Ward Housekeepers in Healthcare: An exploratory review of the role of the ward housekeeper.

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PhD

I, Daryl May confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Acknowledgements

Firstly I wish to thank my Director of Studies Michael Pitt for his support and encouragement during my work. I would also like to acknowledge the feedback received from my supervisor Peter McLennan. Without the support from Sheffield Hallam University and the Sheffield Business School I would not have been able to complete this research. Specifically I would like to mention Kevin Nield, Head of Department and Liz Sharples, Head of Subject Group. I also acknowledge the collaborative work I completed with Louise Suckley during the data collection and analysis on case studies 1-3. Finally I would like to thank my wife Lindsey and children Faith and Rudi for being sympathetic to the demands placed on family life when a student has to write and complete a PhD.

Abstract

The aim of this study was to review the ward housekeeper role, specifically focusing on the impact since the national implementation as a result of the NHS Plan (Department of Health, 2000). The housekeeper role is a ward-based non-clinical multi-skilled position. The ward housekeeper focuses on ensuring the cleaning, food service and maintenance are delivered to appropriate standards in order to make the care environment suitable for the patient (NHS Estates, 2001a).

The study was divided into two parts: An initial investigative phase presented in a series of 13 case studies. A second evaluative phase looking at a longitudinal impact of the role presented in two case studies. As a phenomenological piece of work, the primary methodology employed was a case study design based on the holistic multiple case with single units of analysis (Yin, 2009) i.e. different NHS Trusts that had implemented the new ward housekeeper role. In-depth, semi-structured interviews were used as the principal method of data collection.

Several themes arose from the first set of case studies relating to the Trust's experiences of implementing the ward housekeeping service. The main themes related to six areas that were: Role; Recruitment; Induction; Training; Integration (into the ward team) and Management. The evaluative case studies revisited the themes and found them to still be appropriate. In addition the later case studies also discussed the following: The impact of the Modern Matron role; Importance of auditing; Shift in emphasis from catering to cleaning; A developing tension between FM and ward staff; Lack of National support and co-ordination (for NHS Trusts implementing and managing housekeepers) and Value to patients and contribution to patient care.

The significance of this study emerges through the advancement of methodology within the context of facilities in healthcare and through the contribution to knowledge and practice by way of suggesting two original models:

1. FM department and ward team involvement in ward housekeeper services: a proposed model (Model A).
2. Emotional and function based housekeeper concerns (Model B).

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1. Introduction

The role and function of estates and facilities management in healthcare cannot be underestimated. The importance of non-clinical factors - and specifically services that are considered "facilities" - to patients are now critical. According to figures from the now defunct NHS Estates (2003), the NHS has the largest property portfolio in Europe - 25% of the NHS spend is on estate and facilities management. More up-to-date figures from the Hospital Estates and Facilities Statistics (2009) show that the NHS manages 15,782 different properties. These range from large acute teaching hospitals located in major cities to small community clinics and other non-care based buildings that may house administrative and support staff. The value of these properties is estimated at over £24 billion and there are in access of 160,000 patient beds available (Hospital Estates and Facilities Statistics, 2009). With a property portfolio this large, and the amount of patients seen by the NHS every year, it follows that the hospital cleaning and food services would also be substantial. The cost of hospital cleaning in 2008-2009 was estimated to be £897.2 million. The average cost to feed one patient was in the region of £8.06 per day. Overall, the total annual cost to provide estate and hotel services are estimated at £6,643 million - this does not include capital or finance charges. Therefore, the NHS Estate is one of the largest costs to the NHS, along with staff and drug costs (Hospital Estates and Facilities Statistics, 2009).

The Department of Health (2010) views estates and facilities services in the NHS as organisations or individuals with an interest in land, property, equipment and facilities in order to support the management and utilisation of property and equipment and procurement of new buildings. Putting aside for the moment the obvious critique and paradigm clouded perception of this definition, it could be fair to say that in the past (and present) the facilities and estates functions may have been viewed as support services and a cost centre or overhead rather than an entity that adds value to an organisation.

Ever since the discipline emerged, facilities managers have been searching for the 'holy grail' of how to measure their contribution (or value) to the core business or strategic goals. Price (2004) argued that to move the facilities management (FM) discipline forward to one that is seen as business critical, rather than a low risk support service, facilities managers need to produce evidence that demonstrates their contribution to business. He highlights a few published studies starting to

emerge which link the office environment to productivity (Laframboise *et al.*, 2003 and Bootle and Kaylan, 2002), however he states there are relatively few other examples, NHS included.

There is a growing evidence base on the relationship between hospital design and health outcomes, particularly through the work of Ulrich and Zimring (2004) which is summarised in their report The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in-a-Lifetime Opportunity. Lawson and Phiri (2000) have also attempted to link the ward environment with patient outcomes. Their study compared two wards on the same hospital site - one newly refurbished and the other a conventional 1960's design. Their findings showed that, unsurprisingly, the patients in the newer buildings expressed more satisfaction with the appearance, layout and overall design. But in terms of the patient health outcomes, such as length of stay, the data were inconclusive. There is evidence to suggest the link between the environment and health, particularly around sensory environments. However, what most of the studies show is that it is very difficult to move beyond anecdotal evidence.

Looking specifically at the NHS, in recent years there has been a change in attitude towards facilities services and its contribution to healthcare. For example, in the 2005 general election, 'clean hospitals' were one of the key battle grounds.

The NHS Plan (Department of Health, 2000) can now be seen as one of the catalysts that propelled FM from the background to a more prominent position within healthcare. *The NHS Plan* set out a 10 year programme of modernisation for health and social care to improve the standard of services for patients. The consultation exercise that took place prior to *The NHS Plan* being published showed that the public ranked the cleaning standards and quality of hospital food as high among their priorities:

> *"People want to see the basics put right. Half of people think the condition of hospital buildings needs to be improved. Few people are complimentary about hospital food. One survey found almost a third of patients needed help eating meals but did not always get it. Dirty hospitals are a big concern. Patients are concerned at mixed sex wards."* (The NHS Plan, pg.135 - 136)

Chapter Four of *The NHS Plan* outlined the investment that would take place in healthcare facilities. This included more beds, new hospitals and a commitment to

clean wards and better hospital food. It was these last two items that resulted in the Department of Health launching the "Clean Hospitals" and "Better Hospital Food" initiatives. In addition to this, Chapter Four of The NHS Plan also advocated the introduction of ward housekeepers in at least 50% of hospitals by 2004. Prior to this there had been studies undertaken that investigated the nature and success of hospitals which had implemented a multi-skilled or generic worker since the mid 1990s (Akhlaghi & Mahony, 1997; Mahony *et al*, 1997; Anderson, 1997). The concept of the multi-skilled worker was introduced by a handful of pioneering NHS Trusts who realised the value of having a cleaner or domestic perform basic household maintenance duties such as changing light bulbs on the ward.

The NHS Plan stated that the ward housekeeper was to be a ward-based non-clinical role centred on cleaning, food service and maintenance to ensure that the basics of the care environment were right for the patient. In 2001, NHS Estates (NHS Estates, 2001a) introduced guidance on developing and implementing the ward housekeeper role for NHS Trusts to use locally. The guidance outlined the fundamental principles of the ward housekeeping service as being:

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

After the NHS Estates was disbanded in 2004 the responsibility for co-ordinating support nationally and strategically for the NHS facilities and estates was split across two main organisations. The Department of Health employed a team of core staff to concentrate on delivering policy on engineering, design and asset & property management. The other organisation was the arm's length body (ALB) called the National Patient Safety Agency (NPSA). The NPSA took over responsibility to support NHS Trusts in the delivery and implementation of cleaning, better hospital food and, because the NPSA was focused on patient safety and safe hospital design.

One could view this division in 2004 as a retrospective step which separated out the estates and facilities functions to two different organisations. In reality many front line NHS departments had already integrated estate and facilities functions (or at least had one senior director level staff member to manage the departments). However, under the NPSA, the responsibility for the cleaning and better hospital food programmes, and therefore ward housekeepers in the NHS, was elevated to the status of "patient safety." This it could be argued, was a move towards it no longer being considered as a support service at national level but one that had impact upon patient safety. However, in July 2010 the new coalition Government announced a further review of the ALB's (Department of Health, 2010a) and reported that the NPSA would be abolished, with the responsibility for the patient safety aspects being transferred to a new National Commissioning Board.

After the initial implementation of the ward housekeeper in 2002, the period between 2002 and 2010 saw a number of in-depth research studies completed specifically looking at the role (May and Smith, 2003; May and Smith, 2005; May, 2004;). The main findings from the work during this period concluded that recruitment, induction and training programmes for the ward housekeepers was crucial to underpin the success of the role. In addition, the integration of the housekeepers into the ward team along with a clear line management framework was integral to the implementation of the role. At the same time, other work was completed looking at the wider recruitment and retention issues to do with facilities and estates staff, including ward housekeepers (May and Askham, 2005; May et. al. 2006; Pease, 2009).

The main focus for this study was the introduction of the ward housekeeper role into the NHS. This study was situated within a constructivism paradigm. Constructivism is an interpretive paradigm which is critical of positivism, its belief system is firmly rooted in one of multiple conflicting realities, and an epistemological assumption that the researcher and that being researched are inextricably linked and fuse together to create and generate knowledge (Guba and Lincoln, 1994). As a phenomenological piece of work, the primary methodology employed was a case study design based on the holistic multiple case with single units of analysis (Yin, 2009) i.e. different NHS Trusts that had implemented the new ward housekeeper role. In-depth, semi-structured interviews were used as the principal method of data collection.

1.1 Central Research Question

This study is an exploratory review of the introduction of the ward housekeeper role in the NHS. This is set against a context of facilities services in NHS Trusts and the multidisciplinary approach to patient care. The methodology utilised is a case study approach. Each case is an in-depth study into ward housekeeping services and the ward housekeeper role at 13 different NHS Trusts. They are presented in a series of 15 case studies. The first part of the research took place either shortly after the trusts had implemented the ward housekeeper role, or whilst they were doing so. The findings from the first part are presented in case studies 1 - 13. The focus for this first set of case studies relate to the setting up and implementation of the role.

The second section of the research was to revisit two of the case studies after a period of time to evaluate the longitudinal impact of the ward housekeeper role. Since the first wave of trusts implemented ward housekeepers, there was evidence to suggest that the role had started to evolve, in some cases ward housekeepers taking on new responsibilities not included in the initial role outline. There had been other impacts which emerged demonstrating the need to conduct further evaluation. For example, what has been the impact of the modern matron role and how have they moulded and shaped the ward housekeeping services? The modern matron role was another initiative advocated from the NHS Plan, however it was not included in any detail during the original research with the first set of case studies. The modern matron is not only an important influence over the success of the ward housekeeper role, but also a critical factor in how the facilities services and ward staff interact and work together.

Since the initial research on ward housekeepers, there have also been several policies implemented that would impact either directly or indirectly on the role. For example, the modernisation of the NHS pay and conditions framework called Agenda for Change was implemented in 2005. A small number of studies (May et. al. 2006; Pease, 2009) have taken place looking at the impact of Agenda for Change on facilities and estates staff, but none specifically on ward housekeepers. Patient Choice would arguably have a greater impact. From December 2005 patients needing elective surgery through the NHS had a choice of four or five hospitals to receive their care from. This was known as "Patient Choice." Around the time of implementation, studies (Baldwin, 2005; Coulter et. al., 2004; Taylor et. al., 2004)

concluded that the impact of facilities services on where patients would want to elect to receive their treatment was significant. The two key responsibilities of a ward housekeeper - standards of cleanliness and hospital food - were highlighted as the most important facilities factors (Miller and May, 2006). Therefore it is for these reasons that a further review and evaluation of two case studies took place. The findings from these case studies are presented back in case study 14 and case study 15. The central research question is

> *"What is the impact of the ward housekeeper role? An exploratory review and evaluation of the introduction of the ward housekeeper role."*

1.2 Aim

The aim of the study was to review the ward housekeeper role, specifically focusing on the impact since the implementation nationally as a result of the NHS Plan. The study assessed the impact of the role, primarily focusing on patient care and soft FM (cleaning and catering). In addition the research also investigated the issues of migration of ownership and resulting tension between ward/nursing teams and FM departments. The study is divided into two parts: An initial investigative phase presented in a series of 13 case studies. A second evaluative phase looking at a longitudinal impact of the role.

1.3 Objectives

1. To complete a literature review on the ward housekeeper role. This will include a discussion on the impact of the NHS Plan which was considered the main driver behind the national introduction of the ward housekeeper role in NHS Trusts. In addition a contextual review will be completed on FM services in the NHS. The available secondary data on ward housekeepers will be critiqued. To conclude the literature review the main components of the ward housekeeper role will be dissected and discussed separately - cleaning in the NHS; hospital food programmes; maintenance in the NHS.

2. Through a series of case studies present a description of the impact of the ward housekeeper role. This will be from the perspective of the NHS facilities and estates directors, ward housekeepers, ward sisters/modern matrons and nursing staff. The case studies are split into two parts - phase one which describes the

ward housekeeper role, recruitment, induction, training, integration (into the ward team) and management. Phase two is a longitudinal evaluation of the ward housekeeper using the same themes from phase one as a basis.

3. Discuss, review and analyse the findings in order to suggest new models in relation to the implementation of the ward housekeeper role. The value of this will be for NHS facilities and estates directors wanting to either implement a new ward housekeeping service, or review and evaluate the current provision.

1.4 Tasks

Objective number one will be met through a comprehensive literature review of FM in the NHS the contextual background and history of ward housekeepers.

Objective number two (phase one) will be achieved through presenting the findings from the case studies 1 - 13. The case studies are split into the following areas:

- Ward housekeepers in the NHS
- Ward housekeepers in mental health environments
- Senior ward housekeeper role

Objective number two (phase two) will be achieved through conducting semi-structured interviews with NHS facilities and estates directors, ward housekeepers, ward sisters/modern matrons and nursing staff. These are presented in case studies 14 - 15. The ward housekeeper role in the NHS will be reviewed and evaluated since its introduction.

To meet objective number three, conclusions and recommendations based upon empirical data collection and review of original reference material will be provided. This will include suggested new models in relation to the implementation of the ward housekeeper role to aid NHS Trusts.

1.5 Contribution to knowledge - Introductory discussion

There have been earlier studies looking at FM multi-skilled workers in the NHS (Akhlaghi & Mahony, 1997 & Mahony *et al*, 1997). However, phase one for this study will be the first research on ward housekeepers to look in depth at the new role. The value of this work and the resulting knowledge from the study will enable best practice to be suggested in order to update the Department of Health (2001) ward housekeeper guidance. The findings from the work will be of value to NHS facilities directors who want to implement the ward housekeeper role or to review/evaluate the role. In addition to this the study will add to the wider body of knowledge around the impact of FM on organisations and the relationship between FM and business operations.

At the start of the study there was limited evidence concerning the role and impact of ward housekeepers on the delivery and effectiveness of patient care. Research that had been undertaken suggested that ward housekeepers could make a positive contribution. Given the importance of the cleaning and hospital food (at the time of the ward housekeeper implementation in 2001, both were indicators used by the Healthcare Commission when calculating the Annual Star Ratings for hospital trusts), and the crucial role ward housekeepers have in delivering these services, it was important to evaluate the role of the ward housekeeper. This was both in terms of the impact they had on nurse workloads and the contribution they made to patient care, but also the most appropriate housekeeping model to adopt, through best practice, to maximise health outcomes. This project evaluates ward housekeeping services and identifies the best way to deliver these services in order to maximise patient care.

The contribution to knowledge for the overall study is discussed in further detail at the end of the report within the Conclusion section in chapter 6.

1.6 Structure of thesis

Below is a short summary of the main sections of the thesis and outlines the structure of the report.

Section 2 - Literature Review. This is split into a number of component parts. It starts with a general review of facilities management in the NHS. This is to provide context. This is followed by a critique of the NHS Plan (Department of Health, 2000). At the

time, the NHS Plan was the catalyst for a number of changes that took place related to facilities and estates, including the introduction of ward housekeepers. An introduction to the rather limited body of published work on ward housekeeper is included before a more in-depth focus on their core duties. Specially, cleaning in the NHS; hospital food programmes; maintenance in the NHS.

Section 3 - Research Methodology. This focuses primarily on the data collection for the evaluative case studies. It is however, relevant to all of the case studies completed for the thesis. The section includes a theoretical and practical element for each topic covered. The theoretical framework is discussed and the study is contextualised in the wider general management theory, healthcare and FM organisational structures literature.

Section 4 - Findings and Analysis. The findings are presented in a chronological order. Case studies 1 - 6 focus on NHS Trusts which had implemented the ward housekeeper role in a general/acute setting. Case studies 7 - 10 focus on ward housekeepers in mental health settings. The final set of original case studies 11 - 13 look at senior ward housekeepers. Each set of findings from the original case studies are concluded with a dedicated discussion, summary and conclusion. The section concludes with the findings and analysis from the evaluative case studies 14 - 15.

Section 5 - Discussion. The discussion section provides a commentary on all of the case studies, with a particular focus on case studies 14 - 15. Two key models resulting from the study are presented and explained in detail.

Section 6 - Conclusion. This section summarises the complete work and makes recommendations for future research based on this study. The contribution to knowledge is explored explicitly within the conclusion.

2. Literature Review

The following literature chapter is spilt into several different sections. The first part of the literature review provides an overview of FM in the NHS and a brief vignette of the history of FM in the NHS. There is a critique of the NHS Plan, which is accepted as one of the key drivers for the implementation of ward housekeepers. Some general management theory is also introduced. A review of the current literature and research conducted specifically on ward housekeepers is provided in a separate section.

This is then followed by three sections within the chapter dedicated to providing an in-depth critique on cleaning in the NHS; hospital food programmes and maintenance in the NHS. These three topics are discussed in detail and were selected as they mirror the three main areas of responsibilities under the ward housekeeper role - i.e. cleaning, catering and basic maintenance duties. It is therefore important to understand the wider context and the existing research and knowledge base for these three topic areas.

2.1 Facilities Management in the National Health Service

The bulk of the literature review chapter is dedicated to look in detail at the ward housekeeper role and specific elements of cleaning, catering and maintenance. However, before doing this it is first important to consider what is understood to be facilities management in the NHS. Thus a very brief justification for healthcare cleaning, catering and maintenance is provided under the framework of FM services in the NHS. What this section doesn't consider is the origin and debate over FM in general - for example whether it is a strategic or operational discipline. Nor does it go into detail regarding how healthcare FM service should be provided or the argument between facilities and estates management.

To state a common agreed definition for facilities management is difficult and problematic (Thompson, 1990; Tay & Ooi, 2001). However, environment cleaning of the built environment is generally accepted as a core operational activity for facilities managers and the facility management discipline (Bernard Williams Associates, 1994; Binder, 1992; Park, 1994). Cleaning is also a key operation function for facilities managers operating in healthcare environments. Facilities managers in hospitals bring together the estates and hotel services into one integrated approach

(Alexander, 1993). Cleaning is usually considered a core component of the hotel services function in hospitals.

Operationally, catering in healthcare environments is also considered integral to FM departments and their core processes (Payne and Rees, 1999; Rees 1998; Rees 1997). Often catering, cleaning, security and laundry services (amongst others) are grouped together under the banner of either *hotel services, soft FM services* or *supply services*. The facilities department will need to calculate the best mix of services and the optimal use of in-house and outsourced supply (Shohet and Lavy, 2004).

Maintenance in healthcare is a further area of operational responsibility for facilities departments. Shohet and Lavy (2004, page 216) provide a useful overview of healthcare facilities management and consider *"maintenance management as one of the main domains of knowledge with which FM is faced."* Within the core domain of maintenance management they include a definition of maintenance as *"ensuring the continuous cost-effective fitness for use of buildings at a specified building performance level"* (page 211).

FM in the NHS emerged in response to the challenge to manage healthcare property and buildings in an effective way in order to support patient needs. Its origins can be traced back to the House of Commons Select Committee paper on "Underused and Surplus Property in the NHS." This identified space as a key facility that needed to be more effectively managed (Alexander, 1993). Of course, one could argue that the importance of cleaning in healthcare can be traced further back to Florence Nightingale (Cohen, 1984). Obviously facilities management in the NHS is directly linked with the state of the hospital's built environment and therefore capital investment. Until the Private Finance Initiatives (PFI) was introduced, the lack of strategically planned capital investment created several problems. Much of the infrastructure retains many of the pre-NHS features and a significant proportion of the stock predates the first world war. This results in an increase in backlog maintenance. Since 1992 most new large capital investment has been financed through PFI schemes (Gaffney et. al., 1999).

PFI in the NHS provided a way to fund major capital projects (such as the building on new hospitals) without the need for immediate investment from the Government. Private consortia, usually including large construction firms were contracted to design,

build and manage (with varying degrees of scope) post occupancy new builds. The contracts typically lasted for 30 years during which time the hospital trust would buy the services on a long term basis (Department of Health, 2011a). PFI projects included other public capital investments such as schools and local government administrative buildings. Since the mid 90s there has been research into the impact of PFI (Hodges, 1998; Gaffney and Pollock, 1999; Edwards and Shaoul, 1999) its implementation (Heald, 1997; Mayston, 1999) and methods to appraise (Froud and Shaoul, 2001).

The development of facilities management in the NHS, and particularly the profile and importance of services such as catering and cleaning took a huge leap forward with the publication of the NHS Plan in 2000. The NHS plan had a complete chapter dedicated to facilities services and the environment. It outlined the implementation of a number of key issues related to facilities services. This included the introduction of the ward housekeeper role. The NHS Plan is now discussed in further detail below in the next section.

To conclude this section on Facilities Management in the NHS it is worth briefly touching on the wider general management literature. It has to be remembered that some protagonists (see If Price, Professor of FM, Sheffield Business School, Sheffield Hallam University) strive to see "Facilities Management" as a discipline placed in the wider business and management paradigm. For example, material from the American Society for Quality (ASQ) is relevant and allows the findings from this study to be contextualised in a wider conceptual framework.

Specifically, the following principles from the ASQ could be considered from the wider management literature and applied to FM. The Cost of Quality (COQ) which is the cost every time work is redone, is something very significant for a service focused discipline such as FM. Customer Satisfaction, where the main focus for an organisation (or department) is to satisfy their customers - two important questions need to be considered 1) Who are the customers and 2) What does it take to satisfy them? Continuous improvement, which is an ongoing effort to improve products, services or processes. Improvement can be graduate/incremental or a breakthrough improvement all at once. The ASQ advocates the four step quality model - the plan-do-check-act (American Society for Quality, 2012).

2.2 NHS Plan

The *NHS Plan* was published in 2000 by the Department of Health (Department of Health, 2000). In retrospect, the NHS Plan can now be seen as a key catalyst that shifted FM services in the NHS to a more prominent position within healthcare.

The NHS Plan set out a 10 year programme of modernisation for health and social care to improve the standard of services for patients. The consultation exercise that took place prior to The NHS Plan being published showed that the public ranked the cleaning standards and quality of hospital food as high among their priorities.

Chapter Four of The NHS Plan outlined the investment that would take place in healthcare facilities. This included more beds, new hospitals and a commitment to clean wards and better hospital food. It was these last two items that resulted in the Department of Health launching the "Clean Hospitals" and "Better Hospital Food" initiatives. In addition to this, Chapter Four of The NHS Plan also advocated the introduction of ward housekeepers in at least 50% of hospitals by 2004. A detailed discussion of the NHS Plan and the role it had on the "Clean Hospitals," "Better Hospital Food" and implementation of the ward housekeeper role are discussed in the respective chapters below in the literature review.

The NHS Plan in 2000 was by no means the first reform of the NHS, and will certainly not be the last reform. However, it was critical for FM services in the NHS. Prior to the NHS Plan, there were a number of reforms that did have implications for FM and estates services in the NHS.

The NHS was established in 1948 providing treatment free at point of use financed by Government through a central tax. In 1962 the "Hospital Plan" was approved by Enoch Powell. This separated the NHS into three parts - hospitals, general practice and local health authorities. Additionally the Hospital Plan launched a 10 year hospital building plan. However, the cost and timescale for building the new hospitals was grossly underestimated. Five years later in 1967 the Salmon Report was published and set out recommendations for developing the nursing staff structure and the status of hospital management (O'Dowd, 2008). In 1974 a large scale administrative reorganisation of the NHS in England resulted in all health services being placed into regional and area health authorities (Guardian, 2010). The local

health authority areas were matched to local government boundaries. Therefore hospitals, nursing services, health centres and GPs were brought under the control of the new local authorities.

Margaret Thatcher (at the time the Prime Minister) commissioned a review of the NHS in 1987 and this led to the creation of the "internal market" in 1991 (Guardian, 2010). Under the then Health Secretary Ken Clarke, health authorities were split from hospital trusts and GPs through the NHS Community Care Act. The new market comprised the health authorities (which were responsible for commissioning care for their local population), the hospital trusts (which competed to provide care) and GPs (who had some budget to buy care on behalf of their patients). With the election of New Labour in 1997, Tony Blair (the New Labour Prime Minister) promised to scrap the internal market and competition and replace with collaboration (NHS, 2008; Guardian, 2010; National Archives, 2011). This led onto the NHS Plan and the expansion of the private finance initiative (PFI).

Since its publication and the subsequent implementation of the outlined investment, the NHS Plan has been the subject of limited empirical investigation. There has been some comment and discussion focused on the policy (Rowe and Shepherd, 2002; Hudson and Henwood, 2002; Smith, 2002; Bate et. al. 2004). However, in terms of studies looking at the impact of the NHS Plan on the services it is confined to nurse retention (Newman and Maylor, 2002) and ward housekeepers (May and Smith, 2003; May and Smith, 2005).

The NHS Modernisation Board published a review of the progress of the NHS Plan in 2002 (NHS Modernisation Board, 2002). However, since then there has been little in the way of a review or evaluation of the complete plan. The findings from the report concluded that the NHS were making a good start meeting the targets set in the NHS plan, but further progress was needed. At the review, there were a reported 25% increase in critical care beds and a 0.5% increase in general and acute beds. Ten new major hospitals had opened and 10,000 more nurses were working in the NHS. In terms of the targets set out in Chapter Four around healthcare facilities there was some progress. The adopted traffic light system of red, yellow and green for cleaning showed that there were no more low standard red hospitals with 389 gaining green and 447 yellow. Unfortunately for consistency when reporting targets, the traffic light system was replaced with other performance indicators. The report also stated that hospital food had improved through the new (at the time) NHS menu and 24 hour

catering provision. The ward housekeeper target stated that over 50% of hospitals should have implemented the new role by 2004. During the review in 2002, 29% of acute hospitals and 23% of mental health hospitals were in the process of implementing the role.

Moving forward in 2011 and beyond the new Coalition Government has drawn up plans to radically change the NHS. The Health Secretary Andew Lansley has proposed changes that would give commissioning back to GPs and sideline or dismantle PCTs. The private sector would be given a bigger role and much of the regulation and existing targets would be removed. The remaining hospitals that have not yet become Foundation Trusts will be encouraged to do so (Financial Times, 2010). The next step would be for the published bill to go through parliament. Instead the government has taken the unusual decision to delay its progress. The official reason for this delay is to conduct another consultation (BBC News, 2011). The impact on the built environment of any changes resulting from the NHS reform is likely to be minimal, with even less bearing on the ward housekeeper role.

2.3 Ward Housekeepers

Generally ward housekeepers and the use of multi-skilled non-clinical workers is an under researched sector. The NHS Guidance on ward housekeepers (NHS Estates, 2001a) issued following the NHS Plan (Department of Health, 2000) has to be considered as the primary document for any Trust or hospital wanting to implement the role. The guidance is discussed in more detail below. There have been studies undertaken that have investigated the nature and success of hospitals which have implemented a multi-skilled or generic worker since the mid 1990s (Akhlaghi & Mahony, 1997; Mahony *et al*, 1997; Anderson, 1997). The concept of the multi-skilled worker was introduced by a handful of pioneering NHS Trusts who realised the value of having a cleaner/domestic perform basic household maintenance duties such as changing light bulbs on the ward.

In 2000, the UK Government promoted the concept that hospital services be shaped around the needs of the patient to make their stay in hospital as comfortable as possible (NHS Plan, 2000). The ward environment and services to patients were considered prime influences on the quality of their stay, and in recognition of this the Government advocated the introduction of ward housekeepers in at least 50% of hospitals by 2004. This was a ward-based non-clinical role centred on cleaning, food

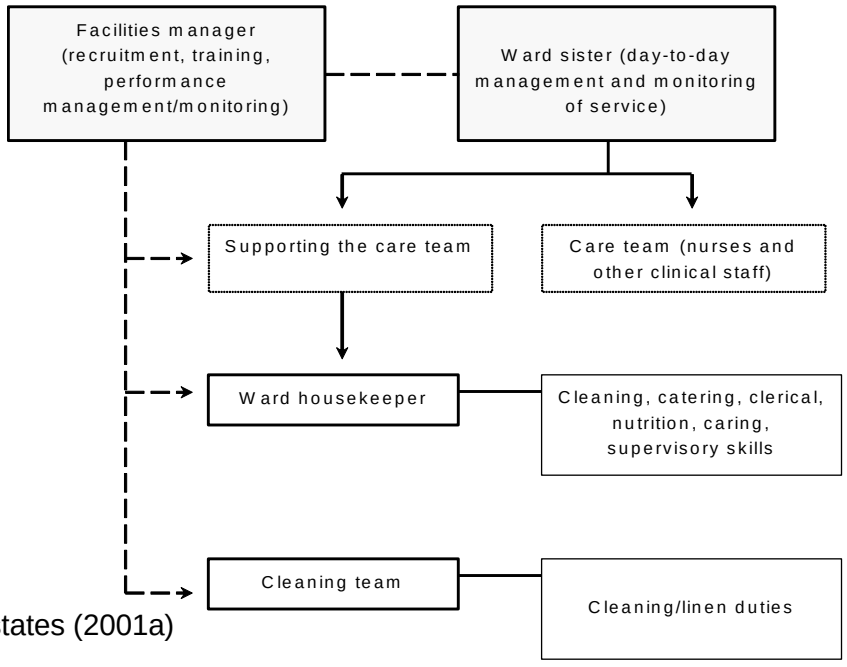
service and maintenance to ensure that the basics of the care environment are right for the patient.

In 2001, NHS Estates introduced guidance on developing and implementing the ward housekeeper role for NHS Trusts to use locally. The guidance outlined the fundamental principles of the ward housekeeping service:

- Ward sisters will manage the ward environment, supported by the Ward Housekeeper.
- Ward housekeepers must be ward based, and must be seen as part of the ward sister's/charge nurse's team.
- Ward housekeeping teams must be multi-skilled and flexible in their work practices.
- Patients must be involved in setting up and evaluating the service.
- There must be commitment from Trust management.
- A system of continuous quality improvement must be in place (NHS Estates, 2001a).

Within the guidance the possible relationships between the facilities manager, ward sister and ward housekeeper were also suggested. These relationships are illustrated in Diagram 1.

Diagram 1 - Suggested relationships between facilities manager, ward sister and ward housekeeper



Adapted from NHS Estates (2001a)

Although the principles of the role were suggested nationally through the guidance, the approach, funding and process of implementation were the devolved responsibility of local NHS Trusts. From Diagram 1 above, the key responsibilities for the role were clustered around cleaning and catering (with some basic maintenance duties). It was suggested that although the ward housekeeper was responsible for these duties, it did not mean they would carry out these tasks alone. In fact the issue of line management responsibilities - both up and down - was a key area of investigation for this study. The guidance suggested the ward housekeeper would be more effective as part of the ward team.

NHS Estates claimed at the time that the benefits of the ward housekeeper role were clear. The guidance listed improved patient satisfaction, improved operational outcomes, increased efficiency of service, less wastage of food, improved public opinion of the hospital, fewer complaints from patients and visitors and increased job satisfaction and reduction in costly staff turnover (NHS Estates, 2001a, pg. 2). There was anecdotal evidence in the form of short best practice vignettes, but little in the way of a robust study to substantiate some of the claims made by NHS Estates.

Following the early implementation of a number of ward housekeeping systems/roles in the NHS, the guidance included a series of "lessons learnt." Some of the advice appears rather basic, rudimentary and without any real grounding or explanation. For example *"take one step at a time"* and *"show you mean it"* (NHS Estates, 2001a, pg. 2). Within the advice was the suggestion of the "reallocation of funding." This was a further issue which become an important line of investigation for this study. The financial implications of implementing the ward housekeeper role were not completely addressed within the guidance, leaving a potentially sensitive issue to be resolved by individual trusts without any direction.

Despite not addressing the issue of finance, the guidance did address how to involve patients and trade unions when setting up the role and career progress and vocational qualifications available. Additionally, there was a section dedicated to the skills a ward housekeeper would need. The core ward housekeeper skills suggested by the NHS Estates were split into personal competencies and organisational competencies. The personal competencies, albeit rather vague in come cases, were assertiveness, managing priorities, solving problems, coping with change, coping with the job and team working. The organisational competencies were listed as communication skills, customer care, team working, coping with difficult situations,

diversity and equal opportunities, health and safety, audit skills and supervisory skills (NHS Estates, 2001a, pg. 15). The distinction between the personal and organisational competencies was not clear. The guidance concluded the main section of the report by providing a general framework for developing the service and examples of good practice in ward housekeeping systems. As part of the appendices included in the guidance a draft generic ward housekeeper role description was provided. Please see Appendix 1 for a copy of this role description.

Following the publication of the guidance there were a small number of NHS Trusts who disseminated their stories regarding the implementation of the new role (Kay, 2003; NHS Estates, 2003a;). For example in 2002 Doncaster & South Humber NHS Trust evaluated the implementation of their Ward Housekeeping service. During the trial the Trust assessed the time spent by staff on catering and household tasks before and after the implementation of the ward housekeeper. The quantitative data showed that after the ward housekeeper was introduced, nursing time spent on the non-clinical tasks was significantly reduced. The data also showed that the percentage of patients who thought that the food service was rushed fell from 31.4% to 11.4% of respondents (NHS Estates, 2003a).

The focus of Ward housekeepers started to make its way into peer reviewed published journals following research studies (May and Smith, 2003; May, 2004; May and Smith, 2005; Richmond, 2007). The work by Richmond (2007) again provides some evidence suggesting the benefit of the ward housekeeper role using measured performance indicators, albeit rather anecdotally and one could challenge the inference made and impact of extraneous variables not controlled (for example protected mealtimes arguably would have had an impact on the KPIs listed below). Following an audit and using nutrition practices as a KPI, the Trust claimed to have decreased the occurrences during mealtimes in the following areas over a three year period (from 2003 - 2005): medicine rounds being carried out, doctors rounds being carried out, inappropriate items on table, tables not clean and tables not cleared. The audit also showed that the following areas over the same three year period increased in their scores: hand washing is offered to those who need it; nurses taking part in meal service, protected mealtimes in operation and when a patient eats an insufficient amount this is documented. It is worth pointing out that "nurses taking part in meal service" was cited as a positive performance indicator as a result of the ward housekeeper role. However, often the justification for the ward housekeeper role is

that it frees up nurse time from cleaning and food duties, so to measure this as a positive indicator is somewhat paradoxical.

One study focused on the ward housekeeper role and specifically the issue of integration of non-clinical and clinical roles to improve the patients' hospital experience (O'Neil and Silver, 2002). Their study found that the full benefits of any new role introduced into a multidisciplinary team could be compromised if they were not fully integrated. If non-clinical staff were "bolted-on" to existing services the potential positive impact on patient care could be lost.

There have other related studies that referred to the ward housekeeper role. For example, work focuses on nurse workloads and the effective use of nursing resources (Jenkins-Clarke and Carr-Hill, 2003) - the link with ward housekeepers is obvious. Based on data collected in 2001, one study suggests that the introduction of housekeepers onto wards may make a difference to the amount of time nurses can spend with patients (Carr-Hill & Jenkins-Clarke, 2003). Although, in general the impact on staff deployment, and the effectiveness of releasing qualified nursing time, is relatively under researched (Carr-Hill et. al., 2003).

Another obvious overlap is that of the Modern Matron role. This was advocated as a result of the NHS Plan and implemented nationally around the same time. Matrons returned to the NHS in 2002 to provide a senior, authoritative nursing figure throughout wards. Their role was to maintain high standards of clinical care and overall staff leadership. In addition, they were responsible for ensuring administrative services were effective and support services delivered high standards of care (Gould, 2008). This included the Matron being responsible for maintaining standards of ward catering and cleanliness. There have been numerous studies reviewing the Modern Matron (Keely, et. al., 2005; Savage and Scott, 2004; Oughtibridge , 2003; Hewson, 2001; Dealey et. al., 2007; Koteyko and Nerlich, 2008; Ashman et. al., 2006; Currie et. al., 2009; Kemp and Morris, 2003). The focus of this literature review does not extend to looking at the research on Modern Matrons in depth. However, one study did refer to the housekeeping services and *"attempts to promote high standards of cleanliness and infection control were less effective because of the shortcomings of the domestic service"* (Gould, 2008, pg 804). The work by Gould identified that maintaining standards was a key area for the Matron, particularly important standards frequently mentioned included cleanliness and infection control and protected mealtimes for patients. The area of infection control and cleaning was of

special importance to the Matrons, yet unfortunately a lot reported *"enormous concern and dissatisfaction with this major aspect of the role"* (pg 809). The frequently cited problems that led to this concern included a general issue with substandard cleaning, lack of cleaners at certain times, inflexibility in the availability of cleaners and what work they would carry out at particular times of the day. Part of the problem, it was felt, was due to the agreed contract schedule for the cleaning.

Aside from the Modern Matron studies, there is further work looking at the overlap between nurse role and non-clinical support worker (Savage and Scott, 2005) and the role of healthcare assistants (HCAs) in the NHS (Kessler et. al., 2010; Stokes and Warden, 2004; Thornley, 1997; Roberts, 1995; Knibb et. al., 2006; Hardie and Hockey, 1978; Bosley and Dale, 2008; Hogan and Playle, 2000; Meek, 1998; Splisbury and Meyer, 2004; Thornley, 2000; Jack et. al., 2004; Workman, 1996; Reeve, 1994; McKenna et. al., 2004; Daykin and Clarke, 2000). Roberts (1995) provides a review of the new HCA role. He delves into the idea that the HCA is a "cheaper" replacement for nursing staff and the resulting drop in standards and quality of patient care and falling morale of professional nurses. He claims that *"far too many hospitals are still unclear as to HCAs real role with the NHS."* The complexity over the numerous new roles also leads him to suggest that *"are they a replacement for the nursing auxiliary, another form of enrolled nurse, or actually a potentially cheaper version of the professionally qualified nurse"* (Roberts, 1995, pg.30). Realistically, these claims could also be made from certain sections of the NHS towards the ward housekeeper role implemented ten years later.

