focussing instead on process models and metrics. Likewise the leadership research and leadership gurus tend to overlook the role of leadership in perceived 'support' functions.

The review was tempered by the authors' experience of working in and with the NHS and in summary led to a model (Table 8) as a first pass model of leadership - that of potential attributes. It iwas based on the works of Bennis and Nannus (1985), Alimo-Metcalfe and Alban-Metcalfe (2003), the Chartered Institute of Management (2003), the NHS Estates Development Centre (2002) and the NHS Leadership Centre (2004). It also included reference to how leaders need to work within the context of their organisation, its culture and the external environment. This model provided a platform against which to analyse observations of the FM leaders in the sample group. Permission was sought to interview and observe groups of FMs responsible for the Patient Environment in the Trusts concerned. Ethics requirements necessitated an initial approach to the research managers at each Trust. Only 6 gave timely consent, 7 refused and 3 discounted for other reasons.

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

Table 8 – First Pass Leadership Model (after Bennis and Nannus 1985, Alimo-Metcalfe and Alban-Metcalfe 2003, Chartered Institute of Management 2003, NHS Estates Development Centre 2002 and the NHS Leadership Centre 2004)

Arrangements were made to talk to 22 FMs at Director, Senior Manager and Operational Manager level. Meetings were arranged to last for 1 hour and were sometimes on a 1:1 basis and sometimes as a 2:1. For example, the Senior Manager at Rhodes invited his Operational Manager to join the conversation, as did one of the Senior Managers at Stein. Lawson provided an opportunity to talk to the contractor's management team and they chose to hold their discussion as a group. At Smith, the Director and one Senior Manager opted for a joint conversation, while other Senior Managers chose a 1:1 approach. Thus, the 22 FMs contributed to the research through 16 conversations.

The interviews were conducted by RM, a former Facilities Director within the NHS. It was evident to her from the visible condition of each site that the Patient Environment rankings were warranted.

It became evident that several of the FMs were sensitive about the conversation and the possibility that they would make statements that could be attributed to them. Whilst they wanted to give a true account of their observations, they were keen that the information was presented in such a way that they could not be identified, either by other members within their Trust, by people reading the thesis, or by other participants in the study. On two occasions RM was asked not to use the tape recorder, one FM Manager saying that

s/he would tell the 'real story' if the tape was turned off. They felt that blame could be apportioned and retribution would follow if they did not reflect the organisational view.

The analysis of the 16 conversations showed there were significant common themes at each of the six sites:

3.1 Theme 1: Pride and Commitment

The FMsdemonstrated pride in their organisation and in their teams, rather than pride in themselves and their attainments; they were rather humble individuals who were modest and self-deprecating. Interestingly they were not the individuals on the national circuit talking about their success and their attainments. They were unaware of their place in the group of Trusts who delivered consistently high standards of Patient Environment, and were keen to retain their anonymity. Their surroundings spoke of an absence of self-aggrandisement and a need to be accessible, with offices being small, often situated in out of the way places and mostly within the operational centre of the FM organisation.

3.2 Theme 2: Personal Style

The FMs defined leaders as those who took responsibility, could win hearts and minds, and create teams both within FM and across the Trust. They spoke of their personal style, and the ability to change their style and conversation to fit individuals and circumstances. They spoke of the need to be able to manage conversations by communicating well and selling ideas and vision to a variety of people at different levels in the organisation. To ensure that FM teams remained motivated and committed the FMs created situations whereby they could be accessible, visible and seen to be leading by example. They wanted to be seen as fair, honest and open. They liked to know what was going on in FM and across the Trust, and to be seen to be inquiring and participating in others agendas.

3.3 Theme 3: Claims of luck and other contributory factors

The FMs seemed to think there were reasons for their success that were outside their control. They spoke of the estate they managed, its situation, geography or condition. For example, they claimed that the size of the organisation could put them in a good starting place. Each group highlighted particular aspects of their Trust's situation and described themselves as being lucky. The desk based study had of course shown the absence of such commonalities.

3.4 Theme 4: Opportunity for personal development

The FMs saw the need for personal development for all staff within FM, whether management or shop floor, NHS or contract staff. When talking of their own personal development their main areas of interest seemed to be in growing the depth and width of their experience. They were keen to use other managers/directors as mentors and coaches and to tap into and build networks, thus keeping informed and up to date. The FMs reported that they felt encouraged to learn and develop their skills, and some were enthusiastic to do this. Despite this emphasis on personal development, career development within FM was not such a strong theme within the conversations. While the FMs saw training as a help in delivering to the standards required and as a basis for their staff to become better qualified or educated, the more important reason for having a strong focus on training was to help the staff members feel valued, and thus become more motivated to contribute their best. When this commitment to training and development is

viewed in tandem with the FMs' commitment to improvement and to increasing staff morale (Themes 5 and 6: Maximising Contribution), we begin to see evidence of the Learning Organisation (e.g. Tran 1983).

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

The FMs acknowledged that staff made up a large part of the FM resource and as such they were seen as key in delivering the services at the standards required. FMs were keen to see all FM staff valued in the same way, whoever employed them. They did not want to see a difference between directly employed and contractor's staff. Where contractors were used they were likely to be well known, selected for quality as well as price and encouraged to become an integral part of the FM team. Such integration was either approached formally (for example, the partnering arrangement at Lawson) or by recognition by the Trust (for example Oliver), or by simply working well together. The two themes are essentially one. The group did not distinguish NHS staff from contractors.