Despite the rather mixed opinion of the HCA role highlighted above, at the time the Royal College of Nursing (RCN) did welcome the concept. They recognised that domestic, clerical and portering services were important and that nursing required the contribution of care workers to support nurses in the delivery of care (RCN, 1992).

The role nurses play within the provision of hospital food is an interesting issue, particularly within the context of the ward housekeeper implementation. Part of the justification for introducing the ward housekeeper was to reduce the demands placed on nursing resources for what could be perceived as non-clinical duties. One such area was that of food delivery. Yet the debate for the role of nurses in feeding patients is still on-going (Kowanko, 1997). The overwhelming opinion and weight of evidence supports the idea that patient outcomes can be improved if there is a strong focus on patient nutrition and the meal service is provided by a multidisciplinary team

of health care professionals. Studies indicate that a lack of attention to nutrition and the overall food delivery by the team can lead to problems (Tobias and Van Itallie, 1977; Warnold et. al., 1978; Isaksson, 1982). In some cases it might be the impersonal mealtime routines and lack of social interaction which doesn't facilitate good nutrition (Pearson, 1994; Gilmore and Russell, 1991).

To conclude, despite its relative lack of profile in the NHS (and arguably the lack of interest in the role) there has been some limited research on the ward housekeeper. This is both pre and post the publication of the NHS Plan. The NHS Estates guidance issued following the NHS Plan is useful on one level - as a framework and initial steering document. However, it lacks detail in places, particularly around the funding of the role.

Some clusters of research that include ward housekeepers are focused on other roles, for example the modern matron and HCA. In these studies the papers refer to the ward housekeeper, yet the focus for attention is on another role which has responsibility, for example, on food delivery or cleaning. The issue of housekeeping services and nursing is also an area considered by several studies. This is relevant due to the initial justification made for implementing ward housekeepers.

Despite the work reviewed in this section, arguably the ward housekeeper, in absolute terms, is an under-researched area. To make up for this lack of depth on the specific role, the three main component parts are considered in isolation, specifically cleaning in the NHS, hospital food programmes and maintenance in the NHS.

2.4 Cleaning in the NHS

Introduction

Before looking in detail at the empirical evidence and research base surrounding cleaning in the NHS it is first worth discussing the contemporary policies and frameworks that have underpinned the current approach to cleanliness. This section focuses on the recent publications from the Department of Health starting with a review of the Clean Hospitals Programme that was co-ordinated by the now abolished NHS Estates. The policies and guidance are presented in a chronological order.

Department of Health Policy and Guidance related to environmental cleaning 2000 - 2010

The Clean Hospitals Programme was launched off the back of the NHS Plan (Department of Health, 2000) and initially was branded through a website www.cleanhospitals.com. One of the aims of the NHS Plan was to improve the standards of cleanliness in hospitals, and financial support to the value of over £68 million was provided through the Clean Hospitals Programme to kick start the improvements (Department of Health, 2010b). The Programme had a number of aims, these included ensuring the patient environment was clean, developing new national standards for cleanliness in all hospitals, allowing patients to provide feedback on the hospital environment and to give the ward sisters and charge nurses greater control over the cleanliness and appearance of their wards. It could be argued that all of the above listed aims of this programme could be met, or at least partly met, through the new Ward Housekeeper role being implemented. Although, this was hardly surprising as the role was advocated also as part of the NHS Plan. Therefore this does demonstrate some level of joined up thinking in the initiatives developed during this period.

One of the key aims of the Programme, and a proposal that is still in use throughout the NHS, was the implementation of the Patient Environment Action Teams (PEAT). The PEAT teams were established in 2000 to make independent assessments in NHS Hospitals (Department of Health 2010b). At the beginning the remit of the PEAT teams was to make an annual assessment of every inpatient healthcare facility in England that had more than ten beds. Each facility was awarded a rating from excellent, good, acceptable, poor or unacceptable. Effectively it was a benchmarking tool based on observational/visual evidence collected through site visits by the PEAT teams. The PEAT teams consisted of NHS staff including nurses, doctors, catering and domestic managers, executive and non-executive directors, dieticians and estates directors. The focus of the PEAT surveys were not just on hospital cleanliness, but also on catering and food and the general hospital environment. Hence the inclusion of catering staff, dieticians and estates directors. In addition to NHS staff the teams also included patients, patient representatives and members of the public. Initially the PEAT teams and resulting surveys were administered by the NHS Estates who co-ordinated and published the scores. The responsibility for managing PEAT passed onto the National Patient Safety Agency after the NHS

Estates was abolished in 2004. The National Patient Safety Agency now publishes the annual results from the PEAT surveys on their website (National Patient Safety Agency, 2010). The 2010 PEAT results - for the "environment" section which includes factors related to cleanliness - show that within the NHS 25% of sites were rated as excellent, 62% of sites were rated as good, 12% of sites were rated as acceptable and less than 0.25% of sites were unacceptable.

While the obvious criticism of the PEAT methodology is that it is based on anecdotal observational evidence to provide a score for each facility (this is explored in more detail later in this chapter). The longevity of the survey, particularly in an ever changing target culture, does suggest that the Department of Health values the scores reported as a result of the PEAT teams. Although one would assume that there should be some correlation between the PEAT cleaning scores and other factors used to rank or measure the impact of cleanliness (hospital infection rates and patient survey satisfaction towards cleanliness), yet research suggests that at best the relationship is very weak, and in some cases contradictory (May and Pinder, 2008; Eaton, 2005; Mears et. al. 2009).

The National Standards of Cleanliness (Department of Health, 2001) were developed by the NHS Estates in consultation with experts and professionals in the fields of hospital cleanliness and infection control in order to improve the standards of cleanliness to an acceptable level throughout the NHS. The National Standards of Cleanliness were renamed as "Standards of Cleanliness in the NHS - A framework in which to measure performance outcomes" (Department of Health, 2003b). Following the publication of the Matron's Charter (Department of Health, 2004a), the Standards were replaced by the National Specifications for Cleanliness (Department of Health, 2007). The latter is discussed later in this chapter.

The report from the Chief Medical Officer titled "Winning Ways: Working together to reduce Healthcare Associated Infection in England" (Department of Health, 2003a) attempted to set out the necessary actions required to tackle healthcare associated infections. The rationale for the report was that the government claimed their investment to tackle healthcare associated infections had been substantial, yet the degree of improvement had been small. The document listed the level of investment starting with the Standing Medical Advisory Committee Report in 1998 (Department of Health, 1998) through to the new performance indicators included for infection rates into the Star Ratings for Trusts in 2003. Despite the guidance and investment,

using post surgery infection rates as a benchmark, only 12% of hospitals had reduced their infection rates. 2.5% of hospitals had seen an increase in infection rates and 72% had shown no improvement. At the time this was against the backdrop of the Severe Acute Respiratory Syndrome (SARS) which had badly affected the Far East. While the healthcare acquired infection problem was not unique to England and posed a challenge worldwide, the rates were higher compared to some European countries which had made improvements. The components of the report set out key actions to be undertaken by Trusts, some directly related to cleaning regimes, others less so. These included active surveillance and investigation; reducing the infection risk from the use of catheters, tubes and cannulised instruments; reducing reservoirs of infection; high standards of hygiene in clinical practice; prudent use of antibiotics; management and organisation; research and development.

The Department of Health publication A Matron's Charter: An action plan for cleaner hospitals (2004a), main purpose was to set out to all NHS staff a broad set of ten points of commitment based on cleaning principles. The Department of Health hoped that following the publication of the charter it would provide a basis for discussion, at all levels throughout trusts, on the importance of cleaning. The ten points of commitment were: 1. Keeping the NHS clean is everybody's responsibility. The principle was that having a clean and tidy environment encouraged a *"virtuous circle of good practice"* and a dirty environment encouraged *"an attitude of sloppiness and neglect"* (Department of Health, 2004a, pg.9). 2. The patient environment will be well maintained, clean and safe. Primarily the argument here was that it was cost effective to keep a ward clean and it would reduce risks to patients. 3. Matrons will establish a cleanliness culture across their units. This included personal hygiene, environmental cleanliness and clinical actions. 4. Cleaning staff will be recognised for the important work they do. Matrons will make sure they feel part of the ward team. This took one of the key aspects from the ward housekeeper role and incorporated it into the Matron's Charter, i.e. that cleaning staff should be made to feel part of the ward team and they should be dedicated to a particular ward or area. 5. Specific roles and responsibilities for cleaning will be clear. The charter stated that *"most patients don't care who cleans the ward"* and that *"complaints about 'it's not my job' can get in the way of delivering a good service"* (Department of Health, 2004a, pg.17). 6. Cleaning routines will be clear, agreed and well-publicised. They argued that an agreed and well publicised routine resulted in more efficient cleaning. 7. Patients will have a part to play in monitoring and reporting on standards of cleanliness. The

Matron's Charter encouraged trusts to seek feedback from patients on the standards of cleanliness on their wards. They used the common idea that many people find it difficult to judge the quality of their clinical care but most are able to report of the standards of cleanliness. 8. All staff working in healthcare will receive education in infection control. The Matron's Charter suggested that the matron be responsible for making sure that all staff - clinical and non-clinical - received on-going training and education related to infection control. This could infer a relationship between cleanliness and infection control, something the Department of Health at the time were keen to suggest was not the case. 9. Nurses and infection control teams will be involved in drawing up cleaning contracts, and matrons have authority and power to withhold payment. This was aimed at providing some authority to matrons to ensure contracted out cleaning services delivered good practice in relation to cleaning. 10. Sufficient resources will be dedicated to keeping hospitals clean. Unfortunately this point on the charter did not actually provide additional resource to invest in cleaning services, just that NHS managers needed to consider their investment in cleaning and the advantage that it would add to overall trust performance should they score well in cleaning. The charter did refer to how some trusts could pool nursing and facilities management budgets together to introduce ward housekeepers.

While no one could argue that the ten points listed in the Matron's Charter would not help to keep hospitals clean, like a lot of guidance issued by the Department of Health around the same time, there was no actual evidence collected to establish the effectiveness and impact of such initiatives. In addition, it would appear there was no review regarding the actual level of implementation amongst NHS Trusts.

In 2004 the Department of Health also issued the NHS Healthcare Cleaning Manual and a report titled "Towards cleaner hospitals and lower rates of infection" (Department of Health, 2004b; Department of Health, 2004c). The NHS Healthcare Cleaning Manual was issued to all Facilities Directors in NHS Trusts/PCTs and also distributed as a CD-ROM with further training material. The Cleaning Manual was aimed to be used by cleaning managers and staff as a resource to assist in *"training, setting standards to help promote high quality, consistent, service levels"* (pg. iii). The Cleaning Manual was also designed to help ward housekeepers judge the service quality. One of the key recommendations from the National Standards of Cleanliness (see above) was that hospitals should have instructions for staff in terms of the best way to undertake cleaning. This was the objective of implementing the Cleaning Manual:

> *"The NHS welcomed the National Standard of Cleanliness and they are now used widely on a day to day basis. Many NHS managers responsible for cleaning services have suggested that an operational manual that sets out 'how to clean' would complement the National Cleanliness Standards."* (pg. 3)

In addition to the advice and guidance on general cleaning, it also covered infection control and the cleaning of patient equipment (a task normally undertaken by nursing staff).

The report called "Towards cleaner hospitals and lower rates of infection" (Department of Health, 2004c) was a broad overview of the work completed towards cleaning and healthcare acquired infections. The Department of Health called it a "campaign" and the accompanying document summarised the main work they had implemented that contributed towards cleaning and infection control. From this campaign the Department of Health advocated being open and honest with the public, therefore data on hospital infection rates would be published and publically available. It suggested giving power to patients to monitor cleaning standards and inspections, although in reality this was already going on through the PEAT visits. It also referred to the implementation of the Matron's Charter and other investment such as the £3 million the Department of Health had already committed to research programmes on health associated infections.

The plethora of guidance and frameworks issued during the period 2000 - 2005 is perhaps a reflection of the work done by the NHS Estates. The effectiveness and impact of the various cleaning and infection control guidance is unclear. However, the NHS Estates was in a vulnerable position, and was later abolished through the review of the Arms Length Bodies in 2004. Therefore the amount of work produced by the NHS Estates at the time may have been a tool to demonstrate the value and effectiveness of their organisation, although ultimately this was in vain. As discussed above, it was very difficult to assess the impact of the various guidance and policy implemented around cleaning. In addition, some of the guidance was not new, but a re-issue of messages and information contained in other earlier formats, for example the *Towards cleaner hospitals and lower rates of infection campaign* (Department of Health, 2004c).

The Healthcare Commission was established to provide independent regulation of health and social care in England. In 2009 the Healthcare Commission ceased to exist and its responsibilities were replaced by Care Quality Commission (Care Quality Commission, 2010). The original standards provided by the Healthcare Commission were known as "Standards for Better Health," these were first published in 2004 and then updated in 2006 (Department of Health, 2006a). The standards were part of the new performance framework for the NHS which set out the level of quality of care for all NHS organisations in England. The updated standards published in 2006 included two that specifically related to cleaning and infection control:

> *"C4 Health care organisations keep patients, staff and visitors safe by having systems to ensure that a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA."* (Department of Health, 2006a, page 10)

> *"C21 Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and nonclinical areas that meet the national specification for clean NHS premises."* (Department of Health, 2006a, page 16).

Following the replacement of the Healthcare Commission with the Quality Care Commission, a new set of standards were issued known as "Essential standards of quality and safety" (Care Quality Commission, 2010a). The new standards consisted of 28 regulations (and associated outcomes) that were set out in two pieces of legislation: the Health and Social Care Act 2008 Regulations 2010 and the Care Quality Commission Regulations 2009. Regulation 12 referred to *Cleanliness and Infection Control* and providing clean environments and protecting users from acquiring infections.

The Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, 2009) came into force for NHS organisations on the 1st April 2010. The code of practice set out the criteria against which the Care Quality Commission would assess the regulations set out in the "Essential standards of quality and safety" referred to above. The document also provided guidance on how

organisations could tackle healthcare associated infections. It gave specific advice to trusts to how they could meet regulation 12 related to cleanliness and infection control and what they needed to do in order to comply. The code listed ten compliance criterion ranging from systems and policies to prevent and control infection, maintaining a clean environment, relevant information available for patients and visitors and staff training and staff protection.

The *"Saving Lives: a delivery programme to reduce healthcare associated infections including MRSA"* was initially launched in June 2005 and then revised in October 2007 (Department of Health, 2011). The *Saving Lives* programme gave birth to the *Clean, Safe Care: Reducing MRSA and other healthcare associated infections* website. The programme and website were aimed at providing tools to health staff to enable them to tackle healthcare associated infections (HCAI). The website refers to cleanliness and the importance it plays in controlling infections. There is also a link to the Department of Health's website containing the *Clean Hospitals* programme (discussed above), which at least demonstrates some attempt to join up the multitude of programmes and guidance issued related to hospital cleanliness and infection control. The actual strategy on the website is contained within the document called "*Clean, safe care: Reducing infections and saving lives"* (Department of Health, 2008). Therefore, running alongside the tools and guidance on the Clean, Safe Care website were initiatives which included introducing screening for MSRA elective admissions by March 2009; the Care Quality Commission (discussed above), 5000 new modern matrons in place by May 2008; a new bare-below-the-elbows dress code for hospitals; every hospital to have undergone a deep clean by March 2008. Although the strategy focused on the high impact interventions on catheter and cannula care to tackle HCAIs, section 5 did detail how a "Clean Environment" could contribute to controlling infections. In addition to referring to the continued use and impact of the PEAT teams, the strategy also outlined the approach to deep cleaning that was required to take place. The Department of Health was investing a total of £57 million in 2007/08 in deep cleaning *"so that the NHS can be reinvigorated with thoroughly clean buildings across the estate and increased awareness of the importance of a properly clean environment"* (Department of Health, 2008, pg 24).

The National Specifications for Cleanliness (Department of Health, 2007) replaced the Standards of Cleanliness in the NHS (Department of Health, 2003b). The Specifications provided a comparative framework for hospitals to assess their technical cleanliness. The new document was issued to take into account all the

changes that had taken place since 2003, for example through the Matron's Charter and the campaign Towards Cleaner Hospitals and Lower Rates of Infection. They also incorporated a specimen strategic cleaning plan, an operational cleaning plan and a cleaning responsibility framework. The specifications were required to be adhered to, regardless of how the cleaning was provided at the trust - i.e. in-house or outsourced. However what made the new specifications different from previous guidance, was the Trusts would now be assessed against them using the results from the PEAT surveys. In essence, trusts were now being audited against the cleaning guidance issued through the Department of Health.

Review of published literature relating to cleaning in UK healthcare environments

Perhaps one of the obvious criticisms of the above policy, guidance and strategies related to environmental cleaning in the NHS issued since 2000 is the lack of a review of the effectiveness. Therefore it is important to look at the published empirical evidence and research related to cleaning in healthcare and attempt to establish if any supports the related Department of Health policy discussed above. Due to the scope and size of the literature available on cleaning in healthcare environments, the literature review is confined to published work in UK hospitals.

Before looking at specific empirical research, this section will start by discussing other literature reviews already completed. The work of Liyanage and Egbu (2005) is useful as it discusses controlling healthcare associated infections (HAI) in the context of facilities management. The paper sets out the impact of HAIs and the associated costs, however the review is perhaps most useful because of the contextualisation within the FM paradigm. The authors state that there are many reasons why patients develop HAIs but they do highlight the vital role that FM departments play in tackling HAIs. They go onto say that HAI is predominately considered a clinical issue by many researchers and healthcare managers, and then put forward some of the recent BBC News related headlines on HAI, however they fail to acknowledge the impact of the media in reporting HAI and the incorrect inference to cleanliness (Chan et. al., 2010). From the FM perspective in controlling HAIs, they argue the service can be broken down into three main dimensions: Hard FM (buildings and fittings); Soft FM (cleaning and catering) and Clinical staffing practices (availability of changing and washing facilities). Within the FM perspective the paper suggests that there is a better need for integration between clinical and FM services staff to *"carry out infection control practices effectively"* (pg 204). Furthermore within their

conclusion they discuss the need to integrate FM services into clinical services to eliminate the duplication of work. Yet one of the underlying gaps of the paper is the lack of discussion of the ward housekeeper role, a role that meets this need to integrate clinical and non-clinical staff and practices (May and Smith, 2003).

Other literature reviews on infection control are very much grounded in the clinical domain (Dettenkofer et. al., 2011; Masterton et. al., 2003; Ward, 2011; Tacconelli, 2009; Harris et. al. 2010). Alternatively, other literature reviews focus on the management side of infection control, for example through auditing, good clinical leadership and staff retention and training (Hay, 2006; Griffiths et. al., 2009) or through risk management (Miller, 2009).

The work by Dettenkofer et. al. (2011), albeit largely clinical in nature does refer to the impact of the environment on HAIs. The focus is on the use of alcohol hand rubs and hospital design (single rooms opposed to multi bedded wards and the sparseness of rooms). Some literature reviews on infection control, although not directly related to cleaning, are important in other ways for facilities services. For example Wilson et. al. (2007) completed a literature review on the impact of staff uniforms and the domestic laundry as vehicles for the transfer of healthcare-associated infections. Their review found no evidence to suggest that uniforms were a potential vehicle for the transmission of infection in the clinical situation. Other reviews looked at the sterilisation of clinical equipment, again not usually an FM service responsibility (Schabrun and Chipchase, 2006; Creamer and Humphreys, 2008).

The literature review by Curtis (2008), was a non-pharmacological review of the prevention of hospital-acquired infections. The work in addition to looking at the morbidity rates, economic costs and infection routes did discuss the prevention of HAIs through interventions such as hand washing, gloving, gowning and personal items. His review of the research found that most studies reported an increase in hand-washing rates significantly reduced rates of HAIs. Also, that the use of alcohol-based hand-washing solutions were considered more effective than plain soap and water. The review also discussed cleaning techniques and staff training. In terms of the cleaning staff, studies reported that they received little initial training, however after training often did a better job of eliminating pathogens through cleaning, thus demonstrating the importance of structured (and on-going) training programmes (Demirturk and Demirdal, 2006; Eckstein et. al., 2007).

Some literature reviews relate to patient perspectives on cleaning and infection rates. This picks up on the issues highlighted over the impact of the media on the perception of cleaning and infection (Chan et. al., 2010). Gould et. al. (2009) undertook a literature review of the lay knowledge and perceptions of the risks of HCAIs; this was in the context that opinion polls demonstrate that the fear of developing HCAIs was the single greatest concern of people going into hospital. They looked at twenty-two studies within their paper and found that the most frequently cited source was the media *"which had been blamed for sensationalist and inaccurate accounts"* (Gould et. al., 2009 pg.1). In addition they found that lay people did not appear to be able to access credible sources of information, and those that were able to find credible information were unable to understand it. Their work concluded by suggesting that research is necessary to explore the *"acceptability, comprehensibility and accessibility of the many sound and credible sources of information available to patients and the public"* (Gould et. al., 2009 pg.7). They also stated that the answer may not lie in providing further information, rather providing more balanced information to meet lay needs. However, their final point related to the scientific community working with the media to improve the standard of reporting of HCAIs, is somewhat naïve and idealistic.

Further work completed around the same time, investigated HCAI and patient experiences (Burnett, el. al., 2010). Their work used face-to-face interviews with patients to explore their experiences around HCAI. The interviews were with patients who had been diagnosed with a bloodstream infection, and patients at the same hospital who had not been diagnosed. The findings centred on the lack communication, both verbal and written, relating to their infection status. A rather limited purposeful sample of 18 patients was taken and it was not clear how many patients from this total had been diagnosed with the bloodstream infection and how many had not. The study had little reference to the impact of cleanliness on patients' perceptions of cleaning. The interview schedule did explore the causes/consequences of HCAIs, but there was no direct question or prompt related to cleaning. In spite of this, patients did highlight poor cleanliness, lack of cleaning staff and lack of toilet and shower facilities. Although, the majority referred to the lack of nursing staff, and the use of bank staff.

Other work completed in the built environment paradigm, continues with the theme of looking at the patient perception of cleaning (Whitehead et. al., 2007). The aim of this

study was to identify the key factors that would influence patients' perceptions of cleanliness and rank them in order of importance. This was in the context of patient choice, and if NHS hospitals wished to influence patients to choose them (over other hospitals to receive their treatment) then, as the literature review suggests, cleanliness will be a key influencing factor in making that choice. Therefore, it would seem important for hospitals to understand what factors lead people to decide whether a hospital is clean or dirty. The findings showed that the main themes that influence the perceptions of cleanliness could be summarised under three broad headings: appearance of the environment; physical cleanliness; staff behaviour. Ultimately the study found that the subject was much more complex than a production of a list, however the appearance of the environment appeared to be the most important factor.

The work by Mears et. al. (2009) rather than focusing on cleaning, looked at the inventions that were effective at controlling HCAIs in acute hospitals. They used a questionnaire to establish how the hospitals were managing and controlling HCAIs. The questionnaire was sent to the Director of Infection Prevention and Control and to the Chief Executive of each Trust. Out of 173 questionnaires distributed, 155 were returned giving a strong response rate (almost 90%). The data from the questionnaires were correlated with the mandatory surveillance data on infections across England. In general their results found that lower rates of infection were linked to better management of HCAIs. For example where a hospital had scored well on hand hygiene (e.g. availability of hand hygiene on wards) there was a significant correlation with lower levels of MRSA. When trusts were unable to isolate a patient with a HCAI (due to the unavailability of a single room) then there was a higher rate of MRSA. They also found a significant association between the PEAT assessment data and Clostridium difficile-associated diarrhoea (CDAD). Other measures reported during their study included bed management - where four out of the five bed management measures were found to be linked with better MRSA and CDAD outcomes (the exception was the frequency of the bed manager liaison with the infection control team which produced higher MRSA rates). The inclusion of infection control in appraisals and PDPs were also associated with lower infection rates. However they did find that increased levels of staff training were related to higher levels of infection. The authors suggest this anomaly could be due to what they have termed *"reactive practice"* (Mears et. al., 2009pg. 312). Appraisals may be seen as a long-term strategic approach to infection control whereas training could seen as a short-term operational reaction to infection; *"it is much easier to set up*

some training sessions than to embed infection control into the staff development process" (page 312). They also cite the literature stating that education is often not sufficient to elicit behaviour change and that feedback and ownership through embedding it in personal growth (appraisals) are more effective (Dubbert et. al., 1990; Tibballs, 1996; Pittet, 2000; Pittet, 2004).

As discussed above, Mears et. al. (2009) found that there was a significant association between PEAT and CDAD, yet they found that MRSA bacteraemia rates were *not* linked to measures of environmental cleanliness - hand hygiene was more important (Eaton, 2005). The work by May and Pinder (2008) does in some cases support the findings from Mears et. al. (2009). However, other research using different measures to assess cleanliness (non-PEAT) does reveal *"widespread contamination of the hospital environment with MRSA"* and it *"highlights the complexities of the problem of contamination, and confirms the need for more-effective cleaning of the hospital environment to eliminate MRSA"* (Hardy et. al., 2006, pg. 127). This provides further evidence to question the validity and effectiveness of the PEAT measures to assess environmental hospital cleanliness on a national scale.

In recent years there have been a number of studies focusing on and evaluating cleaning regimes and standards. This may have been a reflection of the multitude of guidance and policy issued on cleanliness and infection control, combined with the increased media attention in HCAIs. The work by Griffith et. al. (2000) was completed immediately before the publication of the NHS Plan (Department of Health, 2000) and therefore prior to the PEAT inspections being implemented. While they discuss the contradictory evidence surrounding a link between surface contamination and infections, perhaps more interestingly their study looked at the issue of using a "visual assessment" to indicate cleanliness. The authors recognised that a visually unclean environment *"gives a poor impression of healthcare institutions"* (Griffith et. al., 2000, pg.19), yet their results found that visually clean surfaces may be contaminated and therefore a poor indicator of cleanliness. After cleaning 82% of the ward sites were assessed as visually clean, yet only 24% were considered clean using adenosine triphosphate (ATP) bioluminescence (a common technique used in the food industry to monitor cleaning). The sites most contaminated in the ward were the kitchen area and toilets. Overall their data suggested that a visual assessment of cleanliness had a limited value, adding further question marks to the validity of using PEAT assessments.

Further opinion suggests that an integrated and risk-based approach should be adopted to assess surface hygiene. Such an approach is already established by the food industry to manage cleaning in a cost-effective way. To achieve this assessment of surface hygiene a preliminary visual assessment should be used alongside *"rapid sensitive tests for organic deposits and specific microbiological investigations"* (Dancer, 2003, pg. 11). Further work in this area (Sherlock et. al., 2009), compared four methods for determining hospital cleanliness: visual assessment; ATP bioluminescence monitoring; microbial load (ACC) and MRSA detection on the pretext that monitoring cleaning efficacy alone on visual assessment can lead to overestimations. The study concluded *"that the use of chemical tests such as ATP may provide additional information of cleaning efficacy and ATP trends allow identification of environmental surfaces that require additional cleaning or cleaning schedule amendments"* (Sherlock et. al., 2009, pg. 140). More recent work has confirmed these findings (Mulvey et. al., 2011).

Perhaps of more direct interest and relevance for facilities managers or those responsible for domestic duties was the work completed by Griffith et. al. (2007) looking at existing and modified cleaning regimens. The study took one general surgery ward in a modern hospital and monitored infection rates over three periods (each period lasting 14 days). One period used the existing cleaning protocols, one used a modified cleaning protocol with the same detergent and a third used a sanitiser. An in-house team performed the cleaning protocols and the existing routine *"lacked detail and related more to frequency of cleaning rather than how it was undertaken and implemented"* (Griffith et. al., 2007, pg. 353). The modified cleaning protocol provided more detail, for example that each surface be initially wiped with a damp paper towel followed by a clean rayon cloth for at least 15 seconds. The second revised protocol used a *"cationic detergent in place of the non-ionic detergent"* (Griffith et. al., 2007, pg. 353). In addition to the basic visual assessment after cleaning the researchers also tested the surfaces for ATP. Both modifications to the cleaning protocols showed significantly lower bacterial counts. Incorporating the revised sanitiser produced a further slight improvement in cleaning efficacy, although this was not significant. Although not looking at cleaning regimes per se, related work in this field is concerned with establishing a framework or effective method to assess microbiological standards for surface hygiene in hospitals (Al-Hamad & Maxwell, 2008).

The majority of the work related to environment cleaning and infection control discussed above is situated in the clinical literature and the predominant view is that visual inspection of cleanliness is ineffectual, yet there is conflicting evidence on the link between cleaning and infection control. None of them formally assess the guidance issued by the Department of Health related to cleanliness and infection control. It is now worth discussing environmental healthcare cleaning in the FM domain. Considering that the cleaning service is often thought of as a core facilities management element, it is surprising how little work has been published on the subject in healthcare environments from an FM perspective. Early opinion published on cleaning focused more on the operation aspects such as training for cleaning staff (Campbell, 1990).

Research completed before the widespread adoption of the multi-skilled facilities worker role (Akhlaghi & Mahony, 1997) or latterly the ward housekeeper role looked at the heath care assistant (HCA). The HCA role was introduced as part of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting "Project 2000". This wasn't the first type of unqualified nurse to be used by the health service, but at the time there was concern that management was leaning towards "cheaper" staffing by using HCAs to replace nurses and therefore giving ride to poorer quality care for patients (Roberts, 1995; Edwards, 1997). The HCA role, like many unqualified nursing roles, did contain an element of cleaning, assessing hygiene and tidying rooms. This is in addition to other duties such as admissions, care plans, discharging, ward clerking and bed making. Other research published in the FM domain discusses hospital cleaning, specifically the impact of the ward hostess role or generic worker, in the context of in-house versus outsourced services (Smith, 1995).

Whilst not necessarily related to cleaning directly, the importance of hospital design is also understood to be a factor in controlling HCAIs (Ulrich & Zimring, 2004). Additionally innovative designs for hospital furniture and equipment have been used to help make items easier to clean (Anon, 2009). The "Design Bugs Out" project which is part of the Department of Health's "HCAI Technology Innovation Programme" has developed new furniture prototypes and also looked at how they can redesign everyday equipment in order to make them easier and quicker to clean. The new furniture prototypes included a commode (portable toilet) that was easy to take apart for cleaning and storage. In order to eliminate the hard-to-clean corners, internal spaces and inaccessible surfaces that can harbour bacteria, new designs have been put forward for patient bedside systems and cabinets. These utilise new

materials and shapes that aid cleaning. The everyday equipment included an "intelligent" mattress that changed colour when compromised by body fluids and required to be changed.

The research conducted by Griffith (2006) discusses the importance of controlling HCAIs in a quality management context, and although it is not published directly in the FM related press, it does help raise the profile. The paper attempts to draw parallels between hospital cleaning and cleaning in the food industry a number of years earlier.

As discussed previously, there is little evidence available to directly evaluate the government policy and guidance related to the cleaning and infection control initiatives. In a study completed by Macdonald et. al. (2009a), the authors attempted to investigate why some trusts achieved consistently high PEAT scores in the context of leadership in the NHS. This was following a desk top study that discounted some suggested main external factors to influence the trusts in their ability to deliver the required patient environment standards e.g. the type of trust, size of trust and age of the trust; organisational arrangements (in-house versus outsourced), geographic spread; demographics of the local catchment population (Macdonald et. al., 2009b). Ten themes were identified as common traits amongst the, albeit small, sample of six NHS FM senior staff who took part. The ten themes were 1. Pride and Commitment. 2. Personal Style. 3. Luck and other factors. 4. Opportunity for personal development. 5. Maximising the contribution from FM staff. 6. Contractor's team. 7. Stability, experience and change. 8. Integration with clinical teams. 9. Integration with the corporate agenda and the top team. 10. External perspective. (Macdonald, 2009a, pg 146-147).

Conclusion

Considering the importance of cleaning to operational facilities management in the NHS, there is relatively little published work focused on this subject. There is a growing evidence base on the environmental cleaning in general, and more specifically the relationship between environmental cleaning infection controls. However, these studies are generally published in clinically focused journals. Whilst the clinical community recognise the contribution of environmental cleaning and the impact on healthcare there needs to be more done in order to have the relevant

studies published in the FM domain. Conversely there also needs to be work done to allow the FM community to have a "voice" in the infection control journals.

This section discusses the obvious contradiction in the evidence in the suspected correlation between infection control and environmental cleaning. Although the impact of the media and the attention this brings cannot be underestimated when considering this potential correlation. However, one thing does appear to be consistent, is that a performance measure based on an observation (visual) assessment is not a sufficient tool to decide the environmental cleanliness of a hospital ward.

Finally, the lack of either a formal review sponsored by the Department of Health, or local empirical studies to assess the effectiveness of the cleaning and infection control guidance since the NHS Plan is a cause for concern. Since 2000 there has been a significant investment in the co-ordination and guidance related to cleaning and infection control. Yet, there has been very little done in the way of a review of the impact and cost effectiveness.

2.5 Hospital food programmes

Introduction

This section of the literature review is concerned with the catering and food delivery in the NHS. This is in the context of the operation facilities management services responsible for catering in hospital environments. Hospital catering is an essential part of patient care and each year the NHS in spends over £300 million on food and £500 million on catering overall (National Audit Office, 2006).

This part of the literature review will not focus on the dietetic and nutritional elements of the food service. Instead it will be appropriate to draw upon research completed within this field which informs the service delivery element of the catering service.

The review follows a similar format to the discussion in the previous section around cleaning in the NHS. Therefore it begins with an overview of the contemporary policies and frameworks that have been implemented by the Department of Health and other public sector agencies since the NHS Plan (Department of Health, 2000).

There are four main bodies that hold responsibilities for hospital food, these are the NHS Purchasing and Supply Agency (PASA), NHS Logistics Authority, the Department of Health and the National Patient Safety Agency (NPSA) (National Audit Office, 2006). PASA's responsibilities are centred on negotiating national contracts with suppliers and auditing the food safety of suppliers. The NHS Logistics Authority buys some food in bulk and then supplies and delivers directly to NHS Trusts. The Department of Health has overall responsibility for the patient experience including hospital food. The NPSA implements and overseas the PEAT surveys. The policies and frameworks from these various agencies are presented in a chronological order.

After the review of the government policy this section provides an outline of the different types of catering production systems that are common through the NHS - namely cook-chill, cook-freeze, or batch cooking - and ward delivery systems - bulk food service or plated meal service (Hwang et. al., 1999). To conclude this section a discussion is provided on the research evidence on the catering and food service in NHS hospitals from an FM perspective.

Department of Health Policy and Guidance related to hospital food and catering 2000 - 2010

The starting point is a review of the Better Hospital Food Programme co-ordinated at the time by the NHS Estates. The Better Hospital Food Programme was introduced as a result of the NHS Plan (2000). Section Four of the Plan outlined the following investment that would take place over the following year:

• A 24-hour NHS catering service with a new NHS menu, designed by leading chefs. It will cover continental breakfast, cold drinks and snacks at mid-morning and in the afternoon, light lunchtime meals and an improved two-course evening dinner. This will be a minimum standard for all hospitals

• A national franchise for NHS catering will be examined to ensure hospital food is provided by organisations with a national reputation for high quality and customer satisfaction

• Half of all hospitals will have new 'ward housekeepers' in place by 2004 to ensure that the quality, presentation and quantity of meals meets patient needs;

that patients, particularly elderly people, are able to eat the meals on offer; and that the service patients receive is genuinely available round-the-clock

• Dieticians will advise and check on nutritional values in hospital food. Patients' views will be measured as part of the Performance Assessment Framework and there will be unannounced inspections of the quality of hospital food.

(Department of Health, 2000, pg 47)

The Better Hospital Food programme was launched shortly afterwards as a support mechanism to help NHS Trusts achieve the objectives listed above. The programme ran until 2006 and aimed to ensure the consistent delivery of high quality food and food services to patients. In addition to this the Better Hospital Food initiatives included a new national dish selector that contained over 300 recipes from leading chefs to use in hospitals. The programme also advocated protected mealtimes and 24 hour catering. The archived programme content is available on the Hospital Caterers Association Website (www.hospitalcaterers.org).

The PEAT inspections (discussed during the cleaning section) were used as the tool to conduct the (at the time) unannounced inspections of the quality of food. The inspection teams adopted the same methodology for the food element of the PEAT that were used for the cleaning and hospital environment. This entailed an annual assessment of inpatient healthcare facilities in England with more than ten beds (National Patient Safety Agency, 2010). Using a somewhat subjective scoring scale of 1 (unacceptable) to 5 (excellent) the PEAT teams ranked hospitals on the following food related elements: Menu; Choice; Availability; Quality; Quantity of portions; Temperature; Presentation; Service and Support; Beverages.

During the PEAT inspections, Trusts were also ranked according to how many wards operated a protected mealtime policy; how many wards used a nutritional screening policy; whether they had calibrated equipment to measure patients weight/height; if the Trust had a nutritional steering group; % of patients weighed within 24 hours of admission; % of patients that were screened for nutritional care within 24 hours of admission. As described above, some of the PEAT inspection criteria related to food were focused on food service delivery, others were factors based on nutritional care and monitoring.

Food waste is, and has been, a problem in the health service. In 2005 the Department of Health published a document in response to the challenge of food waste (Department of Health, 2005a). This replaced earlier guidance by the Department of Health issued in 2000 (Department of Health, 2000a). Food waste occurs at many different points in the service, including the ordering, distribution and service at ward level. The Department of Health wanted to provide best practice guidance to reduce the amount of waste, this was aimed at modern matrons, doctors, dieticians, catering managers and ward housekeepers. They draw upon data from the Audit Commission to compare the percentage of waste in different types of meal delivery systems. This shows that bulk food service systems have the highest total (plate and unserved meals) waste (37%) compared to a plated service (35%) and a hybrid service (28%) (Audit Commission, 2001). The guidance recommends a series of procedures, most of them fairly obvious and based on common sense, to reduce food waste. The suggestions include accurate ordering of patient food, protected mealtimes, assisting patients to order and eat and other procedural and staff based protocols.

In addition to standards on hospital cleaning, the Standards for Better Health (Department of Health, 2006a) also included food related standards. The standard for food was:

> *"C15 Where food is provided, health care organisations have systems in place to ensure that a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day."* (Department of Health, 2006a, pg. 14)

As already discussed, the Standards of Better Health were eventually replaced by the "Essential standards of quality and safety" (Care Quality Commission, 2010a) and the food and catering related items were listed in regulation 14 (outcome 5). The regulation outlined that care providers must protect service users from the risks of inadequate nutrition and dehydration. This would be met by (a) providing a suitable choice of food and drink; (b) food and drink that meets any reasonable requirements as a result of religious or cultural backgrounds; (c) support service users to eat and drink sufficient amounts for their needs.

Improving Nutritional Care: A joint Action Plan from the Department of Health and Nutrition Summit stakeholders was published in 2007 (Department of Health, 2007a). This was another publication providing best guidance on food and catering, including repeating the advice listed in the Better Hospital Food programme. For example, protected mealtimes, access to 24 hour catering and other nutritional related information. Aside from bringing together stakeholders and resources, there was little new information contained in the 2007 Action Plan, and no additional finance to support and food or catering service in NHS hospitals.

The sustainability of food products and food delivery has become increasingly important to the public. In response to the importance that patients might place of their choice of food and how sustainable it is, the Department of Health issued "Sustainable Food: A guide for hospitals" (Department of Health, 2009a). Within the forward to this document, the then Secretary of State for Health, Ben Bradshaw, stated that *"hospitals are faced with a plethora of food initiatives and assurance schemes as well as regulation relating to both food and sustainability. This guide is intended to help hospitals navigate the various food schemes"* (Department of Health, 2009a, pg. 3). The guide was primarily aimed at catering and procurement staff, and contained information to help hospitals respond to policy and strategy initiatives relating to healthier, sustainable food. Specifically it suggested ideas such as i) using local in-season ingredients to reduce food miles ii) the procurement of food from sources that minimise the harm to the environment and are produced in line with high animal welfare standards iii) choosing fair trade products and avoiding bottled water, instead using plain or filtered tap water.

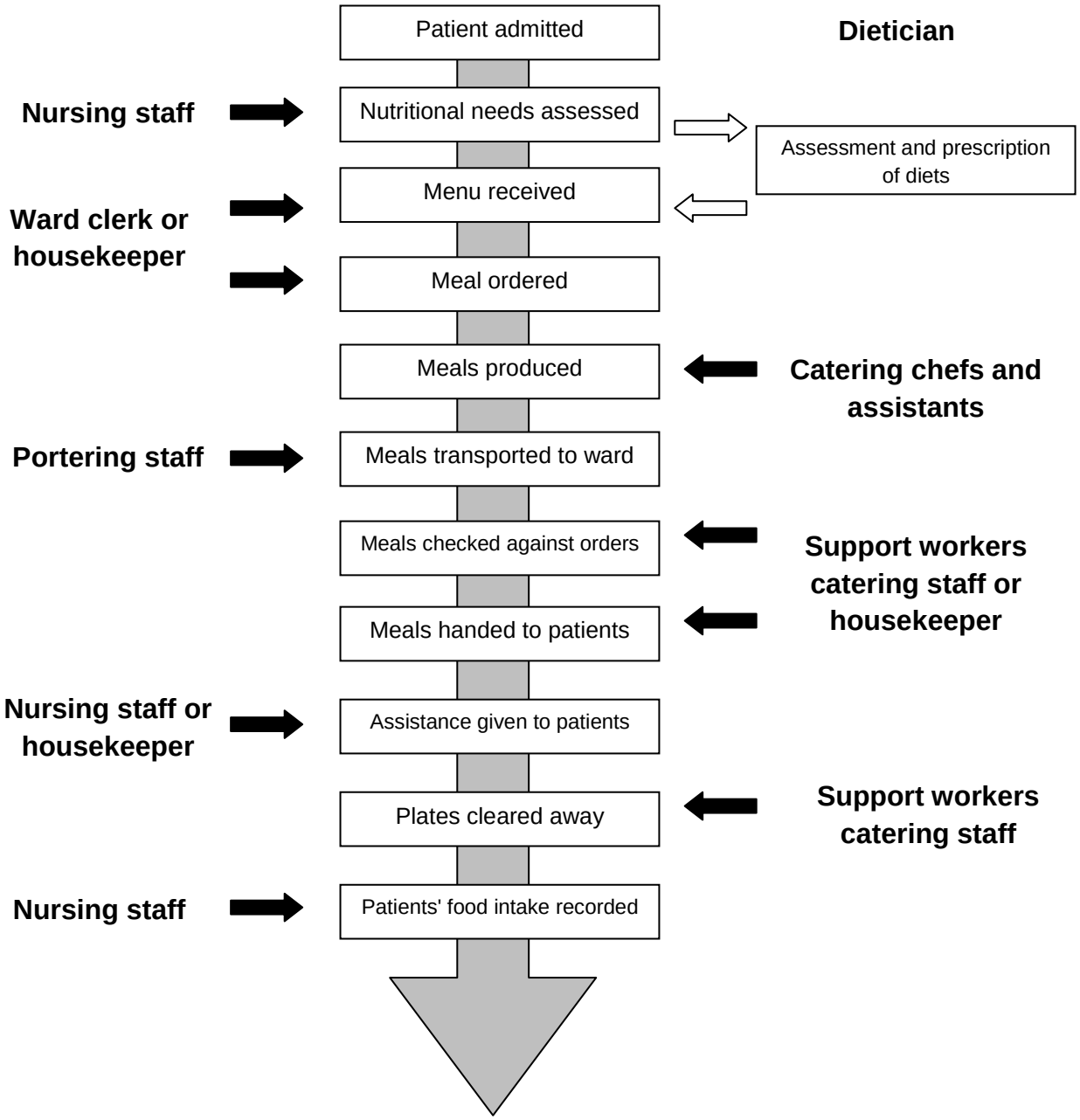
The Department of Health launched the "Healthier Food Mark" scheme in 2009 (Department of Health, 2009). This was a voluntary scheme to enable public sector food providers to reach a standard to make a positive contribution to their service. The Healthier Food Mark had three proposed tiers (bronze, silver and gold). It went through almost two years of testing and piloting involving over 70 public sector organisations only to be dropped before implementation was due in 2011.

The first Essence of Care benchmarks were published in 2001 and the latest version now contains 12 benchmarks (Department of Health, 2010). The Essence of Care benchmarks were developed in partnership with patients and carers and primarily aimed to be used as a quality assurance toolkit, checklist, audit tool, dissemination tool, educational tool, and to provide evidence that the Care Quality Commission's

regulations have been met. There is a separate set of ten detailed benchmarks for food and drink relating to the following aspects: Promoting health; Information; Availability; Provision; Presentation; Environment; Screening and assessment; Planning; Assistance; Monitoring. There is no evidence as to why these set of ten indicators were selected to form the Essence of Care benchmarks and there appears to be no direct link to the PEAT assessment scoring elements.

Although they cannot be considered as direct Department of Health publications, it is worth briefly discussing the findings from the Audit Commission's "Acute Hospital Portfolio Survey of Catering" (Audit Commission, 2001) and the National Audit Office's "Smarter Food Procurement in the Public Sector" (National Audit Office, 2006). The latter survey contains some useful background and contextual data, albeit a little dated now. The survey was conducted against a context of increasing concern over the prevalence of malnutrition in hospital patients. Studies showed that up to 40% of adults were either admitted to hospital with malnutrition or become malnourished during their stay (British Association for Parenteral and Enteral Nutrition, 1999; The Nuffield Trust, 1999). Perhaps the most telling statistic for facilities departments was that at the time there was no relationship between patient satisfaction with food and the cost of providing the catering service. One potential reason suggested for this was that the costs relate solely to the catering department, whereas there are many stages and stakeholders involved in delivering hospital food that could affect the patient satisfaction score. The survey presents a useful diagram illustrating the stages and staff involved in the catering service, this is displayed below.

Diagram 2 - Stages and staff involved in delivering hospital catering services



(Audit Commission, 2001, pg. 7).

The National Audit Office's "Smarter Food Procurement in the Public Sector" (National Audit Office, 2006) was published more recently and looks at food procurement across the public sector rather than specifically on the NHS. The focus of the report was on how public sector organisations could become more effective procurers of food, maintaining or improving the quality of catering or reducing the costs. One of the case studies was the Department of Health and the recommendations included increasing the up-take of national contracts and Trusts joining together to increase buying power. They also suggested that hospitals that

had the capacity to supply neighbouring hospitals in order to promote sustainability should be supported.

NHS Catering departments are also supported by other association bodies that aim to improve food service delivery in the NHS. The British Dietetic Association (BDA) and the Hospital Caterers Association (HCA) are two examples of such organisations. The BDA is the professional association for dieticians. The primary aim is to advance the science and practice of dietetics; however, there are some useful resources for the other stakeholders and staff involved in the delivery of hospital catering. The publication "Delivering Nutritional Care Through Food and Beverage Services" (BDA, 2006) is one such example. Although promoted as a "toolkit for dieticians," it provides a wide resource on areas that are relevant for facilities staff and specially ward housekeepers. For example it covers food waste, protected mealtimes and staff training. On the issue of staff training the document suggests areas such as allergy awareness; menu ordering and procedures; religious diets; basic food hygiene and food safety; the use of equipment trolleys; timeliness of serving meals to ensure food is an appropriate temperature; portion control; food presentation skills; communication positive attitudes towards food and beverages. Other topics included within the toolkit include food composition and food labelling, patient menus and food safety. It also contains a useful section on "working together" and suggests how the dietician can work with other staff involved in hospital catering through joint monitoring; theme days; shared staff induction and work shadowing; joint presentations on healthy eating; hospital open days.

The Hospital Caterers Association (HCA) is a body established to support catering in hospitals. The HCA is focused on the service delivery from the facilities side and also provides a professional development framework for hospital catering managers. After the abolishment of the NHS Estates and the Better Hospital Food Programme, the resources were transferred over to the HCA and their website now contains the national dish selector and associated recipes, menus, protected mealtimes, 24-hour catering, sustainability and nutrition (Hospital Caterers Association, 2011).

It could be argued that the circumstances surrounding cleaning in the NHS is mirrored with the hospital food and catering. There appears very little investment - in terms of financial support - to have taken place to accompany the suggested governmental policy and advice issued through the various agencies. In addition there also appears to be no review of the effectiveness of the initiatives despite the

resources dedicated in implementing them. The report by Sustain (2010) is a useful critique on the investment made by the government and the lack of results. The report states that over £50 million has been spent by the government or third sector agencies with the aim to improve hospital food from 2000 (i.e. when the NHS Plan was launched) to 2010. The authors are particularly critical of the reliance on what they have terms *"celebrity chefs"* and *"costly gimmicks to paper over the problems with their policies on failed hospital food"* (Sustain, 2010, pg. 3). Although Sustain "the alliance for better food and farming" is possibly politically motivated with an agenda, their report is more than just an unsubstantiated rant. They provide a detailed overview, listed in chronological order, with full referencing of the various national and local initiatives related to hospital catering (a lot of which have been already discussed above in this chapter).

Production methods and food delivery to wards

Before looking at the empirical evidence relating to the operational food service delivery in the NHS, it is worth providing an outline of the catering production methods and the catering delivery systems that are common through the NHS. There are three major production/cooking methods. These are cook-chill, cook-freeze or batch cooking. There are two main food delivery/distribution systems. These are bulk food service or plated meal service (Hwant et. al., 1999).

Cook-chill food is prepared chilled and stored before regeneration at ward level using ovens or specially designed heated trolleys. Claimed advantages for this method include a relatively simple process for handling, higher efficiency and lower food costs based on bulk buying and centralised purchasing. The care over temperature control is a disadvantage with this method. Getting this incorrect can spoil the food, negate any nutritional benefits and lead to a poor taste.

Cook-freeze is similar to cook-chill with freezing instead of chilling before storage and transportation. Food can be stored for long periods without impacting on the nutritional value (Insight Research, 1995). However, food that has been frozen and then thawed can lead to a loss of texture. This results in the need for skilled staff to operate the regeneration and distribution to wards making it more expensive (Johns, 1995).

Batch cooking involves cooking relatively smaller quantities of food immediately before serving from special heated trolleys. This enables hospitals to serve freshly cooked food for patients. The cost of the food is controlled by matching output to patients' demands. All three of the above methods are used on wards across the NHS that use housekeepers.

A bulk food service is one way in which food can be distributed from a main hospital (or off-site) kitchen to wards. This is done through an insulated bulk food service trolley. This allows a bedside choice of meal to patients, giving a more pleasurable experience and minimising food wastage (Hwant et. al., 1999).

Plated meal service is where food is served onto plates in a central location and stacked in trolleys ready to be delivered to wards. This allows a fast and efficient way to serve food at ward level with reduced associated staff costs. The disadvantage of using this distribution method is that there is an impersonal patient services and moisture loss due to small portion sizes (NHS Executive, 1997).

Research has been conducted across the NHS using a survey to investigate the utilisation of food production and distribution service. The results show that nearly 58% of Trusts used a batch cooking method to prepare meals. 20% of Trusts used cook-chill and 12% used cook-freeze. In terms of food delivery service at the ward, the differences between the hospital Trusts were small. Just over 40% of Trusts used plated meal service while nearly 35% of Trusts used bulk food service. Almost 25% of Trusts used a combination of bulk and plated service (Hwant et. al., 1999). It should be noted that this study was conducted over a decade ago and since then there may have been technological advances that have influenced Trust choices. It is becoming increasingly common for new hospitals to designed and built without kitchen or cooking facilities, thus reducing the cost of managing kitchens but also resulting in an impact on the choice of food production and distribution that can be managed on-site (British Dietetic Association, 2011).

Review of published literature relating to catering in UK hospitals

The area of hospital/healthcare catering and the management of it is relatively under researched (Baum, 2006; Hwang et. al., 2003). From the angle of nutrition and dietary requirements for patients this is usually considered from a clinical viewpoint. However, the management of the catering function is not a topic that has received

widespread recognition in the facilities related journals. This may seem surprising now, particularly as some of the media attention has now shifted from cleaning in the NHS to the food served in the NHS and the resulting impact on patient care and well being. The recent Channel Four documentary "Dispatches" shown on Monday 21st Feb 2011 is a good example of this. Albeit a very one sided opinion, non scientific in their reporting and non-representative of NHS catering across the UK, it does suggest that hospital food and catering may become as important to the media as hospital cleaning was a few years ago.

Some of the body of literature relates to catering delivery options and production methods, as described above (Hwang et. al., 1999). Other studies take a rigorous approach to assessing the differences between catering delivery options from a patient perspective. For example an assessment of plated versus bulk delivery options (Hartwell et. al., 2007). Furthermore research has looked at the differences between plated meals and a cafeteria trolley system (similar to a bulk delivery option), however this time from both a patient satisfaction perspective and a food safety aspect (Hartwell and Edwards, 2001). Both studies favoured the bulk delivery option over the plated option. Interestingly further work again by Hartwell and Edwards (2003) found that the opportunity for patients to interact with staff serving their meals increased patient meal satisfaction. Using a trolley system 93% of patients were satisfied with their meal compared to 76% with the plate system. Nutritional intake was not dependent on the catering system, but the impact of the study in terms of patient interaction with staff and patients wanting to see and smell the food on offer before making a choice could have potential implications for ward housekeepers. Arguably this is potentially an area where ward housekeepers could have a significant impact on patient satisfaction, if the hospital has the trolley/bulk catering delivery system.

Despite the evidence suggesting that patient satisfaction is higher using bulk type delivery systems the NHS has a legacy of using a plated meal service (Hwang, et. al., 1999). Additionally data from the same survey show that at the time 75% of hospitals use nurses, at least in part, to serve food. Potentially this is a good performance indicator to assess the impact of ward housekeepers by noting a reduction in nurse time spent serving food.

Patient perception is an area also considered by Hwang et. al. (2003). The study investigated the gaps between patients' perceptions and expectations of hospital

meals and their satisfaction with the food services. The gaps between expectations and perceptions were significant for most of the attributes the investigators looked at. Using weighted gap analysis further work completed as part of the same study looked at three dimensions: food properties, interpersonal services, and environmental presentation. According to their findings *"the food dimension was found to be the best predictor of patient satisfaction among the three dimensions, while the interpersonal service dimension was not found to have any correlation with satisfaction"* (Hwang et. al, 2003, pg. 143). The interpersonal dimension consisted of statements describing the attitude of staff, timing of meal delivery, placing of food, helpfulness of staff, individual attentiveness, length of meal-time, and any alternative food provided if a meal was missed. All of these could be considered key ward housekeeper duties, to therefore suggest they have a less of an impact on patient satisfaction undermines the role and also conflicts with the work from Hartwell and Edwards (2003).

More recent work in the area assessing food production systems in hospitals does question the research addressing the topic as subjective and outdated (Assaf, et. al., 2008). The authors claim that there are significant differences between systems with regard to variables such as labour, skill level of employees and size of the production area. This study was confined to a sample of 85 Australian and 11 American hospitals and in spite of cook-chill being the dominant production method employed across these two counties and much of Europe (McCree, 2005), the findings may have limited relevance to UK sites to due the nature of the NHS. Other work looking at how to make decisions on selecting the most appropriate catering production method approach it from the issue of evaluating efficiency, productivity and performance of a particular system (Rodgers, 2005).

Studies focus on the management side of hospital food from the waste perspective. In some cases research indicated that more than 40% of hospital food was wasted (Edwards et. al., 2000; Barton et. al. 2000; Williams et. al., 1998; Dupertuis, 2003). The American based study by Williams et. al. (1998) found that when patients were able to use a "room service" style request for food when they were ready to eat, the patient satisfaction improved significantly and so did the nutritional intake. The work by Kuperberg et. al. (2008) looking at the impact of implementing room service delivery systems in a paediatric hospital also backs up the earlier findings that suggest waste is reduced, satisfaction increased and dietary intake improved using room service.

Catering staff training, development, roles and responsibilities is one area that is considered by several authors (Baum, 2006; Lee-Ross, 1999; Lee-Ross, 2002;). As Diagram 2 above shows, there are multiple staff and stakeholders in the delivery of food to a hospital ward, therefore staff training and development should be considered carefully. The stages involved in hospital catering are multiple and complex. Any part of this hospital food chain from the patients making menu choices through to them actually eating the food can impact upon service provision (Archer, 2000). This contributes to the complexity and challenge when delivering high quality food and good patient satisfaction. There are stages throughout the food delivery process where staff, who are not part of the FM or catering team, are required to contribute to the food journey, for example dieticians and nurses. Diagram 2 above lists ten stages for the delivery of patient food, however, Burke (1997) suggests there could be as many as 16 items that contribute to patients not eating and drinking in hospitals. Xia and McCutcheon (2006) provide a critique of the staff involved in delivering hospital meals to patients, albeit in an Australian context. A lot of the issues they identified such as patients accessing meal, assisting patients to eat, staff (doctors and nurses) and visitor interruptions are addressed in the UK through either protected mealtimes or the use of ward housekeepers.

The issue of outsourced catering production and delivery services is worth discussing briefly. Particularly as this has been a source of debate and discussion for a number of years within the FM domain. In the NHS competitive tendering was introduced in the mid 1980s with the aim to reduce costs and increase efficiency in ancillary services (DHSS, 1983). Typically the studies either argue for or against competitive tendering of FM services (Kelliher, 1996; Bach, 1989; Sheaff, 1988). However, this is of little concern for the ward housekeeping services as the policy was to be implemented without discrimination against NHS Trusts who either managed in-house domestic services or contracted out.

Food safety practices and hygiene is another area of interest for FM and catering staff involved in the delivery of patient meals. The catering system and sequential events involved in delivering patients meals allow for a high degree of contamination. There is evidence to suggest that the decontamination actions on a large number of occasions are frequently inadequate (Clayton and Griffith, 2004). It is estimated that food handler error contributes to 97% of all cases of food related disease in food service organisations and the home (Howes et. al., 1996; Shewmake and Dillon,

1998). This has consequences for the ward housekeeper and particularly the level of training related to food safety and hygiene they receive. Of less importance for the ward housekeeper role is other food safety hygiene issues that have been associated with cost improvements made by hospitals and the use of commercially cooked meat (Regan et. al., 1995). Furthermore there is the issue of patient perception of food safety.

The importance of the actual menu (the tangible item the patients receive to make their food choices, rather than the theoretical one that is examined by dieticians for optimum nutritional value) could be considered important in hospital food and patient satisfaction with catering facilities. However, this appears to be a relatively under researched area, and one that the ward housekeeper wouldn't necessarily be able to make a direct impact on. There is work looking at the impact of menus on consumers (Shoemaker et. al., 2005) and research on the impact of descriptive menus on sales (Painter and Van Ittersum, 2001), however both these studies were undertaken in a retail environment rather than a hospital. Consumer perception research has been applied to hospital menu design. The concept of branding food and adding a description of the dish to the menu has shown that patients prefer this approach (Hartwell and Edwards, 2009).

To conclude the literature review on hospital food it is important to critique the studies on patient satisfaction. The satisfaction studies may be relative to either other FM related factors, or general healthcare factors. The importance of the satisfaction with non-clinical services, including food cannot be underestimated. Angelopoulou et al (1998) suggest that if patients feel unable to judge clinical care they may use hotel services aspects of the service as a proxy for the overall quality. While others (Liyanage & Egbu, 2005, and Ferguson & Lim, 2001) suggest that hotel services are seen by patients as part of an integrated care package, which create lasting impressions and which patients feel they are able to control and influence. In other words they feel they understand these aspects of their service and therefore judge the quality. Todd et al. (2002) carried out an investigation and assessment of attitudes to and perceptions of the built environment of NHS trust hospitals. They stated that if the NHS is to improve the patients' experience an understanding of the nature and basis of stakeholder requirements is essential. Their research identified that patients' perceptions of a hospital ward environment were influenced by factors that affected their ability to eat and sleep, feelings of security or insecurity and issues around privacy (particularly in toilet and washroom areas), as well as being able to

control factors such as lighting and heating in the environment, and being able to see out of the window.

The NHS Plan emerged in part from an exhaustive survey to discover what patients and the public saw as the top priorities for the service. Three of the top 10 were facilities issues: cleanliness, hospital food and a safe warm and comfortable environment (Cole, 2004). A BMA survey undertaken in 2005 found that patients ranked cleanliness in hospitals as the most important spending priority (BBC News, 2005). 2000 patients were asked to rank 10 NHS spending priorities in order of importance, the Better Hospital Food priority was ranked 9 out of 10. However, it has to be remembered that this poll as conducted when the public concern with hospital infections such as MRSA was running very high. Table 1 below shows the full list of public priorities.

Table 1 - BMA Public Spending Priorities 2005

Public priorities (out of 10)
Cleaner hospitals - 9.23
Improved A&E - 8.52
Shorter out-patient waits - 8.42
New treatments research - 8.35
Funds for prevention - 8.07
Better out of hours care - 7.89
Extended GP services - 7.83
More time with a doctor - 7.26
Better hospital food - 6.51
Choice of hospital - 6.43

There have been other surveys completed showing the satisfaction of food in hospitals. Work completed in Switzerland (Stanga et. al., 2003) shows the satisfaction with hospital food from patients, but does not illustrate the relative importance of food compared to other factors. Surprisingly, a high percentage of patients were either satisfied or very satisfied with hospital food (86%) and 78% were satisfied with the way in which the food was served. There was a negative correlation between duration of hospital stay and satisfaction of food. This could be explained by factors such as fatigue and lack of variation with the menu. Overall patients felt that the temperature, appearance and aroma of the food were particularly important. This study was conducted in Switzerland; therefore the context and the relevance to the NHS could be questioned.

Any survey of opinions can be critiqued over the validity of research instrument and therefore the findings, and patient satisfaction surveys are no exception (Cohen et. al., 1996; Williams, 1994; Carr-Hill, 1992; Sitzia, 1997). Nonetheless, in spite of this, the NHS does commission an annual nationwide patient satisfaction survey. This survey includes an element related to "The hospital and ward." This part of the survey has questions on privacy, noise at night, cleanliness, security and the quality of the food. The national NHS patient survey programme is under the responsibility of the Care Quality Commission and is administered by the Picker Institute. The data from the 2009 inpatient survey are currently available and show that of those respondents that had food, 55% rated it as good or very good. There is no change from 2008 but an increase from 2002 when 53% said it was good or very good. In 2009 30% of respondents thought the food was fair. There has been a statistically significant increase from 2008, albeit in less than 1%, in the proportion of respondents who thought the food was poor (14%). Other factors related to food within the survey include whether the patient was always offered choice of hospital food, this stood at 78% in 2009 (no change from 2008). Another 16% said they were offered a choice of food sometimes, and 6% said they were not offered a choice of food during their inpatient stay. Another significant question for the ward housekeeper role asked inpatients whether they received assistance from staff to eat meals. 63% of patients reported that they always received help, this was an increase compared to 2002 when 53% received help. In 2009 19% of patients said they sometimes received help, down from 2002 (24%) and 18% reported they had received no help (the same from 2002) (Care Quality Commission, 2011).

Conclusion

It could now be argued that the relative importance of hospital food is greater than that of cleaning. Certainly this is the argument put forward in the Channel 4 Dispatches programme shown on 21.3.2011. The ward housekeeper has a plural role in the delivery of food to hospital patients. This may be through the distribution and collection of patient menus, assisting patients to make their choice of meal, liaising with the kitchen and catering staff, preparation and distribution of meals and drinks, clearing away of food, monitoring of patient dietary intake, and sometimes assisting patients to eat. This list is not exhaustive, nor is it consistent across all NHS hospital wards. However, it is clear that the ward housekeeper does have an important role to play in what is considered a crucial area of patient care.

Despite the investment in hospital food from the Department of Health over the last decade, the service and provision of food to NHS patients suffers from a similar problem to that of cleaning services, primarily a lack of improvement in standards. The improvement is lacking through either patient satisfaction or using dietetic measures. Sustain provide a comprehensive and useful summary and critique of the investment and relative lack of progress in the NHS.

The NHS appears to be in perpetual change and the provision of food doesn't escape the consequences of this. Without actually quantifying it within this chapter, it is clear there are multiple stakeholders with an interest in hospital food. The complexity of stakeholders is evident at a national level with various agencies acting as policy setters, providing guidance, regulating and advocates. The criticism is a lack of co-ordination across these agencies. Locally hospitals also have to contend with various stakeholders involved in the delivery of food from source to patient.

2.6 Maintenance in the NHS

Introduction

To conclude this chapter is the third area of responsibility for ward housekeepers. This is ward maintenance. Ward housekeepers were not necessarily responsible for the actual physical repair or maintenance of work on the ward. Their duties usually extended to reporting any defects to the relevant department. For this reason it was often overlooked as a core duty for housekeepers and certainly was never as high profile as the cleaning and catering work they undertook.

In terms of setting out patient-focused services, the Department of Health through the guidance first issued for ward housekeepers, (NHS Estates, 2001a) listed "maintenance of the environment" as the key service standard to support the patient experience. Patients must be cared for in a well-maintained environment and all equipment must be in good working order.

The ward housekeeper responsibilities under the heading "maintaining a safe and comfortable environment" include the following areas of work:

	Change window nets and curtains, screen and bed curtains
Linen co-ordination	Prepare beds and handle linen (clean and dirty) according to legal policy
	Maintain the safety of people's belongings and property

	Perform minor maintenance tasks such as oiling hinges, tightening loose screws
	Liaise with estates and works departments in respect of all maintenance
Maintenance	Identify and report all malfunctioning equipment
	Carry out regular equipment monitoring in accordance with procedures
	Change light bulbs

	Respond to requests for general information from patients and visitors
Communication	Maintain confidentiality
	Field complaints to appropriate person

Risk management	Check and maintain a safe and secure environment

Materials management	Receive, unpack, check and put away stores deliveries

Table 2 - Ward housekeeper tasks involved in maintaining the environment (adapted from NHS Estates, 2001a, pg. 9).

The two duties listed in red are those that all ward housekeepers must be able to perform, regardless of their other work and the location they work in. Some of the duties are very basic maintenance. It could be argued that some are more "cleaning" duties rather than maintenance, for example changing window nets and handling linen. Others are clearly maintenance, such as changing light bulbs or oiling door hinges. Some are likely to be associated with "privacy and dignity" such as the safety of people's belongings and property. Other duties outline the need for the ward housekeeper to report and liaise with the estates and maintenance departments. The baseline figures suggested by NHS Estates show that up to 25% of the ward housekeeper time should be dedicated to ward maintenance duties. The remainder of this section now focuses on the FM related published research related to maintenance in healthcare environments.

Review of published literature relating to maintenance in healthcare environments

Out of the three core responsibilities for the ward housekeeper (cleaning, catering and maintenance), the area of maintenance and estate management at ward level is arguable the least researched.

An important starting point when reviewing the empirical evidence is the impact of the built environment and maintenance on the patient and health outcomes. The literature review conducted by Codinhoto et. al. (2009) provides a useful conceptual framework. The paper is more general in that it evaluates the overall built environment on health outcomes, but it does make reference to the importance of the maintenance and estates functions within this. Their literature review suggests that maintenance, cleanliness and decontamination services can have an impact on health outcomes in a number of ways. Particularly as the *"lack of appropriate equipment or maintenance of sub-systems may have extreme consequences"* (Codinhoto et. al., 2009, pg. 144). Other examples they provide are largely focused on contamination and infection through equipment.

There is an, albeit small, amount of research looking at the strategic management of estate services in the NHS (Tanner, 1993; Avis and Dent, 2004). This may not be surprising given that the discipline is usually considered an operational service. Although Tanner (1993) does state that the NHS Estate is one of three major resources used by the NHS (people and finance being the other two). In addition that revenue expenditure associated with the estate can be as much as 30% of total revenue expenditure.

Operationally there are models and frameworks suggested for estates management. In some cases a general conceptual framework for facilities management that might include the estates functions is suggested (McLennan, 2004). McLennan's (2004) paper suggests that a *"successful facility management approach typically uses service management concepts"* ((McLennan, 2004 pg. 347). This and, at the time, the lack of a Standard Industrial Classification (SIC) code formed part of his argument for the use of service management as a conceptual framework. His work showed the "construction services" SIC code was dominant for the FM related companies. If one considers the estate services in isolation from FM, then it becomes hard to argue they are not part of construction services or "real estate and other business activities."

Operationally, estates services are working in a complex set of environments. Nugent (1989) points out that the range of buildings utilised in providing healthcare is wide, non-standard and complex. A lot the NHS estate was inherited from other organisations. Yet the business critical nature of the built environment and the associated maintenance is crucial (Price, 2004). The combination of high business impact (i.e. the impact on health outcomes) and high technological complexity results in the need for careful operational planning of the estates services to ensure the built environment functions correctly.

When reviewing the literature associated with healthcare cleaning and catering the notion of patient perception was discussed. This same concept appears in the research related to estates and maintenance in healthcare environments. This perception is from the perspective of general stakeholders, including patients (Todd et. al., 2002) and from the perception of staff (May and Clark, 2009). May and Clark (2009) attempted to link the perception of estates and maintenance staff to health outcomes. This was in the context of an increasingly consumerist public health service; where did estates services view themselves and could they demonstrate a contribution to patient healthcare? The link between the estates services provided by the builders, maintenance engineers, electrical engineers and grounds staff is unclear. That is not to say the services are not crucial. Quite obviously the hospital electric or gas supply being shut down would be disastrous. However, the actual impact on the patient experience, from the patients' perspective, is hard to assess. In general estates staff appeared to have a neutral view as to the level of importance they believe patients have of the services they provide. In fact only 35% believed that patients felt their jobs were important or very important and 24% believed patients thought it was unimportant or very unimportant. Yet, a large majority of estates staff (93.5%) personally considered their job to be important to the patient experience.

Labour issues have also been studied with regards to estates and maintenance staff (Atkinson and Hall, 2011; May and Askham, 2005). May and Askham (2005) conducted work against the background of a pay reform implemented nationally in the NHS (Agenda for Change). Opinions from senior estates and facilities staff were sought. The focus was on recruitment and retention of their staff. One of the findings suggested that the perceived workplace conditions and environment in the NHS (due to lack of investment in the physical infrastructure) was a limiting factor in recruiting FM and estates staff. Other areas of interest in relation to estates services in the

NHS include the measurement and benchmarking of services (Lavy and Shohet, 2009; Boussabaine and Kirkham, 2006) and outsourcing services with local primary care providers (Ibrahim et. al., 2009).

Conclusion

The maintenance duties for ward housekeepers listed in the NHS Estates guidance (2001a) appear to be a secondary concern behind the catering and cleaning responsibilities. Quite clearly maintenance in healthcare environments is crucial and critical in enabling any facility to deliver the care to patients. Estates and maintenance services in the NHS is relatively under researched. There is no theoretical or conceptual framework to underpin this area. As a result the focus for estates and maintenance studies is rather piecemeal. The published work available that includes discussion on conceptual issues is generalised to the FM discipline, however it does include reference to estates/maintenance and building repairs.

In many ways this piecemeal approach is typified in the aforementioned estates and maintenance duties assigned to the ward housekeeper. The broad range of maintenance duties was perhaps designed for a "catchall" approach for any related work the ward housekeeper might need to undertake. Examples of this are the "liaise with estates and works departments in respect of all maintenance," "identify and report all malfunctioning equipment" and "carry out regular equipment monitoring in accordance with procedures." This is contrasted with some very specific duties such as "change light bulbs" and "perform minor maintenance tasks such as oiling hinges, tightening loose screws."

The research that has been published does appear to focus on operational issues. This is of little surprise and is arguably a reflection of the nature of the actual service.

3. Research Methodology

3.1 Introduction

This section will outline the proposed research methodology and underlying philosophy in the new empirical, evaluative data collection stage. The theoretical framework is discussed and the study is contextualised in the wider general management theory, healthcare and FM organisational structures literature.

The discussion and justification of the research methods for the previous work used as a point of origin or reference is briefly addressed at the start of each section during the findings chapter. Therefore this section is purely concerned with the fieldwork and collection of new data.

The section first briefly considers the philosophical approach to the work, before justifying phenomenology as the research strategy and a case study methodology. The primary method to collect the new data is through the use of semi-structured interviews and this is discussed in detail. To conclude this section, the ethical debate is addressed.

3.2 Philosophical Research Paradigm

A paradigm is a model or framework used to observe or understand how we view reality (Babbie, 2007). This study is situated within a constructivism paradigm. Constructivism is an interpretive paradigm which is critical of positivism, its belief system is firmly routed in one of multiple conflicting realities, and an epistemological assumption that the researcher and that being researched are inextricably linked and fuse together to create and generate knowledge (Guba and Lincoln, 1994). The positivistic paradigm is one which is naive for the social sciences, particularly when the aim of the study is to investigate and interpret in order to understand perceptions with reference to the contextual subjective state (Collis and Hussey, 2003). Positivism aims to explain actions with reference to other variables, an approach redundant for this study. Matthews and Ross (2010, pg. 25) provide a useful summary of constructivism within the social sciences and context of studying social phenomena:

> *"Constructivism asserts that the social phenomena making up our social world are only real in the sense that they are constructed ideas which are continually being reviewed and reworked by those involved in them (the social actors) through social interaction and reflection. There is no social reality apart from the meaning of the social phenomenon for the participants. However, the meanings attributed to and the understandings of a social phenomenon (like an organisation, the family, a community, social care, the law), which are constructed by the social actors, are available for study. Most importantly, the social researcher, as part of the social world herself, brings her own meaning and understandings to her study."*

Thus the research situated as a constructivist piece of work means the research strategy needs to reflect the philosophical paradigm and also complement the objectives of the study. The research strategy allows the philosophical paradigm to be operationalised and thereby illustrating the methods used for empirical inquiry.

Studies grounded within an interpretive paradigm are limited in their choice of research strategy. They include phenomenology, ethnography and hermeneutics (Prasad, 2005). Other major research strategies usually associated under a positivistic paradigm are the experiment and the survey, both of which are not deemed appropriate for this study. Strategies associated with positivism aim to control or manipulate variables, test theories or hypothesis and prove or infer cause and effect. Thus, such strategies are not appropriate for a study which aims to interpret and understand perceptions and comprehend, as far possible, the impact of new NHS roles and reflect this in "their own words."

Phenomenology examines how human beings construct and give meaning to their actions in concrete social situations - participant observation and interviewing are two of the main methods used during the inquiry. Schutz (1962) is credited with the initial application of phenomenology to the social sciences and makes the distinction in the different subject matter between the natural world and the social world. Hence the ontological and epistemological assumptions also differ. Social research or where social research is grounded, is within reality, and therefore this has a meaning for human beings. Human beings act upon these meanings and the interpreted meanings of others. Schutz argues what this means for social research is that the researcher needs to gain access to their "common sense thinking", and interpret understanding from their point of view. The meanings being studied have to be

understood within the context of the situation. Instead of trying to separate the two, the knowledge and context need to be viewed in relation to each other. Knowledge is always local and situated in local cultures - in this case the work place. Holstein & Gubrium (1994) believe that language is the primary symbol system through which the meaning is both constructed and conveyed. According to Van Manen (1990, pg.5) the purposes of phenomenological inquiry are description, interpretation, and critical self-reflection. He outlines the important features that characterise phenomenological research as:

- *Phenomenological research is the study of lived experience*
- *Phenomenological research is the explanation of phenomena as they present themselves to consciousness*
- *Phenomenological research is the study of essences or meaning (depending on the specific approach)*
- *Phenomenological research is the description of the experiential meanings we live as we live them*
- *Phenomenological research is the human scientific study of phenomena*
- *Phenomenological research is the attentive practice of thoughtfulness*
- *Phenomenological research is a search for what it means to be human*
- *Phenomenological research is a poetizing activity*

(Van Manen, 1990, pg.5)

It can sometimes be difficult to actually apply the philosophical position of phenomenology to a practical discipline. Todres and Wheeler (2001) provide an outline of applying phenomenology to health research using the concepts of *grounding*, *reflexivity* and *humanisation*. *Grounding* means taking the basic everyday common experiences as a starting point. The commonplace can be taken for granted, but they have to be questioned and understood in order to "ground" descriptions and clarify meanings and relationships. Any prior assumptions have to be put aside using an open-minded attitude.