3.6 Theme 7: Stability, experience and change

Most of the FMs recounted organisation-wide changes that had occurred within their Trusts and impacted on them and/or their teams, changing the culture of the organisation. These conversations, stories in the memory of the organisation that are part of the cultural web (Johnson and Scholes 1993), were offered as an explanation of how the Trusts came to be where they were today. Thus the FMs demonstrated how they used organisational legends to depict the need for the changes that had happened and help the listener understand the behaviours that were needed to support the new culture. In the hands of these FMs, history became the new rhetoric, rather than an underpinning of the old culture. The FMs' conversations evidenced their ability to abandon the norms of FM and their motivation to change the system. This was demonstrated by the FM from Harriott who said

> *'The NHS is packed with 'we've always done it this way'.'*

Other FMs who spoke positively of the opportunities for change within their Trust further evidence this behaviour.

3.7 Theme 8: Integration with Clinical Teams

Recognising that FM was a service that supported clinical delivery, the FMs saw themselves and their people as part of the hospital team. They were keen to ensure that their teams were integrated within the clinical teams, particularly at ward level. Their desired integration was furthered by the FM working closely with others outwith the FM organisation, for example, Modern Matrons (MM). There is no formal line management relationship between a FM and a MM but the FMs saw an opportunity to engage the MM in their vision and were prepared to invest time and effort into building the relationship.

The FMs not only evidenced a desire to work within and to create processes and/or structures where non existed through the creation of networks, but also an ability to create processes and/or structures that inspired ownership in their staff, thus earning staff a place within the ward or clinical team. They evidenced personal credibility that generated respect and allowed a robust relationship with open dialogue among clinical team members. The traditional clinical and non clinical boundaries were crossed by the FM working as the Strategic Broker.

3.8 Theme 9: Integration with the Corporate Agenda and the Top Team

Many of the behaviours and actions of the FMs in ensuring integration with the corporate agenda and the Top Team are the same as those that ensured integration with the Clinical Teams. There is clear evidence that the FMs understood that there was a need to approach the two (often entwined, but sometimes separate and conflicting) agendas with a different style. This difference was often in the language employed when presenting the FM agenda rather than in the content of the agenda; for example, the FMs had embraced the importance of the relationship between the star ratings and the PEAT inspections, and were prepared to ensure that this was reflected in a way that would be understood and acted upon by the Top Team. By translating the importance of PEAT into the corporate language of outputs and results (bottom line) they had ensured its place on the corporate agenda.

3.9 Theme 10: External Perspective

When considering matters external to their Trust, the FMs were mainly interested in their local communities. Some used the Regional and National networks such as HEFMA, but largely they were not interested in leading the national agenda, becoming involved in a practical way only when it impacted on their Trust and its services. Indeed, theymay have been interested in staying away from the national scene, in the same way as they were keen to ensure that they could not be identified in this research and took a cautious approach to new national rhetoric (Theme 7: Stability, Experience and Change). This may have been to protect their achievements from the glare of publicity, or to avoid the dilution of effort experienced when a manager invests time in the national agenda. Their lack of interest in participating in the national arena echoes the evidence of the Theme 1: Pride and Commitment) FMs being rather humble individuals who were modest and self-deprecating (Theme 1: Pride and Commitment. However, their lack of interest in the national arena does not mean that they are not interested in contributing to and delivering the targets set by the Government and the DoH.

When speaking of their community, the FMs expressed the need for the community to have pride and confidence in their local hospital and how the FMs could ensure this by not taking/allowing actions that could damage that pride and confidence. They wanted to ensure that the community was on board with the Trust's activities and direction and spoke of attending community meetings such as the scrutiny committee.

DISCUSSION: MANAGING MEANING AND ATTENTION

The research identified a sample of 15 Acute Trusts (out of 182 in England) that had achieved persistent high standards in PEAT ratings at all their sites through four rounds of inspection. The sample has neither obvious external commonality nor any discernible commonality of organisational form or contractual arrangement for the provison of the relevant FM services. Where access was granted the F's in the group show common leadership behaviours; managerial styles which might be considered closer to Macgregor's (1960) theory Y rather than theory X or to the adaptive (rather than mechanistic) style proposed for successful FM innovation (Price and Akhlaghi, 1999).

The research cannot claim that such a style is absolutely necessary *ab initio*. It does show such a style to be the apparent common factor in the sample. In a focus group of senior NHS FMs held to review the results one participant did observe that the conclusion was obvious, but that to behave in that way would *'be career suicide in my trust'*. It remains possible that there is an additional common factor in that the culture of these particular

trusts in some way permitted the FMs interviewed to behave as they did. Such larger cultural influences are an interesting area for further research.

More generally the results support a view that leaders manage by framing meanings through 'conversation' where communication is much more than a simple ability to verbalise a vision and where 'language' extends to the use of symbols and expression (Musson and Cohen, 1999), to shape a cultural web (Johnson and Scholes, 1993). The Managers in the sample displayed the ability to present information in a way that gets others to listen and understand, thus capturing their attention (Bennis and Nannus, 1985, Edington, 1997).

FM as a profession or managerial discipline tends to be concerned with tangible processes and inputs (Price, 1992; 1994). The examples described here argue that such concerns are not sufficient; that FM leaders must also manage language, both of the business - ensuring that their vision caught the attention of the clinical teams and the corporate agenda and the top team – but also the actual staff maintaining the Patient Environment. The exercise can involve translation as where Oliver re-wrote the 'middle-class' values of their organisation to show staff how the organisational values relate to them. They then reward their staff members for demonstrating their understanding and commitment to these values.

A separate paper (authors in prep) will examine the results of the research in terms of observations of organisational results being shaped and achieved through conversation (April 1999; Ford and Ford 1995). Meanwhile the research argues for the difference FMs can deliver by creating different and powerful conversations.

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