Reflexivity encompasses the notion that human beings are self reflective. Things happen in a temporal and historic context and depend on our outlook on the world. Texts and situations are open to multiple interpretations because researchers are involved in their own relationships with the world and others.

Humanisation reflects the lived experiences of the participants; phenomenology must go beyond just quantitative measurement. Phenomenological researchers must gain an insight and extract common themes to and present essential structures of a phenomenon.

It is for these reasons that this particular research is situated within a phenomenological strategy - that is one which seeks to understand the new NHS staff roles from the perspective of senior facilities and estates staff, and to draw upon the contextual basis of the study as a necessary feature. The context being the work place and the underlying mechanisms in place such as agenda for change and the recruitment and retention issues. Basic assumptions and everyday occurrences will be explored. Ultimately an essential structure of the ward housekeeper role will be presented through the evaluation.

There is a dilemma. The positivist paradigm is generally considered as the scientific approach to research. It has its foundations in the natural sciences, particularly experimental research (Hennink et. al., 2011). It would be fair to say that this positivist tradition is still the prevailing paradigm in medicine, clinical trials and generally across health services in the Western World (Fulop et. al., 2001). That is not to say that studies adopting an interpretive approach are not widespread in the NHS. Social sciences (as opposed to the natural sciences) and the study of social phenomenon is important in the NHS. A study of social phenomenon could include anything that influences or can be influenced by human beings who interact with and are responsive to each other (Matthews and Ross, 2010). The huge staff resource in the NHS is one area of focus that is often studied using an interpretive approach (for example Morley and Petty, 2010; Sauer and Anderson, 1992;) or user involvement with services (for example Williams et. al., 2003; Trivedi and Wykes, 2002; Curtis et. al., 2004) and quality/systematic reviews (for example Donovan et. al. 2002; Dixon-Woods and Fitzpatrick, 2001; Kalso et. al., 1997). Using qualitative research in nursing studies is also not uncommon. Qualitative research adopts a person-centred and holistic approach. This helps develop an understanding of human experiences which is important for health professionals who focus on caring, communication and patient interaction (Holloway and Wheeler, 2010).

More recently there has been a trend to shift from the qualitative based exploratory research to a more applied research strategy. Applied research aims at providing

knowledge that can be used in solving practical problems. The findings in applied research may be restricted to descriptive knowledge or explanations. To judge the usefulness of an applied study the criteria of how 'useable' it is to the client must be applied rather than the traditional criteria such as credibility, conformability and transferability - that is not to say that these factors should be discounted (Swanborn, 2010). Although this study has been grounded in the interpretive paradigm and uses traditional qualitative based strategies, the importance of the applied nature of the work has to be stressed.

3.3 Theoretical framework

A theoretical framework is a collection of theories and models from literature which typically underpin positivistic studies. The theoretical framework helps to explain the research question or hypothesis. In a phenomenological study, a theoretical framework is less important or less clear. Sometimes with inductive type studies, the theoretical framework emerges as the work progresses. Much applied research also has no theoretical background. However, this is not to state that theory development is not required for a case study, in fact as part of the design phase it is essential. This does not mean a grand theory (in the social sciences sense). Instead it could be a blue print for the study and the appropriate theory may be descriptive theory (Yin, 2009).

At the centre of this study's theoretical framework is not a grand theory, but the ward housekeeper guidance issued by the Department of Health (NHS Estates, 2001a) and a number of interrelated issues associated with organisational behaviour and structures.

The Department of Health guidance (NHS Estates, 2001a) outlines the conditions for implementation of the ward housekeeper role and provides a framework for its application. It can be argued that this part of the theoretical framework is not "theory" driven, but "application" driven. This is a reflection of the applied nature of this research. The theoretical framework states the conditions under which a particular phenomenon is likely to be found. In this study, part of the theoretical framework is substituted by one which is applied.

The ward housekeeper guidance outlines exactly the conditions for the role within the NHS. The main elements of the ward housekeeper guidance are discussed in detail

within the literature review chapter. This guidance will be used as a substitute for part of the theoretical framework.

Discussing organisational behaviour and structures in wider academic writing allows the work and findings from this study to be contextualised within other paradigms outside of the NHS in the UK. General management writing on power; conflict; overlapping authority; and line staff and functional relationships is considered. In addition management and organisational structures are discussed in relation to healthcare. Finally the core academic writing on facilities management (FM) organisational structures is briefly examined.

General Management

Understanding general management theory and academic writing on the related issues of power, conflict, overlapping authority, line staff and functional relationships allows the study and findings to be of use to others outside the field of FM in the NHS.

"Power" within the work environment is difficult to define and measure. It can be viewed in multiple ways. Power has been defined *"as the capacity of individuals to overcome resistance on the part of others, to exert their will and to produce results consistent with their interests and objectives"* (Huczynski and Buchanan, 2007). Power can also be exerted by groups, sections, departments and organisations over others (Dahl, 1957).

As an abstract concept, there are different viewpoints on power offered. Power can be viewed as property, with three further sub-sets: power as a property of individuals; power as a property of relationships; power as an embedded property of structures (Huczynski and Buchanan, 2007). Power as a property of individuals includes structural sources such as formal position and authority within an organisation, ability to cultivate allies/support, and access to information and resources. In addition there are personal sources of individual power, for example energy, endurance, physical stamina, sensitivity and the ability to read and understand others (Pfeffer, 1992). Power as a property of relationships looks at the "relational" power between a power holder and others (French and Raven, 1958). Followers need to perceive that a leader has access to rewards, sanctions etc. The power is exercised on beliefs, perceptions and desires of the followers. A leader may have access to rewards, but if the followers do not believe in this, it may lead to a lack of power. Conversely, a

leader may lack the capacity or the access to rewards, but will gain confidence and power if the followers are convinced they do. French and Raven (1958) suggest five power bases - reward, coercive, referent (charisma), legitimate and expert. The power bases are interrelated, for example using coercive power may result in an individual losing referent power. Individuals can also operate using several different bases of power in different contexts, environments and with different groups of people. Power as an embedded property of structures focuses on organisational power rather than individual power. It includes how power is exerted in an implicit way and how power is designed into organisations. The argument is that when power becomes embedded it then becomes invisible and difficult to change or challenge (Huczynski and Buchanan, 2007). Departments can become more or less powerful due to a number of power sources:

- Dependency creation - a department is powerful if others depend on their products or services.
- Financial resources - a department responsible for financial control gives it power.
- Centrality of activities - this refers to the degree in which the department is critical to producing the main product or service.
- Non-substitutability - if the product or service cannot be done easily by another department then it is considered to be powerful.
- Uncertainty reduction - departments who can reduce uncertainty can gain power and influence.

(Hickson et. al., 1971)

For this study, the concept of power in the organisation is perhaps most relevant when viewed as groups or departments exerting power over others. The complexity of NHS hospital support services, and particularly the ward housekeeper role which is often simultaneously managed by different departments, suggests that power struggles between departments will be evident.

Conflict is a large area of study within the field of organisational behaviour. Conflict can occur within various contexts (e.g. political, economic, social and psychological) and at different levels (e.g. personal, domestic, organisational, communal, national and international) (Huczynski and Buchanan, 2007). It could be argued that the pluralist reference frame for conflict (Fox, 1966; Fox, 1973) is a best fit for the NHS organisational structures. In terms of conflict, pluralist organisations are a collection

of groups, each with their own interests. Some of the time the interests of the groups will coincide, at other times they will clash and cause conflict. The conflict does not prevent an organisation from functioning. Instead the groups recognise that compromise and negotiation are necessary to achieve common goals (Huczynski and Buchanan, 2007). The study of the ward housekeeper role involves conflict through pluralist organisational behaviour in that FM departments, ward teams, senior staff and even patients will have differing interests that will inevitably lead to disagreements and clashes.

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

Healthcare

During the literature review chapter, the ward housekeeper role operational management responsibilities in healthcare have already been discussed in detail. The role in the context of the wider NHS has also been examined in detail. However, it is worth briefly looking specifically at management structures in healthcare. Healthcare systems - i.e. the provision of services through primary and secondary care and the regional and national structures - are not considered. Instead this section focuses on how hospitals, providing secondary care in the UK organise their clinical, support, and administrative functions (as this setting was the primary focus for the research).

Typically acute hospital facilities would include the following services/departments: accident and emergency, general medicine, geriatrics, obstetrics, gynaecology, paediatrics, general surgery, critical care and trauma/orthopaedics. Occasionally additional specialist services such as cancer care, cardiology, neurosurgery and organ transplantation are delivered through hospital services on a regional basis. More recently, a range of technological, financial and social issues have resulted in a shift in the nature of secondary services from the acute hospital setting into primary care and freestanding treatment centres (Evans, 2006).

Acute hospital trusts require a range of support and administrative functions to ensure they can operate effectively. In some circumstances the support and administrative functions are provided on-site (either in-house or contracted out). Alternative models are otherwise implemented where acute hospital trusts work in partnership with other healthcare organisations and share support services - although this appears more prevalent in community, mental health and primary care settings. The range of support and administrative services at acute hospital trusts might typically include:

- Finance
- Planning and strategy
- Procurement
- Marketing
- Patient and public liaison
- Public relations
- Personnel
- Legal services
- Risk management
- Medical records
- Clinical governance
- Capital projects
- Estates management
- Facilities management
- Training and education
- Pharmacy
- Sterile services
- Infection control

- Supplies and purchasing

(Binley's, 2009)

NHS Hospitals are characteristically made up of around 50% of professionally qualified clinical staff. Approximately 35% of staff are in place to support clinical personal and 15% are there to provide infrastructure support (Department of Health, 2005b). This results in a complex relationship between managers and doctors in the NHS. There is potential for tension and conflict between clinical staff and those administrators who manage patient services. Managers and doctors inhabit different cultural worlds that cannot be totally merged. In addition there are organisational structures in places that present challenges for working styles and behaviours (Brooks, 2006).

FM organisational structures

To conclude this section on the theoretical framework, FM organisational structures will be examined in order to identify wider academic writing on the management and delivery of support services outside the NHS in the UK.

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

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

Finch (2012) also makes a case that FM needs to be considered in an organisation subject to rapid change. How best to deliver FM during organisational change? He

argues that the debate between outsourcing and in-house has now moved on. It is not "whether to outsource" but instead "how to outsource" (Finch, 2012, pg.18). Whilst the NHS might not be subject to rapid change, there is certainly the case to be made that it is in perpetual change.

Despite the lack of empirical research on the organisational structures for FM departments, Cotts et. al. (2010) suggests a number of areas to consider:

- Size of department (can range from one employee - to many hundreds) and span of control
- Single or multiple locations
- Local customs for international settings
- Standardised versus user-driven services
- Outsourcing arrangements
- Centralised versus de-centralised control
- Ownership of property versus leasing

Based on the above considerations Cotts et. al. (2010) recommends that FM departments can be put into one of the following six models based on increasing size:

- Office manager model
- One-location, one site model
- One-location, multiple-sites model
- Public works model
- Multiple-locations, strong regional, or divisional headquarters model
- Fully international model

(Cotts et. al., 2010, pg. 35)

The one-location, one site model is the simplest set-up for a full service facilities department. It is found in organisations that are large enough to have a facilities department and are located at one site in a building or buildings that are owned. The model is heavily weighted towards in-house services. The one location, multiple sites model would have a central HQ and several operational sites or buildings in the same geographic area. This model may have decentralised services in the satellite sites. The public works model is perhaps most suited to that of a hospital NHS Trust. These are unique bodies which include everything required to maintain a large

organisation. They support the public by ensuring infrastructure and facilities are planned, funded, constructed, operated and maintained in a cost effective manner.

The work by Cotts (2010) and Barrett and Baldry (2003) provides a useful discussion on facilities management models in different organisational settings, and offers a case study to demonstrate each type. In their analysis of the public sector model, they provide the following:

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

(Barrett and Baldry, 2003, pg. 7)

The example provided for a public sector model is that of an NHS care trust based in the North West of England. Their case study was made up from three departments:

- PFI and Interim Strategic Project Management
- Property and Estate Development
- Hotel and Estate Operation

The departments were then divided into the following functions:

- domestic/linen/accommodation
- portering/transport/receipt/despatch
- medical electronics and maintenance
- operational estates
- printing services
- security
- catering services
- car parking
- patient services
- reprographic services

- receipt and distribution

(Barrett and Baldry, 2003, pg. 37)

The authors conclude the case study by discussing how the department had transformed their facilities strategies to be more closely aligned with the organisational objectives and core business. The concept of "visibility" of the FM services with the core business was also alluded to. This is important to enable FM departments to show they contribute in other ways that are not just financially driven. Previous work on ward housekeepers (May and Smith, 2003; May and Smith, 2005) and work looking at the contribution of facilities services in the NHS and the impact on patient outcomes (May and Pinder, 2008) supports this.

3.4 Methodology - Case Study

The choice of methodology is largely dictated by the philosophical approach that the researcher decides to adopt (Hussey and Hussey, 1997). The case study, like so many concepts and definitions used in research, has differing and contradictory definitions. Hakim (1987, pg.61) puts forward a simple definition that a case study will *"provide descriptive accounts of one or more cases."* She goes onto to say that *"the case study is the social equivalent of the spotlight or microscope."* Yin (1989) goes on to further define case study research as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. Hence the case study methodology concentrates on a specific entity or phenomenon that has identifiable boundaries. The entity taken as the case should normally be studied in its natural setting, using a holistic approach and employing multiple methods (Stake, 1994; Hakim, 1987; de Vaus; 2001). Thomas (2011) describes the case study as concentrating on one thing in detail and not seeking to generalise from it (the issue of being able to generalise or not is discussed in detail later). The case study is interested in the thing as a whole. He describes the "thing" of focus during the case study as including a person, group, an institution, a county, an event, a period of time and so on. Therefore a wide range of entities could constitute the "thing" in focus.

Having established that the case study is a focus on a particular "thing," and this could be a number of phenomena acting as cases - what examples do authors provide. Typically, social science phenomena studied as part of a case study are diverse, for example:

- *individual health histories or labour market careers*
- *production processes or innovations in organisations*
- *riots, strikes, protest marches*
- *selection procedures*
- *initiation rituals*
- *industrial mergers*
- *collective decision-making*
- *procedures of quality care*
- *attempts to de-bureaucratise a public service sector merger*
- *inter-organisational effort against drug use*
- *implementation process of a governmental policy*
- *alliance formation or war termination between nation-states*
- *socialisation processes*
- *election campaigns*
- *causes of traffic accidents*
- *effects of restrictions on the 'policy space' of policy makers*

(Swanborn, 2010, pg. 5)

The case can be confined to one example (single case study). Alternatively multiple case studies can be used to highlight a common but different experience and then lead to an explanation of these differences. The case study for this research was that of the new ward housekeeper role. Principally the case is the impact since the implementation as a result of the NHS Plan and an evaluation since 2004 when an initial investigation was conducted. This research used multiple cases to explore the differences between hospitals. The boundaries for each of the multiple case studies were the individual NHS Hospital Trusts - or in some cases individual units or wards in NHS Trusts, this was dependent on the scale of implementation of the ward housekeeper service.

The issue of boundaries for a case is one worth exploring. Without establishing boundaries the scope and size for any case study would potentially be limitless. The case study therefore needs to be *"carried out with the boundaries of one social system (the case), or within the boundaries of a few social systems (the cases), such as people, organisations, groups, individuals, local communities or nation-states, in*

which the phenomenon to be studied enrols" (Swanborn, 2010, pg. 13). What does this mean practically? The case study is a frame that offers a boundary to the research. It is an edge that requires a definition at the outset of the study. Defining a timescale also provides history with parameters that can be explored or measured (Thomas, 2011). The boundary for each individual case study (NHS Trust or in some cases ward or unit) has been established. Additionally a time scale has been stated (the implementation in 2000, mid point study in 2004 and further evaluation 2010).

Yin (2009) summarises case study design into four different types based on a 2 x 2 matrix. As already discussed above, he makes a distinction between single case study designs and multiple case study designs. He then further suggests that case studies can either be holistic or include embedded units of analysis. This results in potentially four different case study designs. These are illustrated in the diagram below.

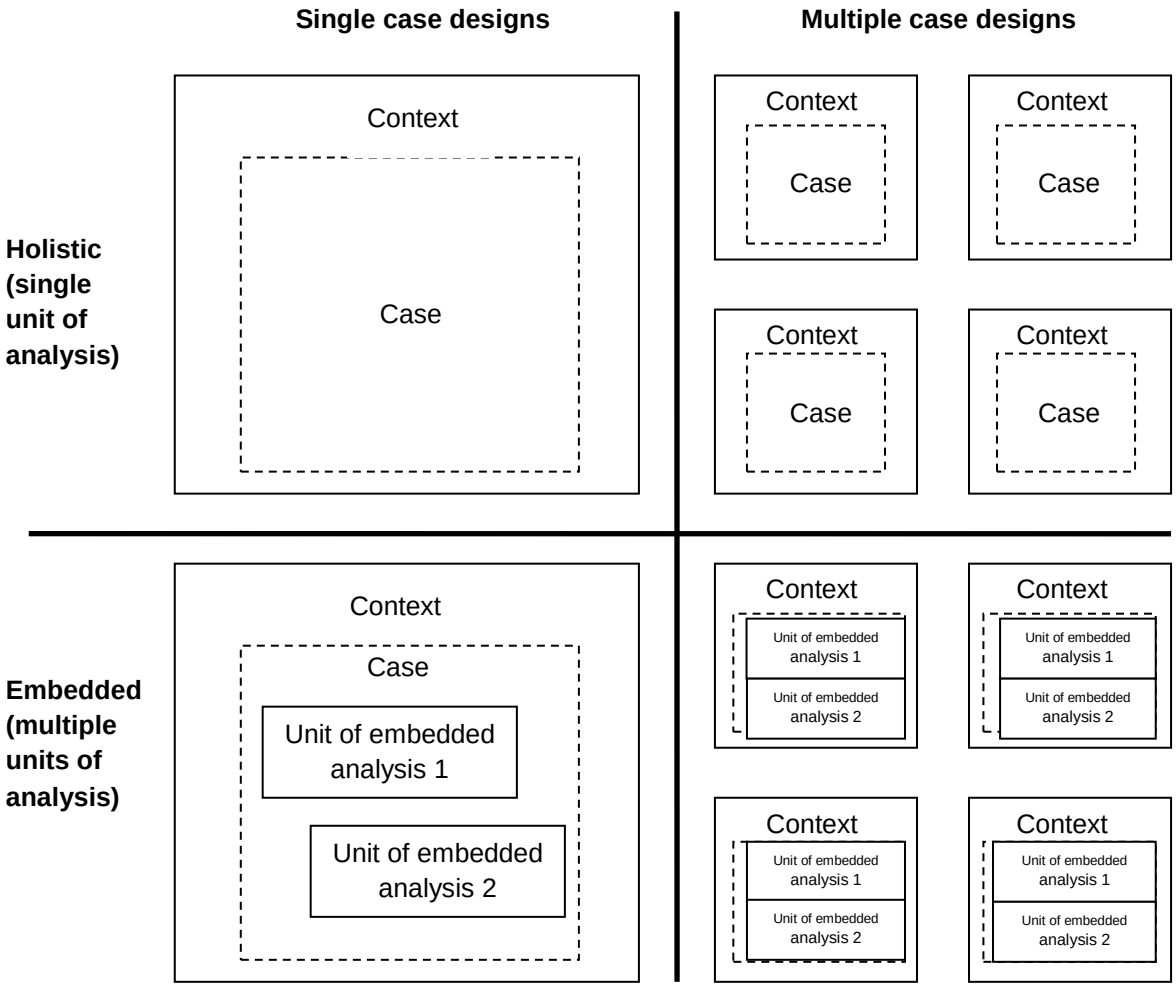


Diagram 3 - Basic types of designs for case studies (Yin, 2009, pg.46)

As already stated, for this study, the case study design was based on the holistic multiple case with single units of analysis - i.e. in the top right quadrant of the matrix. This is where the same study contains more than a single case. The evidence suggests that multiple cases are regarded as more robust (Herriott and Firestone, 1983). However, it should be remembered that two of the NHS Trusts featured as cases are actually longitudinal studies - case study 11 (initial study) and case study 14 (evaluation of the Trust featured in case study 11) - case study 3 and case study 15 (evaluation of the Trust featured in case study 3). Yin (2009) suggests that studying the same single case over a period of time could serve as a single case study design. Although he does further state that there are situations where longitudinal studies may be a multiple case study design instead (for example where the first part is used as a pilot study).

Often the concept of a case study is incorrectly considered as a method. The case study should be thought of as a methodology. The methodology is different to a method. The distinction made is that a methodology is the way in which knowledge and understanding is established. Methodology refers to the overall approach to the research process (Veal, 2011; Hussey and Hussey, 1997). Traditional positivistic studies adopted experimental type design. Experimental design is held up as the gold standard of research. It suggests robustness and trustworthiness. Non-experimental research is often benchmarked (and criticised) against this. However, it is rare in business or organisational type studies to use a true experiment due to the required level of control when dealing with human or organisational behaviour (Bryman and Bell, 2003). A method, on the other hand, is generally accepted as the tool, technique or process to collect data (Hussey and Hussey, 1997). Qualitative, social science based methods were developed from the anthropological disciplines of studying societies. Researchers would involve themselves for long periods of time with the members being studied and in some cases live alongside the community. The qualitative approach to using methods enabled social researchers to gather and work data produced by the participants (Matthews and Ross, 2010). Typical qualitative methods involve interviewing, ethnography or other observational based techniques and focus groups. The research methods adopted for this study are discussed in further detail later during this chapter.

A case study is not a singular tool to be used to collect data, but a holistic approach or strategy used to focus on a particular thing. The "thing" is studied from many angles and in depth (Thomas, 2011). Simons (2009, pg.21) sums the case study as:

> *"Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life' context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic (as in a thesis), programme, policy, institution of system to generate knowledge and/or inform policy development, professional practice and civil or community action."*

To explore this further definition, a useful comparison can be made between the case study and other methodologies. For example a case study would only investigate one case or a small number of cases. A large amount of data would be gathered for each

case and the study would take place in a naturalistic setting. Case studies are generally - although not exclusively - associated with qualitative research, therefore the quantification of data is not a priority. Usually many methods of data collection or sources of data would be utilised. As discussed previously, the overall aim would be to look at the holistic picture and processes involved. To compare this with say the experiment or survey illustrates stark differences. The experiment and survey typically would use a large number of cases (or collect a large amount of individual returns, observations etc.). The experiment is usually conducted in a controlled environment, perhaps a laboratory in order to control variables. Both an experiment and survey seek to quantify the data. A survey is generally accepted as a quantitative social science based methodology. An experiment or survey would use one method of data collection, for example observation and questionnaires respectively. Finally the experiment would try to look for causation and the survey for generalisation (Thomas, 2011; Gomm et. al., 2000).

But why use a case study approach when other alternative methodologies are available? Arguably the decision is based on the research questions. The more the questions seek to explain and describe "how" or "why" some phenomenon works the more the case study will be relevant. Additionally the case study becomes more relevant when questions require an in-depth description (Yin, 2009). The aim of this study is to critically review the ward housekeeper role. This implies a certain level of depth and detail that other methodological choices would be unable to meet. The study involves an investigation and an evaluation over a long period of time. It also utilises the involvement of multiply stakeholders (this is explored in more detail later in this chapter). All of these issues suggest a case study approach is appropriate in these circumstances. Yin (2009) also points out that a case study doesn't require the control of any behavioural elements, yet it does focus on contemporary events.

The criticism of the lack of generalisation is one that is often, somewhat naively, charged at qualitative research. It is worth addressing this issue in relation to case study research. Case study research should not be based on the assumption made by some that all research should be governed by sampling, generalisation and inductive practice. Generalisation is not always wanted from the research process. Inspired and insightful research can result from case studies. Case studies are good for getting a rich picture, and gaining analytical insights (Thomas, 2011). According to Yin (1994) case studies are prone to generalisation, not to populations but to theoretical propositions. His view is that case studies should be treated as new

experiments to test theories. Alternatively Niederkofler (1991) puts forward the argument that with case study research the goal is not to demonstrate the validity of an argument. Instead, it aims to create and expand "rich theoretical frameworks" that are useful in analysing similar cases. Therefore, case study research does not deal with sample to population logic, but with generalising from results to a theory, model or another case. This further backs up the idea of an applied research approach for this study and the usefulness of the findings for other practitioners - perhaps those NHS Trusts wanting to implement a new ward housekeeper model or review their existing provision. See Eisenhardt (1989) for more discussion on case study theory development.

There are other prejudices against the use of case studies as a form of research; for example a lack of rigour, the length they take to complete and lack of randomisation/causal relationships (Yin, 2009). To address the issue of rigour is the responsibility of the researcher or research lead to demonstrate appropriate scientific rigour and good practice to counter any such potential claims. It should be remembered that bias and lack of rigour could be the downfall of any study (for example an experiment, survey etc.) that is poorly conducted and managed. Yin dismisses the time consumption issue pointing out that ethnographies usually involve a long period of time immersed in the field. A case study methodology does not depend solely on the participant-observation element. It could be conducted purely on telephone interviews; therefore the length of time is not always an issue. The importance placed from critics on the importance of establishing casual relationships is downplayed by Yin. He points out that case studies can supplement the evidence from experiments. For example *"for instance, that experiments, though establishing the efficacy of a treatment (or intervention), are limited in their ability to explain how or why the treatment necessarily worked, whereas case studies could investigate such issues"* (Yin, 2009, pg.16).

3.5 Multiple stakeholder involvement

Case study evidence can come from many sources. Yin (2009) suggests that there are six sources; documentation, archival records; interviews; direct observations; participant-observation; physical artefacts. As primary data collection methods (and the principal data collection methods for this study) interviews, observations and participant-observations are dealt with later in this chapter in separate discussions. In

addition to multiple sources of evidence, the case study also utilises multiple stakeholder involvement - perhaps collecting data through interviews or observations.

The case study approach is one that facilitates or encourages multiple stakeholder engagement. Case study research is defined, in part, by the use of several data sources (Swanborn, 2010, Yin, 2009). By adopting a multi-perspective view it takes into account the idea of social constructivism where social reality is created by the individuals involved (Berger and Luckman, 1966; Hosking and Anderson, 1991). A multi-perspective approach also allows for a full picture of the phenomenon being studied within an organisation (Sauer and Anderson, 1992). There are examples of this, although relatively small in number (Bouwen and De Visch 1989; King and Anderson, 1990; Nicholson *et. al.,* 1990).

It is useful to consider the importance of multiple stakeholder involvement during case study research in the context of pluralistic evaluation (Smith and Cantley, 1985). This is also helpful when justifying the use of case study research as opposed to the conventional mode of assessing healthcare through experimental methodologies. Pluralistic evaluation is in itself an alternative evaluative methodology. However, the main principles and guiding arguments are worth exploring as they can be used to justify the multiple stakeholder involvement during case study research.

The main features of pluralistic evaluation include an acknowledgement of the importance of the varied group interests and power bases. The ways in which the multiple groups interact provide a system of checks and balances for the service provided (in this case the ward housekeeper service). In healthcare, Smith and Cantley (1985) state that there is unlikely to be a simple divide between "professionals" and "consumers." Instead, the study would have to be *"sensitized to the importance of understanding the interpretations which professionals, planners, administrators, relatives and patients place upon the operation of the agencies of which they are a part"* (pg. 172). Data should be collected on the groups' interpretations of the success of the service to inform the central evaluation. Any report or project should document the different ideas and notions of success from the different groups, but also take account of the different motives and interests - *"success is a pluralistic notion. It is not a unitary measure"* (pg. 173). Consequently, multiple stakeholder engagement requires multiple methods of data collection - for this study interviews and observations - and thus a form of triangulation. The use of multiple data sources *"reflects the full range of interests, ideologies, interpretations*

and achievements" (pg. 173). Examples of its use include the evaluation of the contribution of integrated nursing teams to teamwork in primary care (Gerrish, 1999), peoples' experiences of stroke services in the community (Hart, 1999), the role of the biological sciences in health care nursing (Jordan *et al*., 2000), nursing/practice development units (Gerrish, 2001) and an adaptation programme for the integration of overseas registered nurses (Gerrish, 2004).

Smith and Cantley (1985) claim the advantages of a pluralistic evaluation to be:

1. It provides a complicated, yet realistic answer to the question of whether the service has been successful or not.
2. The form of evaluation allows the researchers to explain why failures in services provision occur.
3. The explanation opens the ways for change.
4. It details the costs of success. It allows the unanticipated consequences of policy implementation to be documented.
5. It should facilitate the implementation of the research results.
6. Pluralistic evaluation stands a chance of remaining independent and neutral by taking an account of a many perspectives as possible.

In spite of Smith and Cantley's (1985) advocacy over the use of pluralistic evaluation, they do highlight some issues with its use in healthcare settings. One of the key points being that pluralistic evaluation relies heavily on the use of qualitative data - as does this study. Healthcare research, particularly clinically and medically focused work still regards qualitative studies to be far from scientific.

As already discussed, the case study is the methodology adopted for this study. Therefore it wasn't considered as a true pluralistic evaluative study. Nor was it meant to be. It is true that the study was evaluative; however the notion of "success" from the views of the stakeholders as one that should be tested wasn't embraced. Nevertheless, the multiple stakeholder engagement principles that underpin pluralistic evaluation were borrowed. In reality case study methodology recommends the use of multiple stakeholder engagement. Yet pluralistic evaluation totally embeds this notion at the heart of the methodology and it is useful to draw upon these values.

At this stage it is useful to briefly define the stakeholders for this study, who they are and their positions. The methodological discussion related to the sampling strategy -

including recruitment and selection of case study units and individual participants - is covered later in this chapter. Defined stakeholders, for this study include the ward housekeepers, senior ward housekeepers and any other variation of the role utilised by the NHS Trust to perform the housekeeping duties on the ward. In some cases the label or term used to identify this role wasn't a "housekeeper" but instead a "hostess" for example. Other ward based staff included in the study were nurses, HCAs, modern matrons, ward managers and ward clerks. All of these staff groups had an interest in the housekeeping role or housekeeping services more widely. The impact of the housekeeper role on these ward based groups of staff has already been discussed in detail during the literature review. The impact, in some cases, is significant, in fact it was the housekeeper raison d'être. Therefore the need to include the views from these staff is obvious. Where possible the Facilities Director or senior member of the facilities staff was interviewed as part of the study. The initial implementation of the new role was in most cases, the responsibility of the Facilities Director (or equivalent representative from the facilities directorate). This meant their input was important. Other facilities staff interviewed with significant interest as stakeholders included the hotel services manager and/or the housekeeping manager. Both of these positions had some line management responsibilities for housekeeping services. If part of the housekeeping services were outsourced, then representatives from the contracting company were also included.

One group of stakeholders not included were patients or patient representative groups. This was for two reasons. Firstly, the evaluation of the service was from the perspective of internal stakeholders only. This did not include customers, service users or clients - in this case, patients. It could be argued that the internal evaluation was wide spread and comprehensive enough without any external/patient engagement. The second reason why patients were not included was due to their lack of awareness of the role. The findings from some of the early case studies confirmed this lack of awareness. Patients, although aware of the ward housekeeper role, were not necessarily conscious to the fact that it was new, nor were they sensitive to the changes in responsibilities amongst the ward team to accommodate the new role.

3.6 Research Method

The research method is the technique or tool used to collect the data. Logically the method has to align with the initial philosophical position and research strategy. The method allows the actual empirical data to be collected. As Bryman (2001, pg.29) summarises:

> *"A research method is simply a technique for collecting data. It can involve a specific instrument, such as a self-completion questionnaire or structured interview schedule, or participant observation whereby the researcher listens to and watches others."*

Bryman outlines adequately what a research method encapsulates, but it is somewhat simple and fails to recognise the importance of the philosophical position and research strategy in relation to the selected method. Denzin and Lincoln (1994, pg. 353) go on to further explain the importance of the philosophical position when choosing the research method:

> *"The constructionist position tells us that the socially situated researcher creates, through interaction, the realities that constitute the places where empirical materials are collected and analyzed. In such sites, the interpretive practices of qualitative research are implemented. These practices are methods and techniques for producing empirical materials as well as theoretical interpretations of the world."*

The above illustrates that the researcher and the research method are part of the reality in which the inquiry is held. The method is not a separate tool that is used to obtain information from an objective and value free reality, but a method which is used intrinsically in the generation of knowledge; it becomes part of the study. Hence for such an intertwined belief the researcher requires an appropriately chosen method - primarily for this study it involves the qualitative interview.

The interview is not the only method used to collect data for this project. The case study traditionally employs multiple methods and several data sources. These may include using available written or electronic documents, interviews with informants and (participatory) observation (Swanborn, 2011). In terms of primary data collection (new data that is not already in existence), the study utilised both qualitative semi-structured interviews and observation. These two methods are discussed below.

3.6.1 Qualitative Interviews

Qualitative interviewing is one of the most common and powerful methods used within social research to gain an understanding of human beings (Fontana & Frey, 1994). The qualitative interview is the primary research method being employed for this study. But how is a qualitative interview different from perhaps an interview used to collect data during a survey? Mishler (1986, vii) describes this difference by arguing that a qualitative interview is a joint product of what the interviewees and interviewers talk about together, and how they talk with each other. He goes on to say that *"the record of an interview that we researchers make and then use in our work of analysis and interpretation is a representation of that talk."* Miles & Huberman (1994, pg.8) also confirm that a qualitative interview is about knowledge being co-created by stating *"an interview will be a co-elaborated act on the part of both parties, not a gathering of information by one party."*

So the qualitative interview is a method used to generate information during the inquiry, and clearly appropriate when the research is grounded within a phenomenological paradigm - as is for this study. Wengraf (2001, pg.3) provides four key points which he considers the main features of a qualitative (or in-depth) interview, these are:

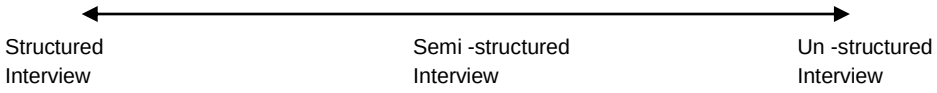
- *The interview is a research interview, are designed for the purpose of improving knowledge*
- *It is a special type of conversation interaction: in some ways it is like other conversations, but it has special features which need to be understood*
- *It has to be planned and prepared for like other forms of research activity, but what is planned is a deliberate, half-scripted or quarter-scripted interview: its questions are only partially prepared in advance (semi-structured), and will*

therefore be largely improvised by you as the interviewer. But only largely: the interview as a whole is a joint production, a co-production, by you and your interviewee

- *It is to go into matters 'in depth'*

Wengraf (2001) also highlights that an interview is a "*co-production*" between interviewee and interviewer and introduces the concept that the interview can be half-scripted or quarter-scripted. Considering this point further, Diagram 4 below illustrates the types of interview by placing them on a continuum which has the highly structured interview at one end, and the unstructured interview or conversation at the other (Bryman and Bell, 2003).

Diagram 4 - Types of interview



The structured interview is arguably not a qualitative method, and is more comfortable under the positivistic paradigm, perhaps used to collect data during a survey when each respondent is asked the same question using exactly the same wording. At the other end of the continuum is the un-structured interview, or perhaps a focused conversation, where the interviewer does not have any set questions or even a set aim/objective for the interview, instead they allow the interview to flow freely and importantly without a script or pre-defined set of questions - perhaps used during ethnographic studies.

Located somewhere in the middle is the semi-structured interview. This involves using a number of predetermined questions and/or special themes. The questions may be asked or covered during the interview in a systematic and consistent order, but the interviewers are allowed freedom to digress - to probe far beyond the answers to their prepared questions (Berg, 1998). Easterby-Smith et. al. (1991) suggest semi-structured interviews are an appropriate method when (amongst other reasons) it is necessary to understand the construct that the interviewee uses as a basis for his or her opinions and beliefs about a particular matter or situation. This is crucial for this study, particularly using a phenomenological strategy, which seeks to understand the context of the knowledge.

There are two main alternatives in which the qualitative semi-structured interview may be conducted - via the telephone or face to face. Doing an interview via the telephone allows the researcher to cover a large geographic area (even internationally) relatively quickly and at low cost. However, this was not a particular issue for this research as the research participants were all based in the UK. With telephone interviews they need to be kept relatively short (15 -20 mins), and the researcher loses the "physical" contact and the advantages of being able to form relationships visually, as well as verbally through rapport. Telephone interviews were not considered as an option in order to collect the data for the case study.

The face to face semi structured interview, although time consuming, enables the researcher to build a relationship with the participant and provides valuable flexibility in the direction the interview takes. Establishing rapport is paramount for a researcher when the goal of qualitative interviews is to "understand." The interviewee must attempt to see the world from the perspective of the respondents, rather than impose the world of academia and preconceptions upon them (Fontana & Frey, 1994).

The approach adopted is an 'informal" semi-structured interview. By this it means the interview being semi-structured in using a number of broad topic areas, with further more detailed questions, or prompt questions, under each topic. However, the aide-memoiré will be used in a 'light touch' way, and this will be explained to the participants. This informal approach will encourage an environment that will allow them to discuss experiences they felt important and relevant. This approach re-enforces the idea that a qualitative interview is a method which allows for a co-construction or co-production of knowledge between interviewer and interviewee - without having to explicitly state the theoretical basis to the interviewee during the interview. See section 3.6.2 on Questionnaire design below for a discussion on the how the questions were constructed and decided for inclusion in the questionnaire.

Semi-structured qualitative interviews are widespread through healthcare related research. Health researchers may wish to interview patients and colleagues to obtain data. Health professionals use interview techniques to elicit information from patients and clients; therefore the use of such tools for research purposes is transferrable (Holloway and Wheeler, 2010). Examples of this type of research method have also been used in studies focusing on similar generic worker roles (Anderson, 1997).

3.6.2 Interview design and interview management

Investigations under case study research should focus on processes, people and their values, expectations, opinions, perceptions, resources, controversies, decisions, relationships and behaviour. Initially the central question could be quite broad before more precise research questions are formulated (Swanborn, 2010). The broad topics and areas to discuss during the interviews are outlined below. As the aim of the study was to critically review the ward housekeeper role and the impact since 2004, the topics and questions for discussion were largely informed by the findings from earlier studies. During the interviews an aide-memoiré was used to help provide some structure. The broad topics for discussion were based around the previous work as an empirical starting point for the critical review. The following areas were used as a discussion:

- Ward housekeeper role
- Recruitment
- Induction
- Training
- Integration (into the ward team)
- Management
- Review / evaluation over period (5 years)

Face-to-face semi-structured interviews were undertaken with staff in each of the selected wards. Interviews were conducted with ward housekeepers, ward managers, health care assistants and nurses. Semi-structured interviews were also undertaken with the facilities director, hotel services manager and housekeeping manager at each trust. Where the NHS Trust contracted out hotel services, including housekeeping arrangements, a representative from the supplier/partner was also included in the interview schedules. The interviews showed how different stakeholder groups in NHS trusts viewed the role and impact of ward housekeepers. See appendix 2 for a list of the interview guides.

The case study at each NHS Trust and the subsequent interviews were all prearranged prior to the visit on site. The arrangements were made through one contact point, usually the Facilities Director or another nominated liaison person in the Facilities Directorate. This enabled an interview schedule to be agreed in

advance of the research visit. Approximately 45 minutes were allocated to each interview slot. Some of the interviews lasted less time - up to 30 minutes, others were longer. This was dependent on how much information each participant was willing to divulge during the interviews.

Interviews were held in a private location on site. This was to reduce any distractions and possible interference with the tape recording of the conversation. Sometimes meetings rooms were booked for the case study interviews. Alternatively, some interviews with the Facilities Directors or Modern Matrons were held in their own private offices. Interviews with ward staff occasionally took place on the ward. However, this was in an interview room that clinical teams used to conduct patient review meetings or confidential meetings.

Data were recorded by using a digital recorder. Key notes were also made during the interview. This served two purposes. One was to start the initial analysis of the interview. Perhaps a key statement was made or something interesting, out of the ordinary mentioned. If this happened then it was noted down for easy reference when writing up the case study. The second purpose for making the notes was to record any points that needed to be followed up during the course of the interview. If the participant mentioned something that wasn't already scheduled to be covered or asked during the interview, yet was important and relevant but needed expanding. A note could be made and the point or issue revisited without interrupting the flow of the interview. Post interview all recordings were transcribed verbatim ready for the data analysis. Further detailed discussion regarding the data analysis is covered in section 3.9 Analytical framework.

3.6.3 Observation

Observation, as a research method, has a long tradition in social research. It is useful in case study and helps to interpret findings and places data from other methods into context. Through observation, a researcher, via a number of methods, can uncover the unspoken rules and informal structures of an organisation (Simons, 2009). Yin (2009) confirms this by suggesting that because the case study should take place in the natural setting it creates opportunities for direct observations. The idea that "scales fall from our eyes" is useful when considering the benefit of using observation during research (DeWalt and DeWalt, 2011).

Observation as a research tool has its roots in the development of hermeneutics and anthropology (Aktinson and Hammersley, 1994). It is worth considering and recognising that observation as a method is usually considered in two ways - as an outsider and detached from the activity being watched or as a participant, being involved (Gillham, 2000). Another way to classify observation can be polarised as formal and informal. Informal approaches are less structured and allow freedom in what information is gathered and how it is recorded. The type of data with informal observation can be unstructured and complex. Formal approaches impose a structure on what is being observed. Only the issues/items specified to be included during the observation are noted, everything else is considered irrelevant (Robson, 2002).

As a research method, the distinction between complete observer and participant observer is rather cumbersome and authors recognise there may be a blurring of the boundaries (Robson, 2002; DeWalt and DeWalt, 2011; Hennink et. al., 2011; Spradley, 1980; Adler and Adler, 1987). Spradley (1980) identifies four levels of participation with the method of participant observation, and these levels are useful to consider for this study. The levels are known as *passive* participation, *moderate* participation, *active* participation and *complete* participation.

Passive participation is when the research is in-situ but acts as a pure observer. The researcher does not interact with people. The role is of a spectator or bystander. With this level of participation, although not covert, those being observed may not know that they are under observation.

Moderate participation occurs when the researcher is present at the scene but does not actively participate. The researcher, however, may occasionally interact with those being observed. This could include structured observation. Examples of moderate observation in health-related research include observation of food intake (Gittelsohn et. al., 1997).

Active participation is when the researcher engages in most of the activities that the participants being observed are doing. This is as a means to learn the cultural rules.

Complete participation the researcher becomes a member of the group that is being studied. The membership of the group is temporary and the move to integrate with

the phenomenon being studied is to allow the researcher to record observations fully (DeWalt and DeWalt, 2011).

There are disadvantages of the complete participative observer role, or "active participation" as Johnson et. al. (2006) prefers to label it. While being treated as an insider does allow privileges to the researcher and opens up new levels of understanding, however there are problems, such as the ability to withdraw and leave the fieldwork. There is also the issue of taking a reflexive stance, as the more the researcher becomes immersed in the community the more they become part of it and the harder to evaluate or reflect on their own impact. There are also the ethical issues when conducting ethnographic work. Even if the researchers make it explicitly clear of their role and the nature of the research, over time the participants and or community - through the process of accepting the researcher as a member - may stop thinking about the researcher and their study (DeWalt and DeWalt, 2011).

For this study, during case studies 14 and 15 where the longitudinal evaluation took place, observation was used to collect data and supplement other primary data collected through the interviews. The type of observation was unstructured or informal in the sense that it was qualitative. There was no structure or guide to instruct the types of activities being observed. The activities undertaken by the ward housekeeper were observed in an informal way. Unstructured interviews were also conducted while completing the observation. The aim of these "conversations" was to enrich the observations and clarify actions as they happened. The level of participation during the observations could be most closely aligned under Spradley's (1980) classification as moderate participation. The use of the unstructured interviews is justification for classing the observation as moderate participation. There was more engagement with the participants than just a passive role as observer. Yet, the observation didn't involve any significant engagement with the activities. Ward cleaning or catering duties were not undertaken by the researcher. Therefore it could not be described as active participation.

Some of the ward housekeepers on each of the selected wards were observed in order to develop a deeper understanding of the way in which they worked with and supported clinical staff. The observation data were used in conjunction with the data received from the semi-structured interviews in order to determine whether the role and perceived impact of ward housekeepers varies according to different implementation models and management structures. Sampling and selection of the

ward housekeepers was non-probable. Two Ward housekeepers were selected to be observed during case studies 14 and 15. The ward housekeepers were suggested by the Facilities Director or senior representative from the Facilities Directorate who acted as a gate keeper during the case study. This was felt to be sufficient in terms of sampling and the amount of observation completed. For the study, primary data collection was completed through the semi-structured interviews. The observation and documentary analysis was used to supplement the interviews and provide further context. Although they were important, the observations were secondary in terms of data collection, therefore the limited number completed and unstructured sampling was justified.

Data collection can be problematic with observational research. Some of the tools to help overcome issues in recording participant observation include establishing a process or system to capture information. Where possible, data should be recorded during the event. Any record of the observation should be gone through shortly afterwards to add detail and unsure understanding (Robson, 2002). The use of field notes is one way in which the observed social situations can be recorded. Field notes taken during observation can become the starting point for the data analysis. Detailed field notes could typically include comments and remarks on multiple elements. For example, the place (setting, sounds, atmosphere), and the people (actions, interactions, conversations) (Hennink, 2011). For the purposes of this study, the data from the observations and unstructured interviews were recorded through the use of written field notes. These were then typed up shortly afterwards at a convenient time.

3.6.4 Document analysis

A third method used during the case studies was making use of secondary data. Stake (1995, pg 68) refers to this as a "document review." He suggests that almost all case studies should use secondary data such as newspapers, annual reports, correspondence and minutes of meetings. Alternatively, secondary data and documents can be thought as "evidence." Documents can provide a formal framework used to relate or contextualise the informal reality (Gillham, 2000).

For this study the types of documents used can be defined as organisational documents (Bryam and Bell, 2003). Organisation documents can include those that are publically available such as annual reports, mission statements, reports to

shareholders and information on websites. Other organisational documents relate to internal publications that may not be publically available. For example a company newsletter, organisational charts, minutes of meetings, manuals for new recruits etc. Organisational documents can provide vital background information on the company or situation being studied in the case study.

This project made use of internal NHS documents to supplement and add context to the interview data. For example, documents used included job descriptions, role descriptions, training manuals, job recruitment adverts, organisational charts and staff resource spreadsheets. The use of documents as evidence within case study research is not without problems and issues. The authenticity, credibility, representativeness and meaning should be considered. Authenticity relates to if the evidence is genuine and unquestionable. Credibility refers to the evidence being error free. Representativeness suggests that the documents should be typical of the kind they represent. Meaning conveys a set of documents that are clear and comprehensible (Scott, 1990). Bryman and Bell (2003) suggest that internal organisational documents are likely to be authentic and meaningful - that is they are clear and comprehensible. The issues of credibility and representativeness still need to be considered when analysing internal documents. Political ideology from particular groups may influence the way in which documents are written and presented.

A framework for interpreting and analysing the documents was not established or deemed necessary. The type of internal organisational documents considered - for example ward housekeeper job descriptions - did not lend themselves to any type of qualitative content analysis or a hermeneutical approach. Nor was it felt necessary to use this type of analysis on the documents. They were used to add context or reinforce the interview or observational data.

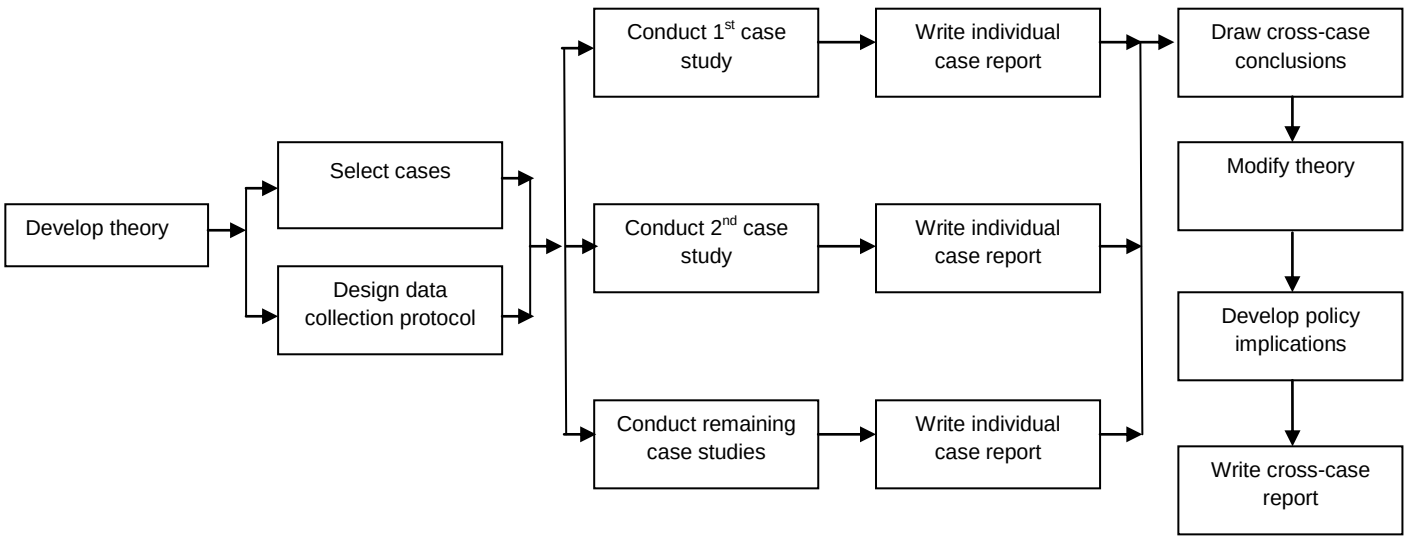
3.7 Selection, sampling and access

For this study the selection and sampling can be considered on two levels. The first level is a selection of NHS Trusts to form the multiple case study design. The second level is sampling and selecting individual respondents to be interviewed to form each case. The former selection dilemma will be considered first.

Yin (2009) suggests that when selecting multiple cases the researcher should consider it in the same way that one would select multiple experiences - that is to follow a replication design. Each case should be selected so that it predicts either i) similar results or ii) predicts contrasting results for anticipatable reasons. An important first step to this is the theoretical framework - for this study the use of the Department of Health ward housekeeper guidance (NHS Estates, 2001a) provides an applied theoretical framework.

The replication logical suggested by Yin circumnavigates the problems of sampling logic (and therefore generalisability) commonly associated with surveys. Sampling logic for surveys are determined by volume of respondents assumed to reflect the entire population. Case studies are not the best methodology in order to assess or measure the prevalence of particular phenomena. Therefore, applying sampling logic to case studies would be wrong. To do so would result in an unmanageably large amount of cases being selected. The relatively small amount of cases selected would also not represent the wider population. The replication logic approach to multiple case study design selection is illustrated in diagram 5 below.

Diagram 5 - Replication approach to multiple-case study design (adapted from Yin, 2009, pg 57)



Although useful as a technique to aid the selection of cases, what Yin's discussion fails to recognise is the compromise evident in most research studies. As well as the replication logic, practically, when choosing a case there are a number of factors that need to be considered - type of case, where it is located, what will yield the most

understanding, travel costs and time (Simons, 2009). Thomas (2011) proposes that case selection should be based on the origin of a case and the subject focus. This is judged on the familiarity with the subject. He categorises case studies as key cases, outlier cases and local knowledge cases. If it is the researcher's own special knowledge that is used to lead to the case then this is a *local knowledge case*. This may lead the researcher to study their own place or work or home. If it isn't the researcher's knowledge that leads to the case then a second question is considered - does the case reveal something by virtual of being special or different? If yes, then it is described as a special or *outlier case*. An outlier case is conspicuously different from the norm. Alternatively, if the case isn't considered as different, but instead chosen because of its inherent interest, then it is termed a *key case*. A key case may be a classic or exemplary case that reveals something from in-depth study.

Selection for the research project was based on the replication approach (Yin, 2009). The study used the NHS Estates Ward Housekeeper guidance as the theoretical framework to sign post subsequent selection of cases based on contrasting conditions and environments. Table 3 below shows the case studies, type of hospital/trust and some notes on the main characteristics of the housekeeper role or housekeeping services. The case studies were also grouped to help the presentation of the findings. The table also illustrates the group for each case study.

Table 3 - Summary of Case Study selection

Case Study	Hospital Type	Main characteristics of housekeeper	Group
1	General	Mainly catering related work, but also responsible for the laundry cupboard, replenishing stores and general tidiness.	Basic ward housekeeper
2	Acute	Purely catering work i.e. ordering and serving patient meals and the clearing of the crockery and cutlery afterwards.	Basic ward housekeeper
3	Acute	Supervisory role, responsible for overseeing all non-clinical work on the ward.	Basic ward housekeeper
4	District	Serving meals, cleaning and tidying the ward, making beds.	Basic ward housekeeper
5	Community	Mainly catering related duties such as ordering and serving patients meals. Some general work such as bed making and checking linen trolleys	Basic ward housekeeper
6	Acute	Mainly focused on cleaning the ward, however they are responsible for serving hot drinks.	Basic ward housekeeper
7	Mental Health and Learning Disabilities	Using housekeepers in acute/long stay in-patients wards and community extended care units.	Ward housekeeper in mental health environments
8	Community and Mental Health	Using ward housekeepers in acute adult inpatient wards and elderly mental illness wards.	Ward housekeeper in mental health environments
9	Primary Care	Using a single ward housekeeper on an adult inpatient mental health unit.	Ward housekeeper in mental health environments

10	Support Service Organisation	The Trust has a children's and adolescent inpatient unit which has one housekeeper.	Ward housekeeper in mental health environments
11	Acute	Large acute hospital Trust - approx. 900 beds. Implemented SWHs 2 years ago, including in the A & E department.	Development of the senior ward housekeeper role
12	General	General hospital Trust - approx. 500 beds. Operating 2 parallel housekeeping models.	Development of the senior ward housekeeper role
13	General	General hospital Trust - approx. 500 beds. Implemented SWH 2 years ago across 85% of the Trust.	Development of the senior ward housekeeper role
14	Acute	Same as case study 11 - repeated as part of the evaluative, longitudinal study.	Evaluative longitudinal case study
15	Acute	Same as case study 3 - repeated as part of the evaluative, longitudinal study.	Evaluative longitudinal case study

Under a multiple case design there is also the question of how many cases is appropriate? Having already established that sampling logic is not necessary for multiple case designs, it follows that the typical criteria regarding sample size is also irrelevant. Instead the number of case studies should be based on discretion and judgemental choice. For example 2 or 3 case studies may be selected to demonstrate the literal replications of the theory. If the theory is subtle or a high degree of certainty is required, then 5 or 6 replications may be required. This may then be followed by a further series of case studies to look at rival explanations of the theory (Yin, 2009). For the first part of the study 13 case studies were selected to investigate the application of the role in a number of different types of Trusts. There were also a combination of ways in which the role had been implemented and the resulting management. Again the number of case studies undertaken tried to reflect some of these combinations. Case studies 14 and 15 were a repeat of case studies 11 and 3 respectively. They were included to allow an evaluative, longitudinal element.

This concludes the discussion on the case study selection. There is also the second sampling and selection issue on how individual respondents were identified to be interviewed inside/within each case. Sampling is the research process by which informants or participants are selected. A good participant is one who has the knowledge and experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate (Morse, 1986). When using surveys, sampling has the key objective to collect information from a representative sample within the population. The prime consideration for qualitative sampling is to select participants based on knowledge or anticipated knowledge - qualitative research in nature is not concerned with making generalisations, but seeks to gain understanding, therefore again as before with the case study selection, random sampling is not necessary, and non-probability techniques can be employed.

Patton (1990) offers a useful typology of "purposeful sampling." He suggests that a mixed purposeful sampling combines various sampling strategies to achieve the desired sample, and is something that helps triangulation, allows for flexibility and meets the needs of this study. The sampling strategy will be a combination of purposive and snowball sampling (Bryman and Bell, 2003). These are both forms of non-probability sampling. Purposeful sampling is generally associated with small, in-depth qualitative based studies. The focus is usually on the exploration and interpretation with these studies and there is no attempt to create a sample that is statistically representative of the population. Participants are selected on the basis of characteristics or experiences directly related to the area of interest (Matthews and Ross, 2010). Theoretical sampling was considered as an alternative. However, this is a sampling approach based on the ideas and principles of Grounded Theory. It assumes the data collection, analysis and sampling are going on concurrently (Glaser and Strauss, 1967). In reality the design for this study was not looking to create Grounded Theory conditions to develop emergent theory.

Matthews and Ross (2010) do provide a useful discussion on the practicalities of using purposive sampling, for example, the need to define the population from which the sample will be drawn. In this study, the population was already established through the case study selection.

There is also the issue of what characteristics are required from the sample selection. These are usually derived from the research question. Staff were identified from each case study (NHS Trust) based on their involvement in the setting up and implementation of the ward housekeeper role - both the strategic and operational elements of the implementation of ward housekeepers. Additionally, staff were identified as having the correct characteristics due to their operational involvement with ward housekeepers. For example, staff selected as part of the sample included ward housekeepers, ward managers, health care assistants, nurses, facilities directors, hotel services managers and housekeeping managers. Where the NHS Trust contracted out hotel services, including housekeeping arrangements, a representative from the supplier/partner was also sampled. In most cases the identification of the appropriate staff to form part of the sample was done in negotiation with the case study gatekeeper. The gatekeeper at each case study was usually the Facilities Director or other senior member of the Facilities department

who had an interest in the ward housekeeping and hotel services. This leads onto the next practical issue which was related to accessibility.

The accessibility of the sample was a key consideration. Particularly given the time pressured environment that stakeholders were operating within. Interviews were conducted during working shift patterns. Therefore finding time to release staff from their working day was a practical issue worthy of consideration. Accessibility for staff was arranged through the gatekeepers. A pre-arranged interview time schedule was the primary method used to manage the issue of accessibility. The time schedule was usually agreed and arranged a number of days before the research visit. The gatekeepers were crucial when arranging the research visits, without them there would have been no access to the study participants. However, there were ethical issues that may lead to gatekeepers controlling or limiting the access to certain individuals in order to maintain a particular image or portray a story. This is explored in more detail in the section below on research ethics.

Snowball sampling or recruitment is usually employed to identify study participants with very specific characteristics, rare experiences or hidden populations. These groups may otherwise be difficult to recruit. Snowball sampling involves asking a study participant whether they know anyone else who meets the study criteria. After interviewing the referred person they are then asked to suggest another who meets the criteria and so on (Hennink et. al., 2011). The issue, similar to purposeful sampling, is that snowball sampling will not be representative of the population (Bryman and Bell, 2003). Snowball sampling was utilised ad-hoc within the study, where the situation allowed deviation from the research visit schedule. For example, a nurse may have suggested that another member of the ward team would also be useful to interview. If time allowed, then they were included in the study and interviewed.

The number of staff sampled was in part limited by relatively finite size of the population drawn from. However, the concept of theoretical saturation was also engaged to decide on the number of staff to sample and therefore the number of interviews conducted. Theoretical sampling means a researcher would carry on collecting data until no new or relevant data was emerging (Strauss and Corbin, 1998).

To conclude the discussion on sampling individual participants; the interviewees (participants) for the research were senior facilities and estates staff at NHS Trusts in England and Wales; ward housekeepers; ward managers; healthcare assistants; nurses; hotel services managers and housekeeping managers. Two of the original case studied NHS Trusts were approached to form part of the longitudinal study (case studies 14 and 15).

3.8 Ethics

This section details the research ethics under consideration for this study. This section deals with research ethics in two ways. Firstly, the sociological debate and discussion surrounding what research ethics is. This includes the dilemmas that qualitative researchers need to consider and the concept of "critical ethics." Secondly this section deals with the guidance set out by the Department of Health under the Research Governance Framework (2005).

Interestingly some prominent case study authors (Yin, 2009; Swanborn, 2010; Gillham, 2000) either fail to recognise the important of research ethics within their research design, or alternatively, choose not to address these issues.

All research that involves human participants raises significant ethical concerns, and researchers have a responsibility to protect participants from harm. Ethics in social research is a complicated area, however Diener & Crandall (1978) break it down into four main areas: (1) Whether there is harm to participants. (2) Whether there is a lack of informed consent. (3) Whether there is an invasion of privacy. (4) Whether there is a deception involved. Diener & Crandall's categorisation of the ethical dilemmas into these four points is on the surface adequate, if what somewhat simplistic. Although they do state that 'harm' to participants includes both the group being studied and the individual. It also includes 'psychological' harm as well as physical. Others take a more pragmatic view regarding research ethics, suggesting, for example, that a researcher should consider the following questions (Thomas, 2011, pg. 69):

- Who is the research benefiting?
- Do you have the right to take up people's time and energy?
- Is there any possible discomfort that participants will have to experience?

- Are you invading participants' privacy?
- Are you diminishing or compromising your participants' standing, of whatever kind, in their communities?

Mason (1996) goes on to introduce how research ethics can also impinge upon the researcher by making two points. Firstly, the rich and detailed character of much qualitative research can mean intimate engagement with the public and private lives of individuals. Secondly, the changing directions of interest and access during the qualitative study mean that new and unexpected ethical dilemmas are likely to arise during the course of the research. This second point was not an issue during this study. Adhering to the sound ethical principals laid out under the Research Governance Framework (2005) avoided any ethical surprises and allowed a plan to deal with any should they arise.

As Simons (2009, pg. 40) points out *"it is wise to not take access granted by a gatekeeper to mean that it covers all in the organisation."* Similarly, it is unwise to assume that the access granted by the gatekeeper to a particular person is without bias. The individual chosen by the gatekeeper to participate may have been selected, not because of their characteristics, but instead because of the picture they will paint or story they will tell that puts the across a certain ideological point. Simons does discuss research ethics in detail and contextualises the issue in relation to the case study design. She also refers the concept of "trust." Unfortunately the concept of trust is applied to seemingly practical considerations rather than any ontological or methodological questions. For example she points out that *"trust is essential to good field relations"* (Simmons, 2009; pg. 100) and implies that trust is aligned with avoiding problems such as being too intrusive, invading privacy, recording participants' perspectives accurately, keeping information confidential and avoiding unfair selection of participants and interpretation of data. However, the role of gatekeeper, and the issue of ethics and trust needs to be considered in the context of truth (in the ethnographic sense). This trust is also two-way. Exposing hidden processes can put the research subject at risk, but what obligation does the researcher have to report this with agreed confidentiality arrangements (Ridley-Duff, 2006)?

Ethical reporting of the research is intertwined with the reporting of the truth. Several stakeholders or parties are likely to be concerned with what is reported. Additionally, participants may well be concerned with how they appear in the report (Robson,

2002). This leads onto two issues. Firstly, will they be willing to report the "truth." Secondly, what assurances can the researcher give over anonymity. Most authors agree that research designs such as experiments and surveys are usually straightforward when it comes to guaranteeing anonymity. However, designs such as case studies where the context is important can pose problems. The usual method to address this is to provide pseudonyms (Robson, 2002; Bryman and Bell, 2003; Veal, 2011; Matthews and Ross, 2010). For this study, instead of using pseudonyms, all names and references to the organisation were removed. The context remained in place within the multiple case study design through the individual units (NHS Trusts).

Most commentators agree there is no absolute ethical decision. Organisations or large overarching bodies (for example the Department of Health, Universities etc.) make ethical decisions based on a consensus. Ethical principles are derived from a democratic model (Simmons, 2009). The way in which research and research ethics are managed and monitored for all health related research is through the Research Governance Framework. Other examples of institutional oversight of research ethics include the British Psychological Society, American Psychological Association, Academy of Management, Market Research Society, Social Research Association, British Sociological Association, Economic and Social Research Council and Barnardos (Robson, 2002; Bryman and Bell, 2003; Matthews and Ross, 2010).

At the time of the study, the National Research Ethics Service (NRES) was the Department of Health arms length body responsible for protecting the rights, safety, dignity and well-being of research participants that were part of clinical trials and other research within the NHS (http://www.nres.npsa.nhs.uk). NRES discriminates between research, audit and service evaluation, and this is an important distinction as it determines whether or not a particular study requires approval under the Research Governance Framework (2005).

The NRES (NPSA, 2008) uses four key discriminators to make a distinction between research, audit and service evaluation. These are:

1. Intent

According to the NRES guidance, the primary aim of the research is to derive new knowledge; audit and service evaluation measure level of care. Research is to find out what *we* should be doing; audit is to find out *if* we are doing. Nevertheless, a project may have more than one intent; in such a case a judgement is needed as to

what the primary aim is. This discriminator is perhaps the hardest to interpret. It is clearly the intention of this study to derive new knowledge (as is the purpose of any PhD). However, in terms of the definition of research from NRES it states that research is finding out what we should be doing. This is not the primary aim of the study. The aim is to review and evaluate and to find out what is being done.

2. Treatment

This discriminator relates to treatment being supported by the clinical community. This is clearly not relevant in this case as the project involves no study of any clinical treatment.

3. Allocation

Again this relates to how treatment is allocated and is not relevant to this study.

4. Randomisation

This discriminator simply states that if randomisation is used it is research. As discussed above, the study will sample using non-probability techniques, therefore randomisation is not used.

While the guidance from NRES does provide some help, it certainly doesn't provide an absolute decision. What is helpful though is the additional information which suggested that a service evaluation or audit usually involves analysis of existing data, but may include administration of a simple interview or questionnaire. Therefore, under the terms of NRES and the Research Governance Framework, the study will be classified as a service evaluation. However, this doesn't mean that the "good" ethical principles of confidentiality, anonymity and informed consent were not followed.

The study also required approval from the Liverpool John Moores University Research Ethics committee[1]. No research conducted as a student at Liverpool John Moores University could be started without full unconditional ethical approval. This involved completing the Research Ethics Committee Application form. The following aspect had to be considered and reported through the application before approval was granted:

[1] I was originally enrolled as a PhD student with Liverpool John Moores University and completed 18 months study there. I then transferred to UCL when my supervisor moved.

- Principal Investigators details
- Experience and qualifications
- Co-applicant details
- Scientific justification
- Purpose, design and methodology of the planned research
- Timetable
- Intervention - i.e. interviews
- Details of any sensitive, embarrassing or upsetting topics
- How the results would be disseminated
- Details on the participants
- Working with vulnerable groups
- Consent arrangements
- Risks and benefits
- Intervention procedures (in case of an emergency, this usually applied to drug trials)
- Adverse effects (again in relation to drug trials)
- Data access and storage
- Declaration from principal investigator

Please see appendix 3 for a copy of the letter confirming ethical approval.

In order to adhere to the recommended ethical principles (at the time of the study) the NRES participant information sheet (see appendix 4) and standard informed consent form (see appendix 5) were used. Information sheets were sent in advance to each participant. These were distributed through the gatekeeper for each case study or in some cases sent directly to each participant. Before the start of each interview participants were asked whether they had received the information sheet and if they understood the research study aims. If necessary, further clarification or information was provided verbally to supplement the participant information sheet. They were also briefed about time constraints and verbally asked if they were happy for the interview to be recorded.

Participants were assured that the study would be both confidential, and they would remain anonymous. The anonymity was assured to all participants, by the removal of names, and references that might identify them. Although it was made clear that direct quotes would be selected and used to illustrate certain points within the

findings. Confidentially was explained that any comments would remain anonymous unless something that divulged that suggested a serious breach of professional misconduct. Given the nature of the research this was deemed highly unlikely, nevertheless, it was important to adhere to good ethical standards and address the issue.

Participants were then asked to sign the consent form. One copy was kept by the participant and a second copy of the consent form was stored for audit purpose in the study file. Ultimately, consent was requested to take part in the research. Participants were also asked to consent that they had read and understood the information provided and had the opportunity to ask questions. They also provided consent in that they understood that their participation was voluntary and they were free to withdraw at any time. Additionally consent was requested for their understanding that the data collected would be anonymised and also remain confidential. The interviews were audio recorded (see below), therefore participants were asked to agree to this and for the use of anonymous direct quotes.

3.9 Analytical framework

Before addressing the data analysis aspect of the research is it worth describing briefly the process by which the data was recorded. With any type of qualitative inquiry, it is important to be clear about the research process, and this includes the way in which data is captured. Often with qualitative research the analysis occurs alongside the data collection, there is no particular moment when analysis starts (Stake, 1995). However, before the analysis of the written record can take place, the oral interview conversation needs to be transformed into a written text in the form of a transcript (Kvale and Brinkmann, 2009). Sound or audio recording of in-depth interviews is common (Veal, 2011). There are other methods that a researcher can use to record data. For example, video recording, note taking or remembering what is said and making notes after the research. Using an audio recording allows what is being said to be captured and frees the interviewer to concentrate on the topic and dynamics of the interview (Kvale and Brinkmann, 2009). There is potentially the downside to audio recording in that participants may feel inhibited that the interview is being recorded (Veal, 2011). All participants were asked for their consent to audio record the interview - see above.

For this study a digital recorder was used to capture the interviews on an mp3 file. Recording the interviews required a private room or quiet space in order to minimise any disruptions or background noise and disturbances. The files were sent to a secretarial service where one secretary transcribed the interviews. Instructions were to transcribe the interviews in a formal written style, albeit still word for word. Verbatim and word-by-word translation is useful for detailed linguistic or conversational analysis (Kvale and Brinkmann, 2009). For this study a more readable account was deemed appropriate. It was felt that any underlying meaning, context or interpretation that was removed during the non-verbatim transcription would be recalled during the reading of the transcripts and checking for accuracy. This was done against the digital audio files after the transcripts were received following transcription. An example of the one of the interview transcripts is available in appendix 6.

There are different approaches to analysing qualitative data - discourse analysis, content analysis, thematic analysis, analytical induction, biographical or narrative analysis and principles from grounded theory (Hennink et. al., 2011; Bryman and Bell, 2003; Collis and Hussey, 2003; Matthews and Ross, 2010). If qualitative research is to yield meaningful and useful results then any data needs to be analysed in a methodical manner (Attride-Stirling, 2011).

The remainder of this section will outline the general strategy for approaching qualitative data analysis adopted in this study. The general strategy of analysis means simply a framework that is meant to guide the analysis of the data (Bryman and Bell, 2003). As discussed above, qualitative research is generally iterative in nature and the analysis of data starts alongside the collection of data. In some cases the implications of analysis influence and change the next steps of the data collection. The main challenges to qualitative data analysis are that there are *"no clear and accepted set of conventions for analysis corresponding to those observed with quantitative data"* (Robson, 1993, pg 370).

One approach is to quantify data in a formal way through content analysis (Easterby-Smith et. al., 1991). Content analysis is a way of converting text to numerical variables for quantitative data analysis. While content analysis of qualitative data may offer some comfort with those concerned with the issues of reliability and validity (Collis and Hussey, 2003). It is not appropriate for this study, as Silverman points out *"its theoretical basis is unclear and its conclusions can often be trite"* (Silverman,

1993, pg.59). To count and record only words or phrases that are considered of interest may mean that large amounts of data that could help with understanding are discarded (Collis and Hussey, 2003).

Some of the tools of grounded theory are useful to help understand and then describe the analytical strategy utilised for this study (Bryman and Bell, 2003; Hennink et.al., 2011). The underlying principles of grounded theory that influence the analysis of qualitative data include:

- Data analysis is an iterative process and not a linear sequential process. Analysis can occur at any point and may overlap with data collection. Initial analysis may then influence future data collection. Data collection and analysis are interlinked. (Dey, 1993; Rubin and Rubin, 2005; Hennick et. al., 2010).

- Verbatim transcripts are used in analysis. This helps the researcher understand and interpret the data from the participants own perspective, i.e. in their own words (Hennick, et. al., 2010)

- Analytical concepts are constructed inductively from the data and not imposed from already established deductive theories (Charmaz, 2006). This could be interpreted to mean that themes, ideas and concepts should emerge from the analysis and interpretation of the data. The researcher should be free to allow concepts to emerge rather than analyse the data from a set of already pre-set ideas.

- A diary and reflexive notes should be kept by the researcher. This helps the transparency of the research process and provides a trail of analytical decisions (Hennick et. al., 2010).

- Analysis goes beyond just description. It also involves interpretation and developing and building explanatory frameworks and potentially theory (Hennick et. al., 2010). Qualitative data analysis points to theory generation rather than theory testing or confirmation. Often, because of the integration of data description and analysis (interpretation) it leads to the presentation of data and analysis to be simultaneously and concurrently displayed.

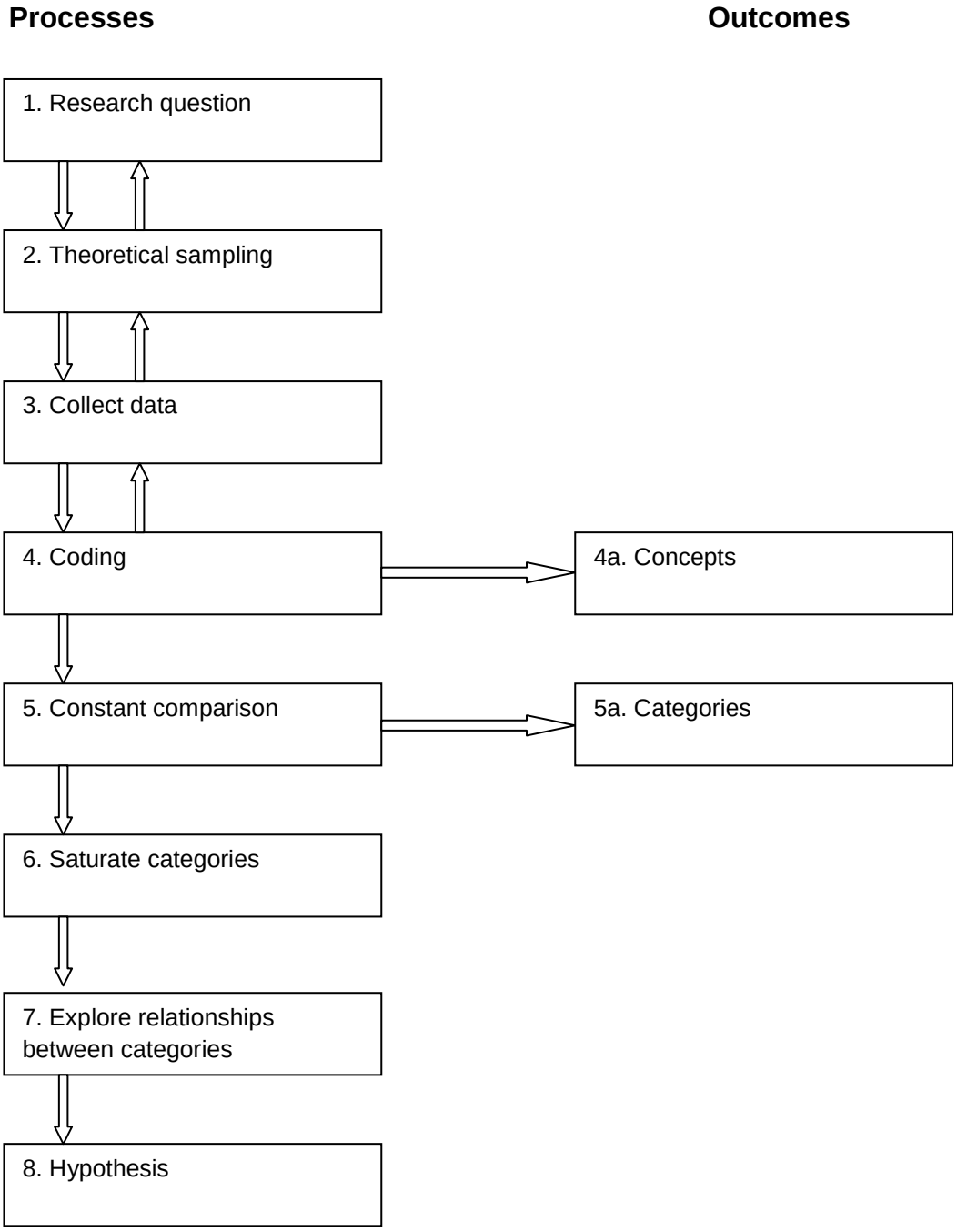
A key pragmatic tool adopted from grounded theory is the concept of coding. This supports the idea that themes and ideas are emergent from the data in an inductive way rather than imposing a set of predefined topics or categories. Coding is one of the *"key processes in grounded theory, whereby data are broken down into component parts, which are given names. It begins soon after the collection of initial data"* (Bryman and Bell, 2003, pg. 428). Charmaz (2000, pg. 515) suggests that *"unlike quantitative research that requires data to fit into pre-conceived standard codes, the researcher's interpretations of data shape his or her emergent codes in ground theory."* Coding involves reviewing transcripts and other data (for example field notes) and providing labels (names) to component parts that seem to be of significance in some way to the study or those being studied. Once coded, the data are treated as potential indicators of concepts and constantly compared back to the original data so the meaning is not lost (Bryman and Bell, 2003). The codes or concepts (Strauss and Corbin, 1998) refer to the building blocks of theory. In order to move from the initial codes or concepts they are placed into categories to develop higher levels of abstractions. An initial code may also serve as a category and have other codes placed underneath it. This process of *"breaking down, examining, comparing, conceptualizing and categorizing data"* (Strauss and Corbin, 1990, pg. 61) is known as open coding.

A further tool from grounded theory used in qualitative data analysis is the idea of constant comparison (Glaser and Strauss, 1967; Hennick, et. al., 2010; Bryman and Bell, 2003). This refers to the process of maintaining a close connection between data and concepts so that the meaning is not lost. The risk of applying codes to chunks of data is that it detextualises it from the original meaning (Collis and Hussey, 2003). Therefore the constant comparison aims to overcome this.

Theoretical sampling has already been discussed in relation to the collection of data. It can also be related to the coding of data. This is where you reach a point where there is no further reason to review the data to see how well they fit with the concepts and categories (Bryman and Bell, 2003).

Diagram 6 below shows one particular interpretation of the qualitative data analysis process, using the grounded theory principles. This has been adapted to show only the stages in relation to those applied in this study.

Diagram 6 - Processes and outcomes in grounded theory data analysis
(Adapted from Bryman and Bell, 2003, pg. 431)



To conclude this section on data analysis a description is provided below outlining the analytical framework adopted for this study. The approach was based around the principles already discussed in relation to grounded theory and qualitative data analysis.

NVivo qualitative analysis software was used to aid the analytical process. NVivo helps researchers manage, shape and make sense of unstructured information. The NVivo software has tools to allow data to be sorted and arranged to identify themes and develop conclusions (QSR International, 2011). NVivo has been previously used in grounded theory studies (Bringer et. al., 2004; Bringer et. al., 2006; Phillips, 2003). However, in this study the NVivo software was simply used as a data warehouse and for its coding analytical capabilities. NVivo is capable of far more advanced applications, and it could be argued that for this study it was applied in a rather basic way (Pease, 2009). In spite of this narrow application of the software, the volume of data produced from the case studies was large, and NVivo was a tool to help manage this and provide an electronic solution to "cutting and pasting" chunks of text. Without this resource, the analytical processes would have been cumbersome and far more time consuming.

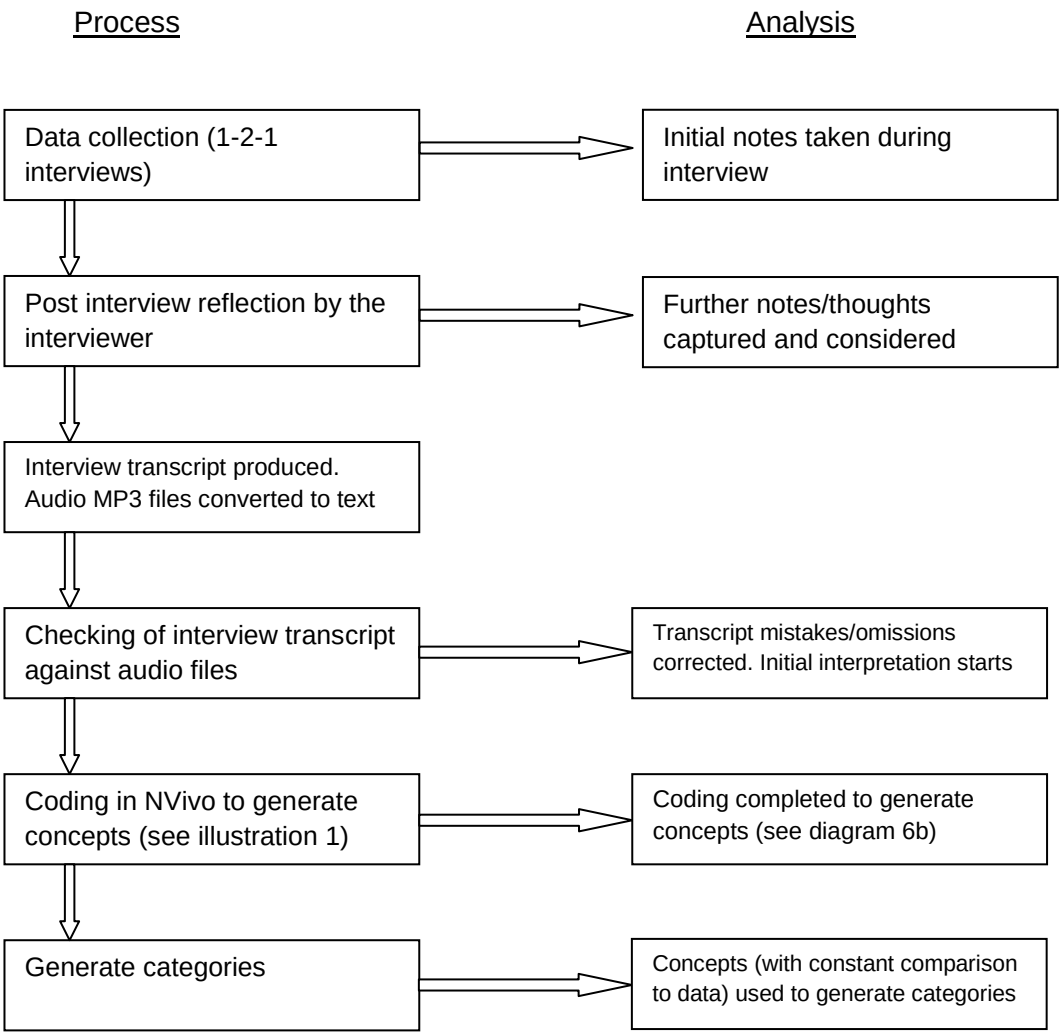
Data analysis started before the production of the transcript. During the data collection stage and the interviews, notes were taken on any pertinent issues raised. This was the first stage of analysis and allowed the initial seeds of ideas and concepts to be planted. The second stage of analysis was a post-interview reflection. This took place immediately after the interviews and resulted in further notes and annotation on the interview guides.

On receipt of the transcription, it was first checked for accuracy. This involved listening back to the recording against the transcript and making any necessary corrections or amendments. Occasionally the acronyms used by participants were incorrectly interpreted and captured in the transcript.

Free analytical concepts (codes) were applied to "chunks" of text in the transcripts. Concepts were constantly compared back to the original interview text in order to confirm and ensure meaning is not lost. Following the generation of concepts a list of codes was produced. The codes were labels or names for the concepts. Following the generation of the concepts/codes, a second level of analysis was completed to try to identify categories. Categories were a higher level of abstraction and used to group together the concepts under certain themes. Constant comparison with the data was again employed to ensure meaning was not lost. This process continued until the saturation of concepts and categories was achieved. Cross analysis between the categories was then conducted in order to explore relationships. For a list of the codes and higher level categories related to case studies 14 and 15 please

see appendix 7. The categories were used as the basis for presenting data under themes in chapter 4 - Findings and Analysis. Diagram 6a below illustrates the process undertaken in order to analyse the data.

Diagram 6a - Process undertaken to analyse the data



The above process was completed for each interview within the case study. This continued until a complete list of concepts and categories had been generated for each case study. For example a category in case study 15 was titled "Training" and it contained the following concepts (see diagram 6b below):

Diagram 6b - Coding to generate concepts

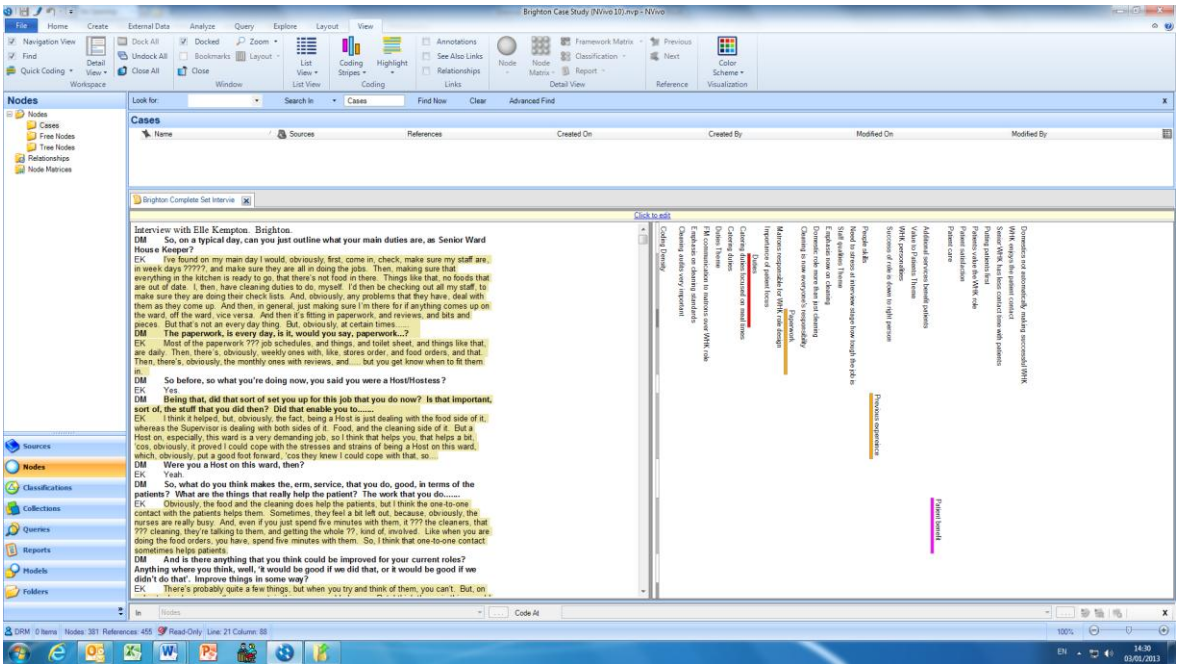
Training (Category)

- Training of WHK
- Training
- Shadowing needs to be done earlier
- NVQ training for WHKs
- Leadership training provided for WHK
- Lack of leadership training
- IT training
- Induction

Concepts

See Illustration 1 below for an example of a coded transcript.

Illustration 1 Example of coded transcript



3.10 Data verification

The section describes the process of data verification through a series of workshop events with research participants and other stakeholders interested in the ward housekeeper role.

Miles and Huberman (1994) suggest that the data analysis is centred on three processes which they call *data reduction*, *data display* and *conclusion drawing and verification.* The first two processes have already been described in detail earlier in

this chapter. It is the last part on data verification that is described below. Data conclusion and verification is the process through which emerging patterns, propositions and explanations are gradually confirmed and verified.

Miles and Huberman (1994) propose a list for verifying conclusions. For example, triangulation, checking on the meaning of outliers, following up surprises and getting feedback from informants. Simons (2009) confirms this and puts forward two main strategies for validation: triangulation and respondent validation. Simons (2009, pg. 131) argues that the latter of these refers to *"checking the accuracy, adequacy and fairness of observations, representations and interpretations of experience with those whom they concern."* Furthermore she proposes that these participants may be people from whom data has been collected for the research, stakeholders who might have an interest in the research or other beneficiaries or audiences who can check the credibility of the case. In one sense respondent validation allows participants to see if they have been represented accurately and fairly. It also allows audiences to decide whether the interpretation is credible (Simons, 2009). Yin (2009), calls this process "A Validating Procedure" in which a draft report is reviewed by not only peers but also the participants and informants. Schatzman and Strauss (1973) refer to the procedure as a way of corroborating the essential facts and evidence presented in a case report. Although Yin (2009, pg. 182) does point out that *"informants and participants may still disagree with an investigator's conclusions and interpretations, but these reviewers should not disagree over the actual facts of the case."*

For this study, the data verification process was managed through a series of workshops in which the data was presented verbally and discussed with an audience that included participants, informants and other stakeholders who had an interest - for example Directors of Facilities and other FM staff at NHS Trusts who were not included within the case studies, but were part of the research group that commissioned the research. Each workshop was interactive and allowed participants to contribute and comment on the findings. Following each event a report was sent to all delegates containing the main findings in a summary form. Please see below for a list of the workshops held and the names of trusts that had participants attending each event:

Workshop 1 10.04.02 London 19 delegates
Representatives from the following organisations attended:

- Brighton & Sussex University Hospitals NHS Trust
- Community Health Sheffield
- Eastbourne Hospitals NHS Trust
- Hull & East Yorkshire Hospital NHS Trust
- Kettering General Hospital
- NHS Estates
- Northern Devon Healthcare NHS Trust
- Oxford Radcliffe Hospitals NHS Trust
- Poole Hospital NHS Trust
- The Princess Alexandra NHS Trust
- Royal Berks & Battle Hospital NHS Trust
- The Royal Marsden NHS Trust
- West Kent Shared Services
- West London Mental Health NHS Trust
- West Sussex Health & Social Care NHS Trust

Workshop 2 14.04.03 London 31 delegates

Representatives from the following organisations attended:

- Berkshire Shared Services Organisation
- Brighton & Sussex University Hospitals NHS Trust
- Community Health Sheffield
- County Durham & Darlington Priority Services NHS Trust
- Havering Primary Care Trust
- Hereford Hospitals NHS Trust
- Hertfordshire Partnership NHS Trust
- Hull & East Riding Community Health
- Kettering General Hospital NHS Trust
- King's College Hospital
- Mid Sussex Primary Care Trust
- Newham Primary Care Trust
- Northern Devon Healthcare NHS Trust
- Portsmouth City Primary Care Trust
- Royal Berkshire & Battle Hospitals NHS Trust
- The Royal Marsden NHS Trust
- Salisbury Health Care NHS Trust
- South Devon Healthcare Trust
- South West London & St George's Mental Health

- West Kent NHS Shared Services Agency
- West London Mental Health NHS Trust
- West Sussex Health & Social Care NHS Trust

Workshop 3 20.04.04 London 41 delegates

Representatives from the following organisations attended:

- Anglia Support Partnership
- Barnet Primary Care Trust
- Bradford Teaching Hospitals NHS Trust
- Brighton & Sussex University Hospitals NHS Trust
- Calderdale & Huddersfield NHS Trust
- East Sussex NHS Trust
- Hereford Hospitals NHS Trust
- Hull & East Riding Community
- King's College Hospital NHS Trust
- Lincolnshire NHS Shared Services
- Northamptonshire Healthcare NHS Trust
- North Tees & Hartlepool NHS Trust
- Poole Hospital NHS Trust
- Portsmouth City Teaching Primary Care Trust
- Royal Berkshire & Battle Hospitals NHS Trust
- Salisbury Health Care NHS Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- Sheffield South West Primary Care Trust
- The Royal Marsden NHS Trust
- The Whittington NHS Trust
- West Kent Shared Services Agency
- West London Mental Health NHS Trust
- Wolverhampton City Primary Care Trust

An additional presentation was also given as part of a special one off event for the Department of Health looking at Ward Housekeepers in mental health environments. The findings from this project were presented at this event to a selected audience of facilities and hotel services managers responsible for housekeeping in NHS trusts.

4. Findings and analysis

This chapter presents the analysed and interpreted data from the case studies. The case studies are grouped together in two ways. Firstly case studies 1 - 13 relate to the initial research completed evaluating the ward housekeeper role. Case studies 14 - 15 relate to the evaluation stage of the research.

Secondly, case studies 1 - 13 are then further grouped together by the type of ward housekeeper at the Trust/organisation. Case studies 1 - 6 relate to a basic ward housekeeper role. Case studies 7 - 10 relate to ward housekeepers in mental health environments. Case studies 11 - 13 relate to the development of the senior ward housekeeper role. The longitudinal evaluative case studies (14 and 15) relate to the senior ward housekeeper role (case study 14) and the basic ward housekeeper role (case study 15). Please see Table 3 - Case Study selection for a summary of the case study selection.

Each group of case studies starts with a short introduction about the research, the context, the type of NHS Trust/Organisation and the characteristics of the ward housekeeper. The research methods are also briefly summarised. The findings from each case study are then presented individually. Each group of case studies is completed with a discussion on the main themes and then a conclusion.

The findings section is a significant element of the thesis and presents and results of the data collection and analysis. As discussed in the previous chapter, qualitative data analysis goes beyond just description it involves interpretation. Due to the nature of the data it means the data presentation and analysis is presented simultaneously and concurrently. Additionally, some of the data is presented in the participants "own words." Therefore certain quotes have been drawn from the transcripts and used selectively throughout the data presentation. This is to illustrate or reinforce certain points, issues etc. where the best way to do this is through using direct quotes.

This chapter starts with the presentation of case studies 1 - 6 which look at the basic ward housekeeper role.

4.1 Ward housekeeper role

4.1.1 Introduction

The following section details the findings from the research undertaken during the initial investigation and subsequent fieldwork into the ward housekeeper role. 55 NHS Trusts took part in the fieldwork in order to undertake an initial evaluation of the various approaches that had been adopted in developing and implementing the ward housekeeper role. A series of six case studies were undertaken that looked at the role across different NHS Trusts. Selection for the case studies was based on the nature of the ward housekeepers' role and their lines of management. Since the NHS Estates guidance insisted that the ward housekeeper be managed on a day-to-day basis by the ward manager, those who fell into this category were considered of greater value for the research.

During the case studies the principle methods of data collection were semi-structured interviews. The interview questions were designed to explore the ward housekeeper core role/duties, management of the role (operationally and strategically), recruitment and selection, pay and conditions, funding of the role, training, team integration, problem areas, suggested improvements, evaluation of the role and the value of the role. Where possible, interviews were conducted at each Trust with the Director of Facilities (or equivalent representative from the facilities department); members of the nursing team (or ward manager); and housekeeper (or a number of housekeepers from different wards). In most instances there were three or four interviews conducted for each case study (a copy of the interview guide can be seen in appendix 2). The interviews were recorded and usually took place in a private meeting room at the hospital. Table 4 summarises the type of hospital during each case study and the main characteristics of the housekeeper.

Table 4 - Summary of case study hospital type and main characteristics of housekeeper

Case Study	Hospital Type	Main characteristics of housekeeper
1	General	Mainly catering related work, but also responsible for the laundry cupboard, replenishing stores and general tidiness.
2	Acute	Purely catering work i.e. ordering and serving patient meals and the clearing of the crockery and cutlery afterwards.
3	Acute	Supervisory role, responsible for overseeing all non-clinical work on the ward.
4	District	Serving meals, cleaning and tidying the ward, making beds.
5	Community	Mainly catering related duties such as ordering and serving patients meals. Some general work such as bed making and checking linen trolleys
6	Acute	Mainly focused on cleaning the ward, however they are responsible for serving hot drinks.

In order to enrich the case study information and provide a fuller picture of the housekeeper role some documentary evidence and financial data was also requested. This included job descriptions, training programmes and pay rates. The interviews were transcribed verbatim and then analysed using content analysis through coding. Several themes arose from the case studies relating to the Trust's experiences of implementing the ward housekeeping service. The main themes identified related to six areas that were:

- Role
- Recruitment
- Induction
- Training
- Integration (into the ward team)
- Management

The findings suggested that, overall the housekeeper role is one that is highly valued by ward clinical staff and welcomed where it has been introduced. The main aim of the role was to take non-clinical duties away from clinical staff so they can spend more time with patients. Previously nurses were responsible for monitoring and ordering stores and supplies, organising repairs, maintenance and chasing these jobs as well as the general tidiness of the ward, all of which leaves them little time to

spend with the patients. At those Trusts where the housekeeper role had recently been introduced, clinical staff see the benefit most since the previous way of working is all too clear to them and still exists on other wards. They were now able to go to a cupboard and the supply was available rather than chasing round to see where it had been left.

4.1.2 Case Study One

The Trust in case study one have Ward Hostesses on 12 wards, and their duties vary to meet the needs of the patients on the ward. Their core role, however, is to maintain the standard of food hygiene and the provision and service of patients' meals, snacks and beverages. In addition, they are there to support ward staff in housekeeping duties such as the linen and suppliers and general tidiness of the ward.

Their role includes distributing menus to patients, assisting and guiding them in their choice, service of meals to patients and providing assistance to patients with eating meals as required. They also clear away meal crockery, provide beverages throughout the day and inform the nursing staff about patients food intake at meal times. Their other duties include clearing up drink and food spillages, ensuring laundry is topped up and put away on delivery, replenishing stores and ensuring cupboards are kept tidy; daily and weekly cleansing duties; removing rubbish; and lifting light goods and equipment.

There is also a Senior Ward Hostess who acts as a direct link between the Hotel Services Department and the wards, and they ensure that the quality of the service is maintained at ward level. This senior role involves training the Ward Hostesses, overseeing the service at ward level and implementing policies and directives.

The nature of the role has changed over the years as has its lines of responsibility and management. Originally the Ward Hostesses were managed by ward and nursing staff, and then Hotel Services were approached to take over this responsibility, several years before the role was advocated in the NHS Plan. Because of the nature of the role, the catering manager is responsible for the overall management of holidays and sickness cover, but day-to-day management is devolved to the ward manager.

Ward managers are encouraged to be involved in the recruitment and selection of the Ward Hostesses. Over the years Hotel Services have formulated a generic job description for this role which is adapted to meet the needs of the ward following consultation with the ward managers. Hotel Services then advertise the role and both are involved in interviewing the candidates. The Trust has experienced some problems with recruiting for the NHS Plan pilot wards mainly because of the initially temporary nature of the role (6 months) and unsociable hours that they are recruiting for (7.30am - 1.00pm or 2.30pm - 6.00pm).

The majority of the Ward Hostesses are funded by individual wards or from the nursing budget. The NHS Plan pilot wards have been funded by the Trust Board and although they are now coming to an end the Board has allocated further funding. This clearly demonstrates the commitment of the Trust to this role in improving the service provided to patients and nursing staff.

On recruitment to the Trust, the Ward Hostess receives information on the Trusts' and Department's policies and procedures. Initial training covers Food Hygiene, Manual Handling, Health & Safety, Fire, COSHH and First Aid. This training is undertaken by a number of key contacts for the role including the dietician, catering and ward managers. There were no problems with integrating the Ward Hostesses into the ward team. This was primarily because the demand for the role is driven by ward staff and for the majority it is funded at ward level. The nurses accept the Hostess as part of their team and the Ward Hostess feels part of the team, *"well if you're a nurse they're only too pleased to work with you for bettering the health of patients, so it's a team effort"* (Ward Hostess).

There was a problem, however, on one ward where the ward manager was less committed to the role, and failed to understand that they were part of the ward team, "*you've got a good manager on the ward with good skills who can handle staff, deal with problems and realise the problems that arise, then it'll work. But if you've got a manager who hasn't got the right skills it doesn't work. It works eventually but it's a slower process"* (Hotel Service Manager).

A further problem experienced at this Trust following the introduction of the Ward Hostess resulted from a lack of communication between all ward team members. On one of the NHS Plan trial wards, auxiliary nurses were less welcoming to the new role than the nursing staff, as they felt the Ward Hostess's duties encroached onto

theirs. They resented losing some of their original tasks to the Hostess which led to a short period of unsettlement and anxiety. This was resolved by the Catering Manager speaking to the Ward Manager and going through the problems and solutions who then relayed this back to the auxiliary nurses and other members of the ward team.

The value of the role is widely recognised by the Hotel Services Manager, Nurses, Dieticians, Patients and the Ward Hostess themselves. The Hotel Services Manager has noticed that there's less food wastage on wards that have Ward Hostesses because patients get what they ask for and at a more rapidly- although the evidence is only anecdotal. Previously if nurses were dealing with an urgent case on the ward when the meal trolley arrived, they would have to deal with the crisis and patients would have to wait for their meals. Now that there is a delegated person to serve food to patients and make sure that they get what they want, there is less waste. Because the same person then clears away after meal times they are able to provide feedback to the dieticians on what patients have and have not eaten.

The Nurses see the most value of the Ward Hostess as they have taken many non-clinical roles and responsibilities from them. With having one individual responsible for patient meals helps to get the meals through at a faster rate, but also ensures that the patients get what they want which is important for their nutritional care. The Ward Hostess is also able to make beverages for patients and visitors outside of meal times which nurses previously struggled to do as their priority is to deal with clinical issues. Overall, the nurses acknowledge that "*it's a really good contribution really, as I say it benefits both the staff and the patients, so I think it's a valuable contribution"* (Nurse).

Table 5 - Case Study One Summary

Type of Trust	**General**
Role	Mainly catering related work, but also responsible for the laundry cupboard, replenishing stores and general tidiness
Recruitment	Hotel services responsible for recruitment with some input from ward managers
Induction	Not known
Training	Food Hygiene, Manual Handling, Health & Safety, Fire, COSHH and First Aid.
Integration	Can be problems with integration if the role is not fully communicated and the ward manager is not committed
Management	Catering manager with some input from ward manager

4.1.3 Case Study Two

Hotel Services at this Trust provide every ward with a dedicated Ward Housekeeper and a Waiter/ Waitress. The Ward Housekeeper is essentially a domestic who works solely on the ward, with their main duty to provide cleaning services in the clinical areas. The Ward Waiter/ Waitress on the other hand is part of the ward team and is closer to the recommendations made by NHS Estates (2001a) for the new ward based non-clinical role. Their job is to work as a part of the ward team and to ensure patients receive meals and drinks that meet their preferences and needs during their hospital stay.

To do this the Waitress assists patients with their choice of food and drink and explains the procedure for ad hoc catering requests. When the meals arrive on the ward the waitress plates them up to meet the requirements specified by the patient in terms of their choice and portion size. They prepare the patients eating environment and ensure crockery and cutlery is available, and clear away when patients have finished. Because the same member of staff is involved in the meal selection, distribution and removal they are able to note the patients' experience of the food service, and are integral in providing appropriate feedback to the nurses, caterers and dieticians on this.

They are also responsible for the cleanliness of the ward kitchen and reporting any maintenance problems with kitchen equipment to their Supervisor. The waitress also maintains adequate stock levels in the kitchen to meet the needs of the patient, such as milk, bread, tea, coffee, cereal and preserves and ensures they are stored safely and appropriately.

The waitress reports to the Patient Food Service Manager but is accountable to the Housekeeping Supervisor and the Ward Manager. Management of the role is therefore jointly undertaken by Hotel Services and the Ward team. Hotel Services are responsible for organising cover in the case of holidays or sickness absence. The waitress is aware of their daily duties, but the nurses can assign any additional duties to the waitress without first gaining approval from Hotel Services. If the waitress had any problems that could not be resolved by themselves or staff on the ward then they would go to the Housekeeping Supervisor.

Recruitment of the Ward Waitress is undertaken by the Hotel Services department and includes the Patient Food Services Manager and the Housekeeping Supervisor. Ward staff are not currently involved in this procedure. Once recruited, there is an induction programme that covers the basics of cleaning and food services that the waitress would need.

Following the introduction of the NHS Plan and the emphasis on the patient as a consumer of healthcare, the Management Board at the Trust had increasingly become interested in the role of the Ward Housekeeper and the Ward Waitress. The Hotel Services Manager reports to the Trust Board about developments in the roles at regular intervals and feedback is filtered down to the rest of the department through meetings and newsletters. Although the day-to-day management of the waitress is ward based, the role is funded by Hotel Services. Ward based management however assists with the integration of the waitress into the ward team, but this is determined by the personalities of the clinical staff. Further indicators of the ward waitresses' integration into the ward team is that they are included in the social events organised by ward staff.

The Hotel Service supervisors and managers recommend that improvements to the service could be made primarily with more hours on the ward. Their current shift is from 7.30 a.m. - 3.00 p.m. to cover breakfasts and lunches, and then an evening waitress comes on at 4.00 p.m. - 5.30 p.m. to cover the evening meal, but with sickness and recruitment they are having difficulty finding cover for the evening waitress. The nurses recognise the disadvantage of not having a dedicated evening waitress following their experience of having their own waitress throughout the day.

Having a dedicated worker to order, plate up the bulk meal service to meet the needs and preferences of the patients, note food wastage and clear away afterwards, takes the onus off the nursing staff. They also benefit from a reduction in non-clinical interruptions throughout the day when patients request hot or cold beverages or snacks.

Table 6 - Case Study Two Summary

Type of Trust	**Acute**
Role	Purely catering work i.e. ordering and serving patient meals and the clearing of the crockery and cutlery afterwards
Recruitment	Undertaken by Hotel Services department. Ward staff not involved in the process
Induction	Induction programme that covers the basics of cleaning and food services required for the job
Training	Not known
Integration	Ward based management assists with the integration of the waitress into the ward team
Management	Management of the role is jointly undertaken by Hotel Services and the Ward team. Waitress reports to the Patient Food Service Manager, but the ward manager for day to day activities

4.1.4 Case Study Three

The Trust in case study three created a brand new Ward Housekeeper role that was based on the recommendations of the NHS Plan. At the time of the NHS Plan being published they had a pilot role in place that was refined and developed in order to meet the ward housekeeper criteria.

A structured approach was adopted in designing the role and selecting the wards where the pilots would be best placed. An initial working group was established headed by the Assistant Director of Facilities. This included all nurse managers and nurse advisors (role between nurse manager and the nurse). In addition, there was a sub-group that was led by the Hotel Services Manager and comprised all ward managers from the pilot wards as well as representatives of the Domestic and Catering contractors that provided these services to the Trust.

Selection of the trial wards was based on a number of criteria that also allowed the evaluation of the role. A variety of ward types were selected that were perceived to be poor performers according to staff and patient satisfaction surveys; staff absence

rates (clinical and non-clinical staff); internal PEAT inspection results; underfunded nursing budgets.

The working group designed the core job description based on the Ward Housekeeper guidance (NHS Estates, 2001a), and then tailored the role to meet the specific needs of each pilot ward. At the time, every ward at the Trust had a dedicated Domestic who cleaned the ward and an Assistant Housekeeper who was responsible for the menu collation, bringing in patient meals and clearing them away. As per the guidance, the Ward Housekeeper role was at a supervisory level between the Assistant Housekeeper and the Ward Manager and they co-ordinated the hotel services in the ward area and worked as a part of the team to ensure the ward environment was clean and safe. The job description outlined that the Ward Housekeeper was responsible for overseeing the duties of the Domestic. This included monitoring and maintaining cleaning standards of the ward; spot cleaning such as spillages; upkeep of ward appearance such as removing clutter and updating notice boards; maintaining the upkeep of patients bedded area; assist in bed making where appropriate; and maintaining linen stocks and ensuring linen staff are notified of returns.

They also oversee the work of the Assistant Housekeeper in their catering duties. This includes assisting patients, where appropriate, in ordering food (including 24hour snack box service); preparing the environment for eating; facilitating the serving and delivery of meals; ensure the kitchen area is kept in order including stock rotation, defrosting fridge; ensure food trolley is cleaned and maintained in working order; and ensure patients water jugs are refilled twice daily. There are also estates related duties included on the job description. They are responsible for the management of the wards defect log book, ensuring all defects are logged, reported, recorded and closed down as appropriate; liaising with the Estates Generic worker, Estates Helpline and other Estates operatives; and establishing progress with incomplete works and requests.

For the period of the trial the Ward Housekeeper reported to the Ward Manager for day-to-day issues. Holidays, sickness cover and work scheduling for the Ward Housekeeper was also the responsibility of the Ward Manager. The sub working group comprising the ward managers and the Hotel Services Manager were quite specific about the type of person that would make the role a success. Because it was a new role they felt that the individual would have to be outgoing, resilient to those

who resisted change and be able to deal with problems. Ideally they were looking for experience working in the hotel or hospitality industry.

They had over 50 applications for the first 4 Ward Housekeeper posts including several nursing auxiliaries. The pilot roles were funded from the nursing budget (where money was left due to nursing recruitment difficulties) and the ward managers from each of the pilot wards and the Hotel Services Manager interviewed for the role. Training for the new recruits was designed to include ward based, non-ward based and mandatory training. The mandatory Trust training incorporated the basic induction (and departmental) programme with a safety induction (fire, H&S, manual handling, COSHH and NAPPI). The non-ward based training focused on the catering aspects of the role (e.g. food hygiene and handling) and customer care/communication skills. The ward based training was around the skills they would need to conduct their job. A Ward Housekeeper training manual was complied in order for them to use as a reference document. The manual contained details of the NHS Plan including the Ward Housekeeper's involvement, Better Hospital Food and Best Practice; Monitoring including quality monitoring, internal and external monitoring and PEAT auditing; and a sample of the Service Level Agreement for the ward on which the Ward Housekeeper is based.

The Trust appears to have successfully integrated the Ward Housekeeper into the ward teams. Through a combination of having the Housekeeper managed by the Ward Manager, by involving the Ward Manager in designing the role and involving ward staff during the recruitment and selection process it enabled the integration.

There were some initial problems from the Domestic staff who were unclear about the role of the Ward Housekeeper and thought that they were infringing on their role and a further level of supervision for them. This was resolved by including the Domestic Contractors on the Working Group, who were then able to reiterate this to their staff. Although the Ward Housekeeper is responsible for the cleanliness of the ward, it was explained to the domestics that they are there to help them and they have a common goal to provide a service for patients.

After the completion of the trial period it highlighted a number of improvements that could be made to the role. Firstly, the induction training that the Ward Housekeepers received was run in the first two weeks, and although they recognised that this was a lot of information to take in but very useful, it would have been of greater use if they

had had some time on the ward first. Their understanding of where the training fits in and being able to apply what they had learnt would have been better if they had had the opportunity to familiarise themselves with the ways of working first. They have also identified a need for a closer and more structured working relationship between the Ward Housekeeper and the Domestic contractor. Further evaluation of the role was planned to take place through various KPIs such as staff absence rates, PEAT inspections and patient surveys. However, early anecdotal evidence and feedback from ward staff indicated that the implementation of the role had been a positive experience.

The role will be fully evaluated at the end of the 6 month trial period according to the factors by which the trial wards were selected (e.g. staff absence rates, PEAT inspections, patient surveys) but the value of the role is clear to Facilities and Ward staff alike. One Ward Sister admitted *" I certainly think that the ward has changed since *** (the ward housekeeper) started. She's certainly taken not a lot of responsibility, but a lot of things off my shoulders from the point of view of overseeing things when I'm not here - stores, supplies, the cleaners, keeping on top of the cleaners, the ward hostesses….and chasing up works, jobs that actually need chasing up as well that I haven't got the time to be looking in the book all the time to see when this was recorded."*

Table 7 - Case Study Three Summary

Type of Trust	**Acute**
Role	Supervisory role, responsible for overseeing all non-clinical work on the ward
Recruitment	Ward managers and the Hotel Services Manager conduct the interviews
Induction	The mandatory trust and departmental training incorporated safety induction (fire, H&S, manual handling, COSHH and NAPPI)
Training	Training included ward based, non-ward based and mandatory training. Training manual put together
Integration	Successful integration through the ward managers being involved in designing the role, recruitment and on-going management
Management	Day to day management through ward managers. Hotel services department oversaw the implementation of the project

4.1.5 Case Study Four

The Trust introduced Ward Housekeepers several years ago, and 12 of the wards use a housekeeping model with a total of 40 ward housekeepers in the Trust. The hotel services, including the ward housekeeper position, are sub contracted out to a third party supplier. The role is tailored to meet the individual ward requirements and is funded through ward budgets with on average 2 housekeepers per ward. When the new housekeeping structure was introduced the level of service was agreed by the ward managers and sisters. The basic housekeeper role includes serving patient food and drinks on the ward, clearing away after meals, cleaning the ward and the general tidiness on the ward.

Before the ward housekeeper role was introduced the nursing auxiliaries dealt with patient food and dedicated domestics handled the cleaning. Since the introduction of the ward housekeeper it has allowed the nurses and nursing auxiliaries to focus on the clinical and patient care, as explained by the Contract Manager, *"It takes the strain away from the nurse life,..... it gives them a chance to carry on with their job while we get on with our job, and we do the food side best rather than a nurse spending the time feeding a patient or actually taking the food to the patient."*

The line management of ward housekeepers is based on one of the models proposed in the NHS Plan (Department of Health, 2000). The domestic services within the hospital are sub-contracted to a supplier, therefore for training, sickness, holidays etc. the ward housekeepers are managed by the contracts supervisor (who also deals with HR and payroll issues). Day to day management is handled by the Ward Sister. Any strategic decisions are in the first instance taken by the Trust's Facilities Manager.

The recruitment of new ward housekeepers is the responsibility of the contractors. Adverts are placed in the local papers and job centres. The Ward Sister and nursing staff were keen to get involved in the recruitment process and see it as crucial when picking, what they consider to be, a new member of the ward team. However the location, like many other parts of the country, suffers problems when trying to recruit domestic and housekeeping staff. This is also made worse due to the pay and hours (the worst times to recruit to are the weekend and evening shifts) which are offered in

the roles. The NHS Plan outlines that ward staff should be involved in the recruitment process but as the Facilities Manager points out, sometimes they are lucky to have people applying for the jobs and they can't hand pick the best people as they simply aren't available and applying for the jobs *"because of what we pay our staff, which is probably a nation-wide thing, we are actually happy to get people to come for an interview..... we are in a really lucky position if we do get a load of people yes, so its like you have to weigh it all up really, sometimes its like you're so desperate to recruit you do try and allocate accordingly."*

New housekeepers receive an induction course which is carried out by the contractors. There is also a formal training programme for the cleaning procedures which involves class room training. However the majority of the training is 'hands-on' and involves the new recruits spending two weeks alongside a housekeeper. As part of the cleaning training, the ward housekeepers receive the BICs (British Institute of Cleaning) certified course. The catering training required for the role was dealt with by the contract catering manager. The catering training appeared to be dealt with in an informal way. This is apparent when the ward housekeepers were asked what catering training they had received and if they were happy with it when changing jobs from a domestic to a housekeeper *"No the kitchen supervisor came over didn't she, and showed us how to do it all"* and *"We trained ourselves really didn't we."*

In general, participants felt the integration of housekeepers into the ward team had been achieved. It was something which the ward housekeepers, nurses and contractors felt was important to the role and all encouraged team working at ward level. Previously when the housekeepers were still working and known as domestics they were not perceived as part of the ward team as much. Some of the benefits from ward housekeeper integration (and the benefit of having dedicated housekeepers on each ward) were highlighted when cover for absenteeism was required. *"I would say the housekeepers are seen as the ward team, what they don't like is the people that go on to cover their housekeepers when they are on leave and sickness because they tend to be domestics, as you call them, they go on and perhaps aren't aware of that area very well"* (Facilities Manager).

The level of ward integration could also be a factor in the morale of the ward housekeepers. They appeared to take pride in their work and place an importance of the quality of their work. While morale was good and the housekeepers are getting job satisfaction from maintaining the standards of their work they did discuss their

workloads and the possible impact on the quality of their work. They viewed the problem resulting from the transition from domestics to housekeepers. As domestics their main responsibility was cleaning. As housekeepers they are now responsible for serving food and feel compromised between responsibilities. The new way (having changed from pre-plated to ward bulk service) in which meals were served added to the pressure, although the housekeepers did stress that the patients preferred the meals served the new way.

At the time, a full evaluation of the ward housekeeping system had not been conducted. However, there was a clear message from staff (nurses, housekeepers and managers) that the ward housekeepers provided a service which had been successful. To bring the ward housekeeping service up to the full requirements of the NHS Plan some additions to the role, such as the meet and greet element, were required. The Trust Facilities Manager also argued that some of the line management needed re-addressing. This may prove difficult while the housekeepers were managed by a third party contractor.

Table 8 - Case Study Four Summary

Type of Trust	**District**
Role	Serving meals, cleaning and tidying the ward, making beds
Recruitment	Managed by the contractors
Induction	Managed by the contractors
Training	Formal training programme for cleaning procedures
Integration	Reported to be good
Management	Domestic services are sub-contracted. WHK Training, sickness, holidays etc. managed by contracts supervisor. Day-to-day management by ward sister

4.1.6 Case Study Five

The Trust in case study five did not use a true housekeeping model as outlined in the NHS Plan but did refer to the staff who serve patient meals as ‘housekeepers’. The wards investigated used housekeepers to serve patient meals and domestics who were responsible for the cleaning. The housekeepers were also known as Health Care Assistants Level One (HCA 1) and they were part of the ward team and

financed through the ward budget. The domestics were part of the Hotel Services Department and were the responsibility of the Hotel Services Manager.

A point to note concerning the Trust was that, at the time, the services were being split up and taken over by a PCT and Mental Health Trust. The knock on effect was that the Estates and Facilities directorate was going through a period of change and new responsibilities were being established for the support services. The consequence of this meant that in the short term decisions were being put on hold, particularly for areas such as housekeeping. Naturally other work may be considered a higher priority while the Trust was being broken up. Participants felt that the Trust board did not consider the evaluation of the housekeeping services and re-structuring in line with the NHS Plan as a priority.

The main duties for the HCA 1s were based around patient food and catering and to *"assist professional nursing staff in providing a high standard of care to patients and contribute towards maintaining a clean and safe environment"* (Job Description). The Trust did also use domestics who undertook the ward cleaning, but the HCA 1s were expected to help with the general tidiness and bed making. In addition, occasionally the HCA 1s carried out ad-hoc work which helped to free up nurse time. Examples of this included helping patients walk around the gardens, reading to patients and performing simple chores for patients.

The HCAs were ward based staff who do not report to the Hotel Services Department. This meant that HCAs were funded through the ward budgets, managed by nurses, recruited by the ward and trained by them. This approach had obvious benefits of allowing the HCAs to become fully integrated as ward staff. It was interesting to note that all aspects of the HCA role were managed by the ward including the training and an introduction to the 'ward philosophy'. This suggested that the best way to achieve ward integration for housekeepers is to allow recruitment and training responsibilities to be shared among the ward and facilities directorate, with perhaps more input coming from the ward. The Ward Sister also stressed that she thought it important the responsibility for patient nutrition - essentially the role the HCAs/housekeepers perform - be nursing orientated rather than estates or catering.

The advantages of using HCAs seemed to be centred on freeing up nurses time and allowing a patient focused approach. By having a designated person responsible for patient food it helped to ease pressure on the nursing staff, however, it did take a

period of readjustment *"but having a designated person, if you trust and rely on them, then yes there is a benefit that you've got that one person concentrating on it. Whereas its took a little while to sort of let go I suppose and not doing it myself, going round chasing my tail finding out if people are drinking or people are eating"* (Ward Sister).

The Ward Sister interviewed had previously worked on a ward which used a slightly different approach to their housekeeping. This provided an interesting point of view and comparison. The central point to note was her opinion of the multi-skilled housekeeper compared to a system where housekeepers had specific or designated tasks. The Ward Sister considered the latter approach to be better - where one housekeeper took responsibility for food, one would focus on cleaning and another would be a nurse helper. This opinion seems to support the findings from Clark's (2001) research on multi-skilling in the NHS where greater patient satisfaction was found in wards which didn't use multi-skilled workers. However, a cost analysis carried out for the same project revealed that for that particular Trust the costs were significantly lower with multi-skilled housekeepers.

The Ward Sister also discussed two potential problem areas which had been highlighted during other case studies. The first was the need for permanent housekeepers on wards which allows continuity and the problem of cover. And the second was the issue of workloads:-

> *"its all well and good if it was your permanent member of staff, but if they were on holiday and you're getting a pool relief person that wasn't (good).And they were one minute doing teas and then next minute doing toilets and things like that, then it didn't work."*
>
> Ward Sister

> *"I think there is probably not enough of them. We have just recruited ** on today to make it our third. But with days off and two shifts, they do morning and afternoon shift you've invariably only got one on per shift, and breakfast time particularly is, you know, a rush to get people up"*
>
> Ward Sister

Table 9 - Case Study Five Summary

Type of Trust	**Community**
Role	Mainly catering related duties such as ordering and serving patients meals. Some general work such as bed making and checking linen trolleys
Recruitment	Recruitment through ward managers and nursing staff
Induction	Managed by ward staff. Exact details not known
Training	Managed by ward staff. Exact details not known
Integration	Full integrated into ward team. No input from FM department
Management	Managed only by ward managers and nursing staff

4.1.7 Case Study Six

The Trust housekeeping arrangements had evolved over a number of years when domestics were gradually given additional tasks to perform such as helping with meal distribution, beverage preparation and other minor duties such as putting flowers in vases. At the time of the research the housekeeping services were managed by an external contractor and funded through a central facilities budget - the way in which the housekeeping services were funded and a number of changes in the contracting company created problems (which were not exclusive to the Trust) and which are discussed later.

The housekeepers reported to supervisors who worked for the contractors and recognised this position as their immediate line manager. Hence all training, recruitment, holidays and sickness was managed by the contractor. If the Trust were to implement the new housekeeping role (as outlined by the NHS Plan) then it would mean the Ward Manager would be responsible for recruitment and the posts funded through ward budgets.

At the time the basic tasks undertaken by the housekeepers were centred on the ward cleaning and supporting in meal distribution. The role was essentially that of a domestic but with some additional (but limited) catering responsibilities. In additional, the task of meal distribution was apparently not performed on all wards and was an area of conflict between what housekeepers were asked to do and what the contractor had agreed in the SLAs. Another was that nurses on some wards were

expected to notify the housekeeper when the meals are ready to be distributed. The Facilities Manager sums up both these issues:-

> *"so the spec is quite detailed, so theoretically everybody knows what's on offer. But you find that because you get changes in senior staff at board level they lose sight. The new ones coming in maybe lose sight of what actually is on offer, so for instance meal times, where it is worded that the housekeeper will assist with meal distribution but you need to initiate it by saying to them 'right I'm ready to do it now', that doesn't always happen. Some wards are very good and it happens as slickly as you like. Other wards are reluctant, they don't see the need, they don't see why they should go to the housekeeper and beg her to do something."*
>
> Facilities Manager

The Trust had made progress in order to evaluate the current housekeeping services. This had allowed them to make decisions on how to take the role forward and what needed to be done. One solution was to create a new role to support (or replace) the ward clerk and low level nursing duties. Another issue to be resolved was the title of the new role. The current housekeepers were in essence domestic staff with a few extra tasks. Yet they were very protective of their job title. One suggestion was to give the new role the title of "Senior Housekeeper" which inferred a hierarchy over the domestics.

The ward sister and housekeepers both discussed the workload. Due to imposed efficiency savings over the years the number of housekeepers working on each ward had been cut. At the time there are two housekeepers working to a ward and the feeling was that any increased workload would impact upon patient care. This was not a view shared by the Facilities department who believed the workload was achievable. The Ward Sister and the housekeepers believed that the workloads of the whole ward were inter-linked:-

> *"their job must be incredibly hard. It's a very busy ward and obviously our work load has a knock on affect on their work. If we are really busy with very dependant patients with lots of attachments, drips, machines and they are trying to clean..... so its quite hard for them sometimes to do basic things like pull out chairs and beds to*

> *clean when we are in there with all sorts of machines so our workload has really a direct affect on what they are able to do and not do"*
>
> Ward Sister

> *"I know they're busy but if they cannot get their patients washed and dressed and if they can't get it together then you can't clean, you are stumped. You are walking up and down a ward looking at eight bays with every curtain pulled and you've got till dinner time.... that's when it can get really (busy), if you got a well organised ward its fine"*
>
> Ward Housekeeper

There were differing opinions on the level of team integration of ward housekeepers. The housekeepers might have been prohibited from feeling a full member of the ward team due to them being employed by a contractor. This could be interpreted as a barrier and distinguished the housekeeper from other staff who were employed by the Trust. A further feeling of separation may have been evident when vacant positions were advertised for posts that the housekeepers might consider applying for. For example if a nursing auxiliary post was advertised internally, which could be considered a possible promotion for a ward housekeeper, became vacant the housekeepers were unable to apply.

The ward housekeepers found the patient contact element of their job satisfying. The Ward Sister observed that often patients would find it easier to chat and talk to staff who they don't view as "nurses." While the Housekeepers wished to have more time for dedicated patient contact, their workloads did not allow for this.

Table 10 - Case Study Six Summary

Type of Trust	**Acute**
Role	Mainly focused on cleaning the ward, however they are responsible for serving hot drinks
Recruitment	Managed by contractor
Induction	Managed by contractor. Exact details not known
Training	Managed by contractor. Exact details not known
Integration	Limited integration due to weak partnership working arrangements between Trust and contractors
Management	Hotel services contracted out. WHK managed by contracts manager

4.1.8 Discussion

Role

The case studies demonstrated that the housekeeper role had been adapted and modified by each Trust to meet their needs and the needs of their patients. For example, at some of the hospitals the ward housekeeper was responsible for the patient meal service in terms of menu completion, ordering the meals, regenerating and serving the food to patients. In other hospitals members of the catering team performed these roles. The historic practices, finance and the availability of time all contributed to influence the aspects of the support service that the housekeeper can perform.

The case studies also showed that the housekeeping service was more effective when wards had a dedicated and permanent housekeeper. This was because they were able to take ownership of the ward, which developed their pride in the service they delivered and helped to nurture trust between them and ward staff. They reported that being dedicated to a ward also allowed more continuity for patients during their stay and allowed the housekeeper to get to know the patient's particular needs (e.g. diets) and to understand the culture and routines of the ward and therefore ultimately provide a better service for the customer.

Only one of the Trusts involved in the research included the ward housekeeper at a supervisory level, as recommended in the NHS Estates guidance. While other Trusts

did not view the role at this level, the Trust that chose to take this route felt that it would help raise the profile of the housekeeper and assist in their responsibility of overseeing non-clinical duties in the absence of the Ward Manager.

Recruitment

Some problems were identified with recruiting housekeepers. The main issues related to the role's unsociable hours, pay levels and for some its temporary nature since the new role was only on trial. Some of the case studies had sufficient funding to position the role at a supervisory level and they experienced fewer problems with recruitment.

One recurring theme relating to recruitment was the importance of involving ward managers and if possible nursing staff in the process. The case studies that did involve the ward managers and nurses, as early as possible, during the recruitment process believed it helped to gain the trust and "buy-in" from ward staff. One example of this was a working group that was set up which included representatives from the Hotel Services department, ward managers and nurse managers. The working group was responsible for forming a core job description and then tailoring this to meet the specific needs of each ward.

Induction

The case studies identified some interesting examples included in the housekeeper induction programme. One Trust identified a 'buddy' from the ward team for the ward housekeeper, who explained the structure and roles of the rest of the ward team and was a point of contact for the housekeeper during their introductory period. Another Trust recommended that their induction training should include visits to other Hotel Service departments which the housekeeper may have to liaise with as this would help them understand the physical structure, functions of the organisation and where they fit into the 'bigger picture'.

Training

The research indicated that training structures and programmes were pragmatic and aligned to the ward housekeeper role. Included in the programmes were basic food

hygiene, cleaning procedures and standards and other ward based skills required for the housekeeper role.

Training away from the ward introduced the housekeeper to the other departments they may encounter in Hotel Services and the wider Trust including Estates, Dietician, Chaplaincy, Security and Infection Control. Representatives from each department were involved in this training (rather than using the ward managers' understanding of the services) which provided the ward housekeeper with greater knowledge of the functions they will be dealing with and the wider structure of the organisation.

A number of Trusts had introduced National Vocation Qualifications (NVQs) that the housekeepers could undertake such as in 'customer-care' and cleaning and building interiors. Most Trusts were waiting for the introduction of the Ward Housekeeper NVQ that the UK organisation 'Skills for Health' are currently developing in consultation with hospital managers and professional associations. Other Trusts had worked with local colleges to develop a Hospitality Award or customer service training that the staff found beneficial.

The development of a training manual for the housekeeper, which they could keep for day-to-day referencing, was one particularly good example of best practice. Within this manual was information on the NHS Plan and how the Housekeeper's role fit into this, details of the NHS' Better Hospital Food initiative with serving and presentation suggestions for meals, details of the NHS' Patient Environment Action Teams (PEAT), auditing and a Service Level Agreement for the ward to communicate the standard expected of the service delivered.

Integration

The case studies demonstrated that failing to communicate effectively with both the clinical and non-clinical ward based staff about the new addition to the ward, has been shown to cause problems in some of the case studies. For example, domestic and catering staff were unwelcoming to the housekeeper at one Trust, as they thought they were monitoring their work and occasionally undertook the same tasks as them, so they were uncertain about their own future on the ward and in the organisation. Auxiliary nurses were also concerned for similar reasons, which again, highlights the importance of communicating with staff.

Management

The case studies showed that to avoid confusion or tension it was necessary to define clear lines of management for all involved in the housekeeper role. In many case studies the Hotel Services/ FM departments took the lead on the role specification, advertising of the post, interviewing and the final recruitment of the housekeeper with some involvement from the ward manager. Once recruited though, the ward manager was given overall responsibility for the housekeeper including their roistering, holidays and organising cover.

Table 11 - Case Studies One - Six Summaries

Case Study	One	Two	Three	Four	Five	Six
Role	Catering	Catering	Supervisory for all non-clinical	Catering and cleaning	Catering	Cleaning
Recruitment	Hotel services lead. Input from ward managers	Hotel services only	Ward mangers and hotel services manger	By the contractors	Ward managers and nursing staff	By the contractors
Induction	Not known	Basics required for job	Mandatory trust and department	By the contractors	By ward staff	By the contractors
Training	Statutory	Not known	Ward and non-ward training	Formal training for cleaning	By ward staff	By the contractors
Integration	Mixed success	Ok, ward based management helps	Successful	Good	Full integration	Limited / poor
Management	Catering manager leads	Joint between hotel services and ward team	Day-to-day by ward mangers. Hotel services oversaw the project	Joint between contractors and ward sister	Ward managers /nursing staff only	By the contractors

4.1.9 Conclusions

The case studies demonstrate that a variety of approaches have been used in designing, recruiting and managing the ward housekeeper role that were influenced by the local management culture, conditions and the scope for adapting existing support provision to the hospital ward. However, some areas of best practice are

suggested which will contribute to the implementation of a successful ward housekeeper. Table 11 provides a summary and comparison of case studies one to six and the various issues related to the role, recruitment, induction, training, integration and management.

The research has shown that adopting a structured approach is crucial when designing, recruiting and implementing the ward housekeeper role. One of the most important aspects of the role is that it can be tailored to meet the needs of the ward. A generic job description should be developed jointly by FM and ward staff and then adapted to the specific requirements of the staff and ultimately the patients on the ward.

By involving ward staff in the development of the ward housekeeper role right from the start, it encourages their acceptance of the role as they understand its function, how it will assist their work load and promotes integration of the new member to their ward team once recruited. The ward managers, nursing and other non-clinical staff should also be involved during the recruitment process. This helps to ensure that the right person is chosen for the job, will perform the role to the clinical staffs' expectations, and will fit in with the ward team. Their involvement at this stage also helps to emphasise the role as being a member of the ward team.

Housekeepers should receive a full induction to the Trust, as is the case with all staff. The concept of identifying a 'buddy' from the ward team which can act as a point of contact during their induction period may be useful. The 'buddy' can explain the ward structure, roles of the rest of the team and the general ethos within the ward. During the induction period the ward housekeeper should also be introduced to other Hotel Service departments which they may have to liaise with, this enables them to understand the wider fabric of the organisation.

The training programme for the housekeeper should be structured and cover skills needed for use on the ward, in the wider department and the Trust. It ought to encompass the mandatory training for the NHS such as lifting & handling and health & safety. Ward-based training will cover catering and domestic duties, as well as understanding the structure of the ward and team members' roles and responsibilities that will help integrate the housekeeper into the ward philosophy.

The integration of the housekeeper into the ward team is considered most important to making the role successful, and is strongly recommended in the NHS Estates guidance (2001a). As with any role the team integration will largely be down to individual personalities, however, there are practices that can aid this. The 'buy-in' from ward staff at an early stage will help gain their commitment to the role and maybe avoid any feelings that changes are being imposed. This can be done by involving them in the role's development so that they will be able to see the value of the new worker. It is also important to explain the new role to other non-clinical staff on the ward, such as dedicated domestic or catering assistants, as they also need to accept the new worker for them to be fully integrated into the ward.

The ward manager or sister needs to have some form of management responsibility over the roles that the housekeepers undertake. The management of the role has to be flexible enough for the ward manager to be able to assign other tasks. This will avoid conflicts between the ward and Hotel Services/ Facilities departments and confusion for the housekeeper over who they are responsible to. Ideally the housekeeper should be treated like any other member of the ward team, which of course will help integration.

4.2 Ward housekeepers in mental health environments

4.2.1 Introduction

Much of the national guidance for the ward housekeeper role focussed on its development and implementation in an acute hospital setting. The following section details the findings from research conducted in NHS Trusts, to evaluate the various approaches that had been adopted in developing and implementing the ward housekeeper role in mental health environments.

Following on from the initial findings outlined on ward housekeepers in a general acute setting, the study focused on learning about the roles development implementation and how it needs to be adapted for mental health services. The aim was to focus on how the ward housekeeper role could be adapted and implemented to meet the need of mental health environments. Four case studies were undertaken in a variety of mental health settings ranging from acute, long-stay wards in hospitals to community extended care units.

From preliminary investigations it was anticipated that there would only be a handful of Trusts who had implemented the housekeeping model into mental health units/environments. The key selection criterion for identifying case studies was that the Trust had used the guidance model as suggested by NHS Estates. Therefore a purposeful sampling technique was employed, and the Trusts selected as case studies were not representative of the wider NHS ward housekeeping models. Instead, they were chosen to provide illustrative examples of the limited amount of work to date surrounding housekeepers in mental health environments. During the case studies the principle method of data collection was again semi-structured interviewing. Where possible, interviews were conducted with the Director of Facilities (or equivalent representative from the facilities department); members of the nursing team (or ward manager); a housekeeper (or a number of housekeepers from different wards).

In order to make comparisons with previous housekeeper research in Acute Trusts the questions for discussion during the interviews were based on the themes that emerged during the previous study. These were designed to explore the ward housekeeper core role/duties, management of the role (operationally and strategically), recruitment and selection, pay and conditions, funding of the role,

training, team integration, problem areas, suggested improvements, evaluation of the role and the value of the role.

Interview questions were also added to reflect the different needs for mental health patients. These additional questions explored specific mental health requirements such as the level of patient interaction and helping to "stimulate senses". The interviews were designed to probe for further information and provide an in-depth, rich picture of the housekeeping services. Consequently, the account and narrative presented in the case studies reflect the perceptions from the respondents, and are therefore inherently subjective (a copy of the interview guide can be seen in appendix 2). A total of 17 interviews were conducted across the four NHS Trusts. In order to enrich the case study information and provide a fuller picture of the housekeeper role some documentary evidence and financial data was also requested. This included job descriptions, training programmes and pay rates. Two of the housekeepers provided a "day in the life"; these were descriptive narratives sharing their work experience and helped to enhance the case study data. Table 5 below summarises the type of Trust/Organisation used in the case studies and the main characteristics of the housekeeper.

Table 12 - Summary of case study type and main characteristics of housekeeper

Case Study	Trust/Organisation	Ward/Unit where housekeeper is based
7	Mental Health and Learning Disabilities Trust	Using housekeepers in acute/long stay in-patients wards and community extended care units.
8	Community and Mental Health Trust	Using ward housekeepers in acute adult inpatient wards and elderly mental illness wards.
9	Primary Care Trust	Using a single ward housekeeper on an adult inpatient mental health unit.
10	Support Service Organisation supplying FM and estates to a Mental Health Trust	The Trust has a children's and adolescent inpatient unit which has one housekeeper.

In general the findings supported the earlier work focusing on the role in acute trusts. However, while the four case studies supported the themes, there are a number of variations identified in the role for mental health services. These related primarily to the patients' needs and their environment and were summarised as:

- Perception of the environment
- Patient relationships
- Flexibility of the role

The three themes listed above are explored in further detail following the findings presented from each case study.

4.2.2 Case Study Seven

The Trust in case study seven was a Mental Health and Learning Disabilities Trust had ward housekeepers in 14 wards/units ranging from acute and long stay in-patient wards to community extended care units. The role varied according to the nature of the patients on each unit, but the core responsibilities of the ward housekeeper were to cover the domestic and catering duties and support in managing the basic maintenance work. The domestic duties were to ensure the ward was clean and tidy and in line with the cleaning specification set. Catering duties included making beverages and snacks for patients, preparing the dining rooms for and serving and ordering patient meals. Some of the general duties were maintaining stock levels of the consumable goods; assisting with washing and ironing and checking the condition of the linen; making and changing beds; and reporting any general maintenance to the Estates department.

There were some differences to the ward housekeeper role from the acute setting because of the nature of the mental health patients. The greatest variation was noted on the smaller community extended care units which housed younger patients with functional illnesses. In these units the patients were regarded as residents in their own home and were encouraged to be as independent as possible as part of their care treatment. The residents often did their own shopping, made several of their own meals, cleared and set the table, made their own beds, cleared their bedrooms, did their own clothes washing and ironing and did their own washing up. The role of the ward housekeeper therefore had to run alongside the residents' activities and be flexible to their needs, although they did still have the same core responsibilities listed above. For example, in this setting the residents cleaned their own room which involved making the bed, washing the basin and vacuuming the floor. The ward housekeeper would initially encourage the resident to undertake these activities, provide any help they may need and then undertake a thorough clean once the resident had left. The residents were also encouraged to make their own breakfast

and supper and then their lunch and evening meal were prepared for them by the ward housekeeper using a cook chill system. The ward housekeepers' catering responsibilities were therefore to order and regenerate two of the residents' meals, but also to ascertain and order supplies for the meals that the residents prepared themselves.

Due to the nature of the illnesses that the patients or residents had, there was much less scope for the ward housekeeper to have 'meaningful' contact with them. At the Trust nursing staff requested that the ward housekeepers have little direct impact on the patients, as contact with some may have had an adverse effect on their rehabilitation.

Usually there were three ward housekeepers dedicated to a typical in-patient ward, but this could vary for particularly large or smaller units. Their shift covered the ward from 7.00 a.m. - 7.00 p.m. every day of the week which ensured that all the patient meals were covered so the responsibility did not fall back with the nursing staff. The Trust found that this approach was more conducive with the needs of the staff and patients on the wards and more importantly one that was affordable. Initially the individual ward housekeeper per ward model recommended by NHS Estates was piloted at the Trust, but they found that this was too costly with the sheer volume of duties included in the role. They could only afford to fund the role for a limited amount of hours from Monday to Friday which didn't allow enough time for all duties to be undertaken, particularly providing cover for all meal times. This meant that non-clinical duties were again being left to the nursing staff. To overcome this problem, a more generic role had been implemented (and therefore less financially resource intensive) so they could cover seven days a week for the full day shift pattern.

Through having an increased staff base of ward housekeepers it was easier to organise cover for sickness or holidays. This responsibility was undertaken by the Facilities department, as well as recruitment, training, appraisals and monitoring the quality of their work. Facilities supervisors tended to visit the ward housekeepers every week or fortnight to check if there were any issues or problems. Day to day management of the ward housekeeper was handled by the ward manager which involved including them in team briefings and dealing with any immediate problems they had. The facilities supervisors and managers then met with the ward managers or modern matrons once a month to communicate any issues, changes or problems.

When the ward housekeeper role was initially designed the facilities supervisors and managers asked nursing staff and ward managers to produce a 'wish list' of all the services that they wanted the role to provide. The facilities staff then worked with the clinical staff to develop the list, a job description, build up rotas and determine funding. The role was then advertised and both the facilities staff and ward manager were involved in interviewing and selecting the candidates. There was no recurring finance available for the ward housekeeper role from either the Facilities or Nursing budget, and this was still the case. The role continued to be funded by the Facilities department by finding additional finances through several means, such as bringing services back in-house and localising other previously centralised services that the housekeepers now performed. A bid was also submitted every year for central Trust funds to help finance the role.

Following the return of the domestic contract in-house, many of the ward housekeepers in the Trust were previously domestic staff. The training that these staff and newly recruited ward housekeepers received was a two day induction programme given by the Facilities department. This involved the distribution of uniforms, meeting the supervisor and other team members and a site visit to the locations in which they will be working. Following this there was a two day housekeeping induction programme that the Trust monitoring officers organised and ran. This including a general introduction to the ward housekeeper role, its importance, familiarising them with cleaning methods, substances and equipment (for example using the re-generation trolley used to heat food on the wards) and the hygiene codes of practice. The new staff also received mandatory training, such as lifting and handling and COSHH as well as a two day customer care programme.

New recruits did not receive training that was specific for staff working in a mental health environment. However, it was covered briefly in the Trust induction programme that all staff undertook, and the ward manager would highlight the nature of patient's illnesses on their particular ward and what the ward housekeeper needed to be aware of in such an environment. In spite of the comprehensive training package available to the ward housekeepers, there was some criticism that the volume of information included in the induction programme proved difficult to digest. One suggestion was to provide a written manual to supplement the training programme.

As day-to-day management of the ward housekeeper was through the ward manager it enabled them to become integrated into the ward team. On the larger wards where more than one ward housekeeper worked together, they considered themselves to be primarily a member of the housekeeping team. They were actively involved in the ward meetings, briefs, nights out and fund-raising events and the ward manager recognised the ward housekeepers as an integral part of the ward team. They did consider themselves as members of the ward team, but this was secondary. In the smaller units where overall, fewer staff were employed, respondents reported that the clinical and non-clinical staff integrated fully into one team.

Before the ward housekeeper role was implemented, the only non-clinical support given to wards were domestic staff, who maintained the standards of cleanliness. At the time, the nursing staff were responsible for making beds, keeping the ward environment tidy, menu collation, table setting, meal regeneration and clearing away. Since the introduction of the ward housekeeper role they have been able to take over these responsibilities and nurses reported that they had a large proportion of their time freed up. The role was also valued by the Facilities department as they had more control over introducing new approaches on the ward that aimed to enhance the patient experience, such as improving the dining experience in terms of appropriate place settings, crockery and condiments.

Table 13 - Case Study Seven Summary

Type of Trust	**Mental Health and Learning Disabilities Trust**
Role	Using housekeepers in acute/long stay in-patients wards and community extended care units. Domestic (cleaning) and catering support
Recruitment	Facilities department lead recruitment with input from ward managers
Induction	Two day induction programme given by Facilities department followed by a two day trust induction
Training	Mandatory training, such as lifting and handling and COSHH as well as a two day customer care programme.
Integration	Good. Ward manager recognises the WHK as an integral part of the ward team
Management	Day-to-day managed by ward manager. Sickness, holiday and training through facilities department

4.2.3 Case Study Eight

The focus for case study eight was a Community and Mental Health Trust. They had ward housekeepers in several of the mental health wards and units across the Trust's 19 sites. Again, the same core elements were included in the ward housekeeper's role at this Trust, with slight variations according to the arrangements with different clientele. The core duties were around a) regenerating patient meals, which the nursing staff would then distribute in the dining room. b) The general tidiness and order of the ward, including returning personal belongings to the appropriate location when patients have been discharged. Other work the housekeepers undertook included monitoring, ordering and distributing linen; bed making; monitoring, ordering and distributing stores including breakfast and beverage provisions; identifying repairs and reporting this to the ward/unit secretary, who then liaised the Estates department.

The normal shift pattern for the housekeepers was 9.00 a.m. – 5.30 p.m. Monday to Friday. Outside of these times the nursing staff would perform any immediate tasks but normally work was left until the ward housekeeper returned on shift. The core duties of the role in this setting were similar to those found in the acute setting, however there were slight variations to the tasks because of the mental health setting. One of the key differences was dealing with residents' clothing. Allowing the patients to take pride in their appearance and look respectable was an important contribution to the patient's dignity and their relatives. This was one of the main drivers for the manager on one ward to push for a housekeeper since so many complaints were received from patients' relatives. This aspect of their role involved labelling clothing, compiling an inventory of their belongings, washing, drying, ironing as well as making any repairs and then returning the clothing to the residents' room. Some of the residents either preferred or were encouraged to do their own laundering, so the ward housekeeper was responsible for facilitating this activity. This did cause some issues for the ward housekeeper in restricting the use of the washing and ironing equipment, but it was regarded as part of the residents' treatment in keeping them independent and active.

This was also the case with regard to cleaning and tidying the residents' bedrooms. Although this was part of the role of the ward housekeeper, some residents were

encouraged to take responsibility for their own bedroom in terms of changing their bedding, vacuuming, dusting and general tidiness. However, the housekeeper still had the responsibility of checking the rooms to ensure they met the appropriate cleanliness standards. There were further housekeeping activities that the residents undertook as part of their treatment, but clinical staff assisted with these duties rather that the ward housekeeper. For example, residents could get involved in gardening, cooking and baking to help regain independence and freedom, but this was directed by the Trust occupational therapists and not FM staff.

The ward housekeepers in the mental health units at this Trust were funded, employed and managed completely by the ward budgets. This included designing the role, advertising, interviewing and selecting candidates, organising rotas, holidays and sickness cover and dealing with any problems that the ward housekeeper may have. It was likely that this approach had been taken because of the geographic spread of the Trust - it provided mental health services to over 70 different locations including 19 hospitals across a 70 mile square area. It would subsequently not be appropriate for the Trust to design a single model of ward housekeeper that performed the same role and was managed in the same way. Since the units they served were so different and support would be very difficult to provide logistically. All the responsibilities for this role had therefore been assigned locally to nursing staff as they had a greater awareness of their needs and those of their clients.

The funding for the role had been through the ward (nursing) budget and this caused concern for some nurses initially, particularly as the perception at the time of implementation was of nurse shortages. However, when the nursing staff observed and realised the benefit of having one person responsible for the housekeeping work on the ward this ceased to be a problem. Prior to the introduction of the ward housekeeper the nursing staff, ward manager and administrator were responsible for putting away linen and stores, regenerating patient meals, reporting and chasing estate issues, and dealing with patients' laundry with an external contractor. Now the ward housekeeper could co-ordinate all of these activities and undertake the patients' laundry duties in-house to a consistent service level.

Due to the localised nature and ownership of the role, it facilitated the integration of ward housekeeper into the ward/until team - although it was stated that this was still ultimately dependant on the personalities of the staff involved.

Overall it appeared the service that the ward housekeepers provided was appreciated by the nursing staff and of great value to the mental health setting. As one nurse commented *"I think it's a really good service and I think she would always come and alert us if anything was not right or she found something in a bedroom that shouldn't be there and she's got a good relationship with us and yes I think the service is really good."*

Table 14 - Case Study Eight Summary

Type of Trust	**Community and Mental Health Trust**
Role	Using ward housekeepers in acute adult inpatient wards and elderly mental illness wards. Catering and general ward tidiness
Recruitment	Managed completely by individual wards / clinical units
Induction	Managed completely by individual wards / clinical units
Training	Managed completely by individual wards / clinical units
Integration	Good due to the management of the role
Management	By ward manager or unit manager

4.2.4 Case Study Nine

Case study nine was based on a PCT with a Mental Health Directorate. The focus for this particular case study was a single ward housekeeper based on an adult inpatient mental health unit. The unit was split into two sixteen bedded mixed wards and had had a ward housekeeper in place for nearly a year. The post was initially set up as a pilot scheme to identify any issues, problems, positives and negatives but it quickly developed into a permanent position. The job summary for the role outlined the ward housekeeper as "*part of the ward team. He/she will be responsible for the co-ordination of all patient facilities services in the ward area and ensure a clean, safe and comfortable environment. The main elements of the role are to support nursing staff to ensure patients needs are met working with the domestic staff to maintain a clean and tidy environment, working with the unit administrator to monitor quality standards, report deficiencies and take appropriate action."*

The primary cleaning duties for the housekeeper were to maintain the upkeep of the patients' bed areas. This included either changing bed linen or making beds. There

were domestics based on the ward who undertook the bulk of the cleaning. The general rule of thumb was for domestics to clean all the "outside" surfaces on the ward while the housekeeper concentrated on linen and inside the furniture, wardrobes, drawers etc. While the housekeeper did not have direct line management responsibilities over the domestics they were involved in the cleaning quality control. Any problems or issues identified related to the cleaning were fed back to the domestic supervisor and ward manager.

In terms of the catering arrangements on the ward, the patient meals came from the hospital kitchen as cook chill. The housekeeper was responsible for making sure any special dietary requirements for patients were noted and an order placed with the catering department. During mealtimes it was important for the housekeeper to be present to oversee the meals being served and make sure there is enough food for all the patients. The actual meals themselves were served by the ward domestics. In addition to overseeing mealtimes the housekeeper ensured that there was enough crockery, cutlery and places for all the patients to eat. The housekeeper also played a vital part in monitoring and maintaining special dietary needs for individual patients. Some patients had care plans involving specific dietary requirements and the housekeeper was available to report back on what they had eaten and had to drink. This was important when the nurses were not able to observe during mealtimes.

The other role the housekeeper played, in respect to patients' dietary needs, was during mealtimes to help manage portion control. The housekeeper provided the following example:

> *"We have a patient on the ward at the moment who weighed in at 20 stone and the Doctor wanted this patient, not necessarily on a diet, but the patient was overeating by quite a large amount, so a care plan was written. He could have soup and he could have dinner and he could have the pudding but instead of coming up two or three times it would be better if he only had the one meal, so we're told about that, and if he comes up we tend to give him lots of vegetables rather than a lot of the curry or something."*
>
> Ward Housekeeper

The above illustrates how the housekeeper made a direct contribution to patients' clinical needs through the non-clinical services they provided. It also gave the housekeeper responsibility for implementing some aspects of the clinical care plans which would otherwise be managed by nurses.

Other general catering work included monitoring the food and beverage stocks in the pantry. Patients were able to help themselves to make toast, although the toaster was kept locked away due to the potential fire risk and because patients were using it as a way of self harming - the housekeeper was responsible for supervising patients who wanted to use the kitchen.

In addition to the catering and cleaning duties, the housekeeper also had general responsibilities surrounding the maintenance of the environment. This included monitoring the linen supplies, portering and rubbish collection and reporting any defects to the unit administrator. The housekeeper also made sure that there were enough personal hygiene supplies, as sometimes patients may arrive on the ward without toothpaste, soap etc. Among other general duties listed for the housekeeper was to meet new patients and welcome and guide visitors around the ward. After meeting or receiving information regarding the patient the housekeeper may feel it was appropriate to pass on relevant information to the domestics such as whether the patient was anxious, aggressive, violent and if it was safe for them to clean the individual patient rooms.

The housekeepers' duties were very much focused on the needs of their patients, which for mental health were different to general acute patients. The Unit had tailored the housekeeper role to mirror the needs of their patients and this is reflected in the interaction between the housekeeper and patients. Prior to working as the housekeeper on the ward she was employed as a nursing assistant and was able to compare her relationship with the patients between the two roles. As the housekeeper the patients talk to her more openly and will chat away while she is making beds, however she is clear where the boundaries were and explained to patients that if they want to talk about their problems then they need to speak to their allocated nurse.

The following extract from the housekeeper interview provides an excellent insight into how the personal qualities they bring to the role make a real difference to patients' well-being and ultimately the level of care they receive. It also hints at the

motivations behind working as a housekeeper and the satisfaction that can be achieved from the role:

> *"I don't obviously want to put a foot wrong in whatever I say but they (the patients) will come and talk to me about anything, I mean not necessarily problems they're having. They'll cuddle me (and say) 'I'm glad you spoke to me'. But I've got time for everyone, and I like it when I come on the ward and people say 'ooh I missed you yesterday'. They deserve having somebody sitting listening to them and I'll sit making beds and I'll chat away to them and I think they appreciate that."*
>
> Ward Housekeeper

The workload and nature of the role rules out further patient interaction, but sometimes if there was a spare half an hour the housekeeper could sit and play scrabble or cards with the patients. In addition to patient interaction, the housekeeper sometimes gets questions from patients' visitors. If it concerned, for example personal patient belongings that were missing, then the housekeeper could deal with it, however if it was a medical related query then they would ask the appropriate member of nursing staff to speak to the visitors.

At times nurses or doctors approached the housekeeper to ask about specific patients' dietary intakes or what a particular patient had been talking about. The significance of the housekeeper's role as an "information gateway" between patients and doctors was highly valuable, arguably more so in a mental health unit than an acute ward. Examples of this include when they had been observed chatting to a patient who would not talk and when they managed to get someone to eat after they hadn't eaten for three days because the housekeeper knew the patient from a previous stay and remembered what they preferred to eat.

The management of the housekeeper was almost entirely handled within the ward. The ward manager was accountable for both the operational and strategic management of this service, including organising sickness and holiday cover, training needs and day to day supervision. The Facilities department had virtually no involvement in the management of the housekeeper and played a minimal part during the implementation.

The Trust were fortunate during the implementation of the housekeeper role, as the Director who was responsible for facilities was also responsible for mental health and learning disabilities and this helped in getting commitment from the Board. The fact that the ward funded the housekeeper position also made it easier for them to succeed in its establishment. The development of the housekeeper role was driven by the increasing number of complaints being received from both patients and carers surrounding the ward environment. The Community Health Council had many complaints about the environment so the ward took the decision to fund the housekeeper by sacrificing a nursing assistant post.

The Facilities department's function during the recruitment of the housekeeper was to provide advice on the nature of the role and the type of duties that needed to be included, but the main responsibility for recruitment was with the ward manager. The responsibility for the housekeeper training programme was again with the ward manager but with advice from the Facilities department. The basic training needs for the housekeeper were met with regards to food hygiene and cleaning duties. The ward management also felt it was important for the housekeeper to be trained in CPR, understanding the mental health environment and how medication affects patients. New housekeepers also spent time with the facilities manager, being shown the department, relevant procedures and documents they may need to use.

The way the role was set up helped enable the housekeeper to be fully integrated into the ward team and was seen as an integral part of it. The housekeeper attended the weekly communication meeting where the patients met with a member of staff and any concerns could be raised.

The housekeeper was supported on the ward by a team of domestics who covered the cleaning duties and distribute meals at lunchtime with supervision from the housekeeper. The domestic services were managed by the Hotel Services department and contracted out to a commercial organisation. The line management relationship between the housekeeper and domestics was, as the facilities manager described it, a *"dotted line"*. This sometimes posed a problem for the housekeeper who could not ask them to change their cleaning routine or occasionally pick up additional duties. The housekeeper provided the following example of the difficulty with the current set up:

> *".... I feel that because they don't come under me, I can ask (them) very politely to do it, but it would be nice it they were (under me). I'll give you an example, we have a smoking area, the smoking area is done at ten o'clock every day. But at eight o'clock in the morning it's empty. Now me personally, I would just say to the domestic, just get in there when you can, don't wait until ten, if it's empty at eight do it..... So in a sense yeah, I would like the domestics under us, but we work well as a team."*
>
> Ward Housekeeper

At the time no formal evaluation of the role had been conducted, but feedback had shown that staff had noticed a difference in the ward environment. The Facilities Manager reported that the ward nursing staff *"could not sing the praises enough"*. Visitors and patients had also noticed the change since the housekeeper had been employed. Anecdotal evidence suggested that patients who had been re-admitted to ward had noticed the changes and passed comments on the new curtains which the housekeeper had put up and that there were towels and water jugs available. These may have seemed trivial areas, but they were a result of small changes the housekeeper had made which impacted directly, and contributed to improving patient care.

Table 15 - Case Study Nine Summary

Type of Trust	**Primary Care Trust**
Role	Using a single ward housekeeper on an adult inpatient mental health unit. Supervision level for catering and general tidiness of the ward
Recruitment	Ward manager with advice from facilities department
Induction	Through ward manager
Training	Ward manager responsible. Food hygiene and cleaning covered. CPR included and introduction to patient medication.
Integration	Fully integrated due to management structure and use of WHK
Management	Ward manager

4.2.5 Case Study Ten

The housekeeper studied during case study four worked on a children's and adolescent unit, which was part of a mental health trust. The unit had a housekeeper for the past seven years. The main duties were split into cleaning tasks and housekeeping tasks. The reason for the split in duties came about as originally the unit had a domestic employed and the housekeeping duties were added on. The additional housekeeping duties added onto the existing domestic duties were: ordering food, stores and linen into the unit - this was done weekly. The housekeeper would also do local shopping in a supermarket for any additional supplies required.

In general the food supplied was for the children. However, some parents did stay overnight in the unit and although they are supposed to provide meals for themselves they can use the food in the kitchen. Parents who stayed at the unit cooked meals for their children. For unaccompanied children, nursing staff cooked their meals. The children were able to go into the kitchen, but were not allowed to prepare food or drinks.

The cleaning focused housekeeping duties were centred on stripping and re-making the patient beds and washing duvets and covers. The unit had its own laundry room which handled the bedding but towels were sent to the Trust's central laundry unit. All the patient's personal clothing was washed by the nurses or parents. They would also clean bedrooms, toilets, bathrooms, the kitchen (including washing up after meals) and common areas. Some of the cleaning was routine daily work such as vacuuming the carpets. Other work was planned periodic such as the carpet shampooing.

The last main area of work outlined in the standard housekeeper model (NHS Estates, 2001a) is basic maintenance duties. For the children's unit the housekeeper did not perform any maintenance at all. The main reason for this was the lack of storage space of equipment, ladders etc. If any maintenance was required the housekeeper acted as a point of contact with the estates department and would report any defects to them.

Within the Unit it was very clear where the boundaries and responsibilities for the housekeeper started and finished. The pure nature of the role meant the

housekeeper did have contact with patients and visitors, but the nursing staff and housekeeper both agreed that this was only on a superficial level and not linked to patient clinical needs. The housekeeper dealt with any food and cleaning related requests from parents and children. However, in other case studies the housekeeper acts as an "information gateway" for certain issues between patients and staff, this was not the situation for this Trust. The housekeeper was rarely approached by the patients or parents but should this happen the housekeeper knew to direct them to the nursing staff.

During the case study the nurses drew attention to the gender issues which surround the housekeeping role. Observational evidence suggested that the majority of housekeepers employed within Trusts were female. A possible reason for this is the connotation which the name "housekeeper" has with a traditional female role. Some Trusts were aware of this and had deliberately renamed the housekeeper, for example to "Ward Co-ordinator", and had been successful in recruiting a much better balance of male and female staff. The gender issue raised by the nurses highlighted the importance of having a male housekeeper present in what was a predominately female unit. As one nurse explained *"Yeah, and it's nice for the kids to have, because it's mainly female staff and it's nice for the kids to see other men on the unit too*." The advantage of balancing the staff gender inequalities for the unit was arguably more acute for a children's unit than for adult or geriatric one.

The evolution of the housekeeper role had meant that the management responsibilities were spilt three ways. Operational management of the housekeeper, such as day to day issues, sickness and holiday cover regarding the "housekeeping" work, was the responsibility of the ward manager. Due to the independent nature of the unit, sickness and holiday cover for the ward housekeeping duties were managed internally by the nursing staff as there was not a resource which they could call upon to help deal with the work.

The management duties for the "cleaning" work which the housekeeper did were the responsibility of the domestic supervisor. They were also responsible for monitoring the cleaning work through the monthly quality audit, but this didn't include monitoring the "housekeeping" element.

The third element of the housekeeper management accountability was with the hotel services department who funded the role and was responsible for training. This was

unique for the children's unit as other wards within the Trust which utilised housekeepers funded the role themselves. This presented potential problems, particularly when the current housekeeper retires, as the hotel services department would not re-fund the position. This will be the responsibility of the ward manager who will need to decide if they want to fund and recruit a housekeeper for the ward. The Trust Board had not made any funding available for the housekeeper role, so any ward that employed a housekeeper had to do so from their own budget.

In spite of the above split in line management duties it was reported that the housekeeper was very much part of the ward and integrated into the team. The domestic supervisor pointed out *"I think he's more classed as a member of the ward, with them.... if he is not there they are terribly lost without him and they have the highest respect for him."*

The importance placed upon the housekeeper role, particularly from the nursing staff, also points towards the level of integration into the ward team. The domestic supervisor provides an example of the value of the role:

> *".....they do miss him very much when he is not there for a week or two because they soon start screaming 'ooh can you do this linen' I say sorry I am not a housekeeper..... (by) the time he comes in on a Monday morning everybody is there waiting".*
>
> Domestic supervisor

The nursing staff also explained why they value the contribution the housekeeper made to the ward:

> *"Compared to what I've experienced before this is much better because it takes a lot of pressure off the nurses, things like keeping the kitchen in a reasonable state throughout the day, where I've worked before we just would constantly load the dishwasher and it took time away from what we could do with the kids. So this is much better, somebody that we know is there, who we know can do that."*
>
> Nurse

At the time of the study, there wasn't a structured training programme for the housekeeper, but they had received mandatory training in food hygiene and cleaning standards. There was no specific training geared towards the patient group i.e. children. However, there were plans to introduce a child protection training course for the housekeeper to attend.

The unit had been using a housekeeper for seven years and had managed to hone the service into a routine that operated well with few problems. One difficulty the housekeeper did encounter though, was trying to manage the food stocks for the unit when at times there could be a quick turnover of patients. Often children arrive and leave the unit without much forewarning hence the requirements for food were also liable to fluctuate without warning. This resulted in either there being insufficient food available for all patients and the need for extra shopping trips or too much which caused food wastage.

Table 16 - Case Study Ten Summary

Type of Trust	**Support Service Organisation supply FM and estates to a Mental Health Trust**
Role	The Trust has a children's and adolescent inpatient unit which has one housekeeper. Mainly focused on cleaning, limited food provision on the unit
Recruitment	Ward manager
Induction	No known
Training	Mandatory training in food hygiene and cleaning standards. No structured WHK training programme
Integration	Good. Valued member of the team despite limited interaction with patients
Management	Split three ways. Ward manager for day-to-day issues. Domestic supervisor for cleaning. Hotel services who funded the role and managed training

4.2.6 Discussion

Perception of the environment

The perception (and reality) for some patients in community extended care units and long stay wards is that they were, in essence, the patients' home and therefore should be treated as such.

Mental health patients with predominantly functional illnesses (as opposed to organic illnesses) were encouraged to be as independent as possible to maintain their life skills, and this was an important part of their treatment. Often patients did their own shopping, made several of their own meals, cleared and set the table, made their own beds, cleared their bedrooms and did their own washing up. The role of the ward housekeeper therefore had to run alongside the patients' activities and be flexible to their needs.

This meant the housekeeper at times, worked in "partnership" with patients. For example, the ward housekeeper might be responsible for making the beds with the patients, encouraging them to tidy their room, ordering supplies for them to prepare their own breakfast and lunches.

Perhaps the most important point related to this was focused on patient independence and dignity. The ward housekeeper needed to respect the patients' needs and adopt flexible working patterns to reflect this.

Patient relationships

Two of the case studies (cases studies eight and nine) highlighted a slightly different relationship between the ward housekeeper and mental health patients compared to that found with acute patients. It could be argued that they were viewed more as a "mother/father figure", that patients were happy to chat with and confide in, compared to the more formal arrangements that existed between mental health patients and the nursing staff or doctors.

The informal contact which housekeepers had with patients enabled them to be perceived differently. Hence the ward housekeeper acting as an "information gateway" between the patients and doctors was valuable, arguably more so in a mental health unit compared to an acute ward.

Flexibility of the role

The research highlighted several areas in which the actual role in the mental health setting was different to that in the acute setting. However, this supported a finding from the original research, which stated the importance for the ward housekeeper role to be tailored to the needs of the patients on the ward. Mental health patients had different needs to those in an acute setting, so it followed that the housekeeper role would also differ. Differences found in the case studies included dealing with patient clothing, assisting patients/residents with meal preparation and performing shopping duties.

Consequently, the housekeeper training programme needed to be modified to meet individual ward requirements. This might include providing housekeepers with basic information about what certain drugs do and how they could affect patients' conditions, moods etc. In addition, the basic training should include patient illnesses and how to handle aggressive and challenging behaviour. In some Trusts it was the responsibility of the nurses to provide these clinical training requirements, done on an ad-hoc basis - but in most cases this seemed to be an area of weakness in the training plans.

Table 17 - Case Studies Seven - Ten Summaries

Case Study	Seven	Eight	Nine	Ten
Role	Cleaning and catering	Catering	Supervisory level for catering and tidiness	Cleaning
Recruitment	Facilities department lead with input from ward staff	Ward managers	Ward manger leads with advices from facilities department	Ward manager
Induction	Facilities department and trust inductions	Ward managers	Through ward manager	Not known
Training	Mandatory training + customer care	Ward managers	Ward manager. Food hygiene and cleaning + CPR and patient medication	Mandatory training in food hygiene and cleaning standards. No formal structured programme
Integration	Good	Good	Full integrated	Good
Management	Joint between ward manager and facilities department	Ward managers	Ward manager	Split between ward manager, domestic supervisor and hotel services department

4.2.7 Conclusions

Table 17 provides a summary and comparison of case studies seven to ten and the various issues related to the role, recruitment, induction, training, integration and management. All the housekeepers interviewed for the case studies showed a high level of commitment and pride in their work. The case studies illustrate where the housekeeper and non-clinical care they provided, directly contributed to patients' clinical needs. Examples of this have been managing portion control during mealtimes, helping to maintain patients' "life-skills" and for certain issues acting as the "information gateway" between patients and doctors.

As discussed, the six original themes were still relevant for the ward housekeeper in mental health environments, and the individual case studies show that some Trusts have made successful modifications to the acute focused NHS Estates guidelines. For instance the facilities department in case studies eight and nine had taken an "advisory role" in the development of the housekeeper role; the recruitment, selection and management was almost entirely driven by the ward management.

Case studies eight and nine also showed that the introduction of the housekeeper was a result of responding to complaints received about the unit/ward environment. After the introduction of the housekeeper both units/wards had received positive feedback relating to the environment from patients, visitors and staff.

Finally it seemed the funding responsibilities for the housekeeper role were still unresolved/unclear. This was both in terms of what pay and conditions ought to be offered to recruit and retain quality staff and also what department/budget should fund the housekeeper.

4.3 Senior ward housekeeper role

4.3.1 Introduction

The work looking at the d*evelopment of the senior ward housekeeper role* built upon the previous research and identified best practice through a series of case studies within Trusts where the senior ward housekeeper role had already been implemented. The research focused on the development of the senior ward housekeeper role, but also looked at this in context of the overall housekeeping arrangements. To help identify Trusts as suitable case studies, the following generic definition of a senior ward housekeeper put together and used:

- The senior ward housekeeper will support the clinical ward team to ensure that the environment is comfortable for patients.
- They will be responsible for cleanliness, food and maintaining the environment. However the main difference to that of the standard ward housekeeper model is that they will have supervisory responsibilities, perhaps for other ward housekeepers or other facilities staff (domestics, catering assistants).
- The senior ward housekeeper may be given an alternative title in some Trusts such as senior ward hostess or senior ward co-ordinator.

Semi-structured interviews were used to collect the data using questions based upon the themes from the previous work (a copy of the interview guide can be seen in appendix 2). A total of 18 interviews were conducted. Where possible, interviews were conducted with the Director of Facilities (or equivalent representative from the facilities department); members of the nursing team (or ward manager); and senior ward housekeepers. The case studies illustrated examples where the senior ward housekeeper can contribute to patient care and support, manage and create more efficient communication channels for the ward based housekeeping team. The danger Trusts face is avoiding the perceived extra bureaucracy or "just another layer of management" that the senior role may bring. Table 6 below summarises the type of Trust/Organisation used in the case studies and the main characteristics of the senior housekeeper.

Table 18 - Summary of case study type and main characteristics of the NHS Trust

Case study	Trust
11	Large acute hospital Trust - approx. 900 beds. Implemented SWHs 2 years ago, including in the A & E department.
12	General hospital Trust - approx. 500 beds. Operating 2 parallel housekeeping models.
13	General hospital Trust - approx. 500 beds. Implemented SWH 2 years ago across 85% of the Trust.

The following the sections present the findings from each case study in more detail.

4.3.2 Case Study Eleven

Case study eleven was based on a large acute hospital Trust which introduced senior ward housekeepers (SWH) approximately 18 months to 2 years prior to the study. The Trust had been selected nationally to act as a pilot for the SWH role and initially implemented SWHs onto three wards.

The SWHs were included as part of a hotel services contract with a commercial healthcare supplier. Additionally one SWH was working in the Accident & Emergency ward. Consequently the case study not only provided an interesting look at SWHs but also demonstrates how it could be successfully implemented in partnership with sub-contractors and onto an A & E ward, both factors which were often cited as stumbling blocks.

This case study considered the experience of implementing the SWHs across the Trust. However due to the peculiarities of implementing a SWH on an A & E department this was also considered independently.

The set-up prior to the introduction of SWHs saw 12 housekeeping supervisors covering 27 wards. The supervisors, who were employed by the contractors, were responsible for overseeing the ward-based domestic and catering staff. On such a busy and large site this led to obvious problems, such as at times taking up to an hour for the supervisors to respond to problems and arrive on wards.

The SWHs were set up as an addition to the housekeeping contract and piloted on three wards. Part of the funding for the pilot was money acquired through the Strategic Health Authority's in the form of the Local Delivery Plans. At the time of the research the Trust was tendering for a new hotel services contract. Due to the success of the initial pilot the new contact included SWH cover for every ward. The initial model for the SWH role and a generic job description were produced by the Facilities Director. The job description was developed using the NHS Estates guidance and tailored to meet the particular needs of the Trust.

The Trust has adopted the policy which allowed wards to modify the SWH role to meet their individual requirements. However the main purpose of the post, as outlined in the job description, was to be *"intrinsic to the ward areas and incorporates housekeeping, catering and operational functions for these areas. The post holder will ensure there is ownership of housekeeping, catering, maintenance facilities customer services for all patients, staff and visitors who attend the ward areas."*

The job description also made specific reference to the housekeeper assisting with nursing staff or dieticians in order to ensure patients receive their overall nutritional intake as required.

Each ward had a team of hosts who were responsible for serving the food to patients and a team of housekeepers (domestics) who completed the cleaning tasks. The number of hosts and housekeepers based on the wards were dependent on its size (number of beds). In general the SWH was responsible for overseeing the work of the hosts and housekeepers. The Trust had found that as the SWH role had developed it had changed to suit the particular requirements of the ward and sister. For example on some wards the SWH, if the host was short of time, would help to serve meals or would go round and take orders from patients. However on other wards the sisters were clear that the SWH should not be covering the host or housekeeper responsibilities.

By allowing the wards to take ownership of the role and introduce a degree of flexibility it might have been a factor in its success. Instead of being a rigid new role that was imposed upon the wards they were allowed to tailor it to their needs. In fact some wards sisters had modified the SWH job description to reflect the additional duties. The contracts manager explained how it was an iterative process with the

ward sisters in order to reach an agreement on the work to be included in the SWH job description:

> *"What we originally did with the sisters, as soon as the SWH were let loose we all had meetings with the sisters and said 'this is what we want', they went through the job descriptions together and said 'well we don't want them to do that because healthcare assistants do that, we want them to do this, this and this"*
>
> Contracts Manager

Appendix 8 shows a comprehensive list of the main responsibilities for the SWH.

The SWH acted in the capacity as a line manager to the hosts and housekeepers, hence they were in charge of arranging cover in the event of sickness or holiday. In such circumstances the SWH would liaise with the hotel services supervisors and arrange cover in a joint fashion. While the SWH had line management responsibilities for the hosts and housekeepers based on their wards they did not have the authority to, for example, permit them go home early.

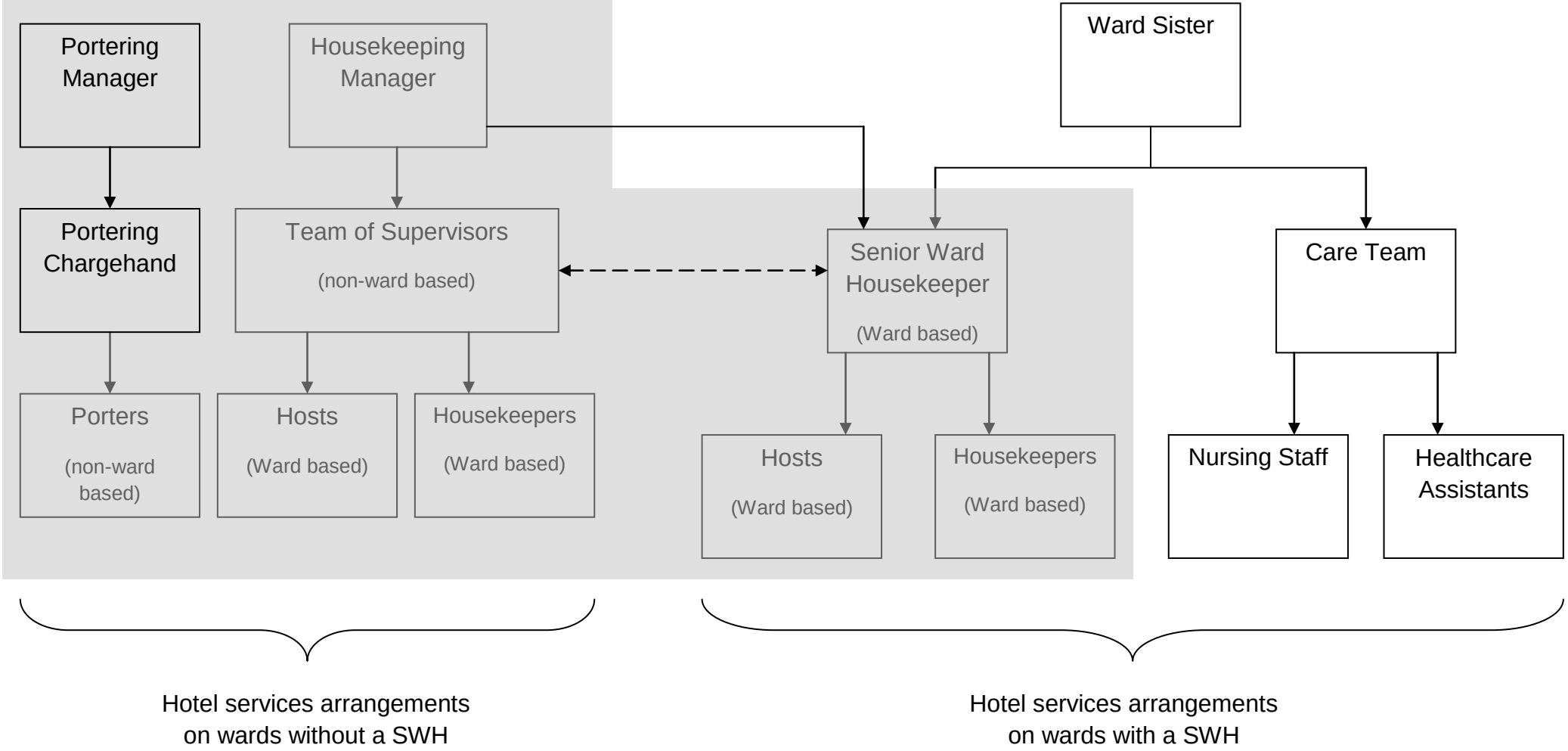
The hotel services supervisors have access to spare capacity in the form of "floating" housekeepers or being able to arrange overtime. Although when cover was not possible the SWHs had to prioritise their work to ensure that the essential catering and cleaning duties (normally done by the hosts and housekeepers) were completed.

The SWHs were employed by the contractor as part of the hotel services contract in place with the Trust. Day to day management of SWHs was under the control of the ward sisters, who ultimately had overall responsibility for patient food and making sure the ward was clean. As one SWH pointed out *"Well I think when I'm up on that ward really, Sister is my boss."*

For training, holiday, sickness and issues related to their contract of employment the SWHs reported to the Housekeeping Manager (part of the contractor). Arranging holiday cover for the SWHs became difficult as there was no spare capacity and in these situations the duties normally done by the SWH had to be undertaken by the ward staff. In addition if the SWHs needed to arrange cover for their own hosts or housekeepers, due to holiday or sickness, then they would liaise with the Housekeeping Manager or Supervisors.

The Housekeeping Manager organised monthly meetings which allowed the SWHs to come together and discuss problems, these were principally focused around staffing issues which needed to be rectified. In-between the meetings the SWHs were encouraged to communicate problems to the Housekeeping Manager. Appraisals were conducted quarterly with the SWHs by the Housekeeping and Contracts Managers and once a year the Assistant Director of Facilities and Estates. Diagram 7 below shows the team structure (organisational chart) for the housekeeping services at the Trust in case study eleven.

Diagram 7 - Team structure (organisational chart) for the housekeeping services



The recruitment for the first cohort of SWHs was managed jointly by the Trust and contractor. After the job descriptions were finalised adverts were placed in the local newspapers, on the radio and internally in the hospital. The initial vetting of job applications was done by the Contracts Manager and Housekeeping Manager. The selected candidates, who had met the criteria, were then invited into the Trust to have a second interview with the sisters on their respective wards. It was the ward sisters who made the final decision of which candidate to appoint. By allowing ward sisters to be involved in the recruitment process it meant that they could choose the appropriate candidate to meet their expectations. An additional benefit of allowing the ward sisters to make the final decision on whom to appoint was that it helped integration of the SWH onto the ward and broke down the barriers between Trust and Contractor.

The Trust was looking for candidates to ideally have some hospital background or catering experience. However the Trust felt that the type of job meant it was more important for the successful candidate to be someone who was assertive and able to take ownership of the role. The communication and interpersonal skills were also crucial as the SWHs would have a lot of patient contact and at times have to deal with people in distressed or irate states. Quite a few of the applications were from candidates who had experience in care homes, nursing homes, hotels or the catering industry.

Recruitment and selection also extended to the SWH involvement in appointing hosts and housekeepers for the ward. As part of the SWH training programme (described in more detail below) they received training on vetting application forms and interview techniques. This allowed the SWHs to shortlist and interview applicants for host and housekeeper positions on their wards.

For the first cohort of SWHs there was an initial six week training programme they completed before starting on the ward. The first component on the training programme was spent in the "classroom" and covered basic procedures and polices. The second component of the programme was practical training and spent working with or shadowing various departments they would be liaising with. A summary of the training programme was as follows:

- Introduction to company (the Contractor)
- Company profile and services
- Management philosophy
- Contract of employment, terms and conditions, job description
- Patient confidentiality

- Sickness and absence policy
- Tour of site
- Health and safety training, COSHH, Waste management, Manual handling
- Better Hospital Food
- Cook chill training
- Observation in the kitchens and ward areas
- Shadowing catering department
- Shadowing with a porter
- Shadowing with a hotel services supervisor
- Customer care, wall washing, bleep system, complaints handling
- Security, fire training
- Quality monitoring arrangements, quality control systems
- National standards for cleanliness
- Equipment training
- Bed cleaning
- Barrier rooms
- Bathrooms, toilets, floors and stairs
- Two week period shadowing an existing SWH

Depending on the requirements of the ward sisters some of the SWHs received training alongside nurses in how to feed patients. Feedback was gathered after the first SWHs finished the training and it was found that the six week programme was too long and subsequently shortened to four weeks. The feedback showed that they also found the practical elements of the training, such as shadowing various members of staff, the most beneficial.

After the SWHs had received the necessary training they started work on the wards. In this particular case study the success of SWHs integrating with the ward teams appeared to hinge upon the level of advance communication delivered to the nurses, particularly from the ward sisters. Where the ward sisters had explained the role to the care team in advance the level of acceptance and team integration was far superior compared with the wards where there had been limited or no prior communication. The Housekeeping Manager reflects upon this:

> *"There was one particular ward where the sister was great and everything worked really well and obviously she had spoken to all her staff and they knew what the role was. But the other two ward sisters didn't so those SWHs found it difficult the first couple of months..... because they didn't understand who they were, why they were there and what their role was. We've just rolled out a month ago onto another ward, and believe it or not it happened again, where the two ladies went onto the ward and the nurses didn't know what they were there for and again thought they were cleaners and were asking them to 'can you clean the toilet, can you get this done, can you get done"*
>
> Housekeeping Manager

Due to the lack of communication on some wards the SWHs had to work hard to identity their position and responsibilities. However, it was anticipated as more SWHs were rolled out across the hospital the general awareness amongst nursing staff would increase. Despite the initial confusion surrounding the SWH role, it was generally recognised that they were starting to be accepted by the clinical staff.

The issue surrounding housekeepers and SWHs being part of a hotel services contract was often cited as a barrier to success. It was therefore interesting to find that in this case study, apart from the initial problems with communication, it did not hinder the team integration of the SWH onto the ward. One of the SWHs explained this as being "in a little world of my own" when on the ward, and some days had no contact at all with staff outside of their ward. Hence they felt part of the ward team and equally accepted as part of the ward team from the nurses and doctors. What also appeared to have helped team integration was the ward based system the Trust was using - SWHs were dedicated to one ward and worked closely with the healthcare assistants, particularly at mealtimes.

Although there had been no formal evaluation, those interviewed for the case study were able to identify problems during the implementation of the SWH role. Some actions had already been taken to rectify the problems, such as appropriate communication for nursing staff regarding what work the SWH does. The title of the role "*Senior Ward Housekeeper"* was discussed as potentially being confusing. The Trust used the job title "*housekeeper*" for domestics or staff only performing cleaning duties, therefore having the term *housekeeper* in the title for the SWHs suggested a member of staff who also was responsible for cleaning only. The job title "*Senior Ward Co-ordinator"* was considered as an alternative but not pursued any further.

As discussed above, some of the problems were down to resource issues, specifically no cover being available when SWHs were on holiday or ill. The resource issue also extended to the lack of hosts and housekeepers on the weekend shifts, one SWH explains how she felt about working weekends:

> *"I think it's the shortage of staff, I used to love weekends and now I dread weekends. At least Monday to Friday you've got regular staff, Saturday and Sunday you just have whoever turns up. Because you haven't got regular people at the weekend they don't care, they're there for the money, they've got no pride in, you know they don't think oh that looks a bit dirty I'll clean that today. (They) just get in and mop it and get out again."*
>
> SWH

The SWH role was initially a pilot study on three of the wards, which had now been extended to cover five more wards. The remaining wards continued to use the old system with a central team of supervisors covering the whole site.

Comparisons of the two systems using anecdotal evidence and results from the cleaning quality audits had shown marked increases on the wards using SWH. One of the main benefits reported had been having someone permanently based on the ward that was able to oversee the everyday problems that occurred. The increased patient contact from the ward based SWHs had also appeared to make a difference, compared to the supervisors who had virtually nil patient contact.

The housekeeping teams had also benefited from the new role, which as the Housekeeping Manager explained had resulted in standards of patient care improving in general:

> *"they've actually got a co-ordinator there with them working all day so they don't feel they haven't got anyone to support them, because there's that person's presence there all day long so that benefits them and it benefits me because obviously the standards improved, patient care has improved and so I'm happier because the Trust are happier so all round I think its been a positive move."*
>
> Housekeeping Manager

The facilities department believed that the improved management of the housekeeping teams had meant that ward sisters were in general more confident of the hotel services arrangements. The Assistant Director of Estates and Facilities also considered the success of the SWH role not only to have raised the profile of the Trust amongst its peers, but also allowed the barriers to be broken down between the housekeeping team and the ward team.

As a result of the SWH role other small benefits had been noticed, for example if patients didn't want anything from the Trust menu the SWH was on hand to contact the kitchen and arrange for alternative food to be provided. Previously this was not possible as the hosts were too busy to perform such tasks. The feedback from patient surveys has indicated other direct patient benefits such as the SWH making it easier for patients to choose from the menu. Other small changes had included being able to offer alternatives to tea and coffee, such as peppermint tea and fruit teas. This was particularly well received on the digestive disease wards where it was also important to administer and document exactly what patients were eating.

Some of the initial problems with the SWH role had already been recognised and rectified, for example changing the length of the training programme from six weeks to four weeks. One of the key priorities in improving the service was the need to cover the workload during annual leave. There were ten weeks each year when the wards were short of a SWH. During these periods the ward team (nurses) had to cover the duties normally undertaken by the SWH and the result was a decline in the standard of patient care offered.

Another suggested improvement was focused on offering the SWH a structured career progression pathway. There were some possible routes for the SWH to progress, but these

were fairly limited and confined within the contracting company. However, if the SWH wished to switch into a clinical role then this was possible, the healthcare assistant being the most appropriate.

4.3.2.1 A & E Senior Ward Housekeeper

One of the three pilot wards which first implemented the SWH role was in Accident and Emergency. Throughout the NHS as a whole, general observational evidence suggests that at the time of the research Trusts had been slow to develop the ward housekeeper role in A & E, perhaps due to the different type of patient catering needs. Hence it was worth taking the A & E SWH from the case study and looking at the role separately and in further detail.

The model for the A & E SWH was based upon the same principles - the ward environment and supporting and supervising the ward housekeeping team. However, when it was implemented it was seen more as an experimental type role in terms of giving the ward manager flexibility for management and assigning additional duties. The A & E ward sister described the situation before the SWH started:

> *"Well what happened before she came into post, we would have sandwiches delivered but that would be hit and miss, sometimes they wouldn't turn up and then nobody would realise until somebody went to get a sandwich. We didn't have regular refreshment rounds we just kind of did it when our patients said they wanted something to eat and the place wasn't kept tidy, things like the curtains were hanging off because nurses never had time to do anything like that"*
>
> A & E ward sister

Although the main duties for the SWH were based around the catering, cleaning and ward environment, the work didn't appear to be as routine as the other ward based SWHs (mainly due to the diverse nature of the patients and illnesses dealt with on an A & E ward).

The majority of the A & E SWH time was spent co-ordinating the catering requirements. During the early morning period the SWH was not present so the nursing staff would cover breakfasts which consisted of serving tea and toast. The SWH then was responsible for the remaining patient catering which roughly corresponded to rounds at lunchtime, teatime and suppertime. Patients on A & E were provided with sandwiches or if they specifically asked

for it, hot food. The sandwiches were provided pre-packed by the kitchen in bulk. The SWH then prepared the sandwiches by cutting them up into smaller portions and adding garnish and salad (which were also provided by the kitchen). If the patients requested hot food the SWH would collect it from the kitchen, however, this could be a time consuming process, particularly if there were a number of unexpected requests.

With regards to the cleaning element of the role, the SWH was responsible for a team of housekeepers based on A & E who performed the day to day cleaning work. The specialist cleaning jobs were also co-ordinated by the SWH, for example managing the periodic jet washing of the trolleys and changing the curtains. One of the jobs which proved more difficult was resealing the floor, especially in A & E where the patients tended to be more transient.

The SWH on A & E had the same lines of management as the other ward based SWHs. The SWH was employed by the contractor and reported to the Housekeeping Manager for training, holiday, sickness and issues related to their contract of employment. For day to day issues the SWH liaised with the A & E ward manager. The housekeeping team in A & E was the responsibility of the SWH who managed them on a day to day basis. If the nursing staff wanted to arrange some specific cleaning they were able to contact the SWH via a pager. The SWH would then liaise with the housekeeping staff to co-ordinate the cleaning. The A & E SWH believed that some of the housekeeping team found it uncomfortable at first with the new management arrangements, particularly the concept of a ward based supervisor. As a result of staff turnover the new staff on A & E didn't have experience of the previous system and appeared to be happy with the management arrangements.

The A & E SWH received the same basic six week training programme as outlined above. The flexibility of the new role allowed the ward manager to consider the benefits in allocating additional duties to the SWH. Subsequently, the SWH was given the appropriate training and they could now assist patients sitting up in bed, help to feed patients and make beds. The SWH believed the joint nature of the training alongside nurses helped them build a good working relationship and allowed integration into the ward team. The SWH also identified another benefit of the joint training which was the opportunity to make it clear what their job role was away from the work environment, the SWH explained:

> *"and also you go on team away days, obviously they are mostly nursing based anyway but its an opportunity to pick up a few things and also to make clear to them exactly what my job role was away from a hostile environment"*
>
> A & E SWH

As the SWH was dedicated to managing the ward catering and ensuring the housekeeping team worked efficiently, they were immediately seen as a bonus by nursing staff. Consequently the integration of the SWH and nursing staff didn't pose any problems; in fact they felt it was harder for them to integrate with the housekeeping team.

The main problem encountered by the SWH in A & E was related to resourcing (a common theme with the other SWH based across the Trust). However, the specific problem for A & E was not having 24 hour SWH cover. The A & E ward operated 24 hours a day and accommodated patients that needed feeding at all times. Outside the core SWH hours (which were 8am - 8pm) the catering duties were managed by nursing staff. The problem was at its most acute when the ward was busiest during Friday and Saturday nights and patient food and the ward environment were not given priority, the consequence of this meant additional work for the SWH the following morning. The demands placed on the A & E ward in terms of the ward environment and building fabric was also a problem which the SWH had to deal with, and keeping on top of the maintenance jobs was an on-going issue. As the SWH described it was a "*24 hour environment"* coupled with the fact that it was probably treated with a *"little more disrespect than the rest of the hospital"* due to the type of patients.

Since the introduction of the SWH the complaints, related to the standards of cleanliness and catering, had been virtually eliminated. So from the patient perspective there had been a huge benefit. There had also been advantages for the nursing staff, particularly centred around having a dedicated member of staff responsible for the patient catering requirements, which allowed them to focus on clinical duties. In addition to the advantages listed above, the nurses believed the SWH brought a personal touch to the A & E ward. The ward sister explains why this was important, especially on an A & E ward:

> *"she's a very good communicator, she chats with us all, she talks to all the patients she makes them feel, like a good housekeeper should. She makes them feel at home and nothing is ever too much trouble for her and she'll sort of do things for them which is really nice and not something that often happens in an A & E department, it tends to be a bit more impersonal with the nurses being too busy to do anything, so that is a really nice service for the patients."*
>
> A & E ward sister

This demonstrated that the type of person required to work successfully as a SWH needed the so called "soft" skills. In addition the quote hinted towards the altruistic nature of the type of person attracted, or best suited, to work as a SWH. The SWH provided examples of when they have performed additional jobs to their role that have made a difference to the patients' experience on A & E. In fact some of the patients had been so impressed with the service related to the SWH they had offered money.

This case study is a good example of where the SWH role has been successfully implemented. It has demonstrated where a SWH can be implemented in Trusts where the housekeeping services are outsourced to an external contractor as part of a hotel services contract. What the case study also showed is how important it is to select the correct person for the role. The SWH working in A & E illustrated that enthusiasm and being proactive are two attributes which had made the role successful. The role was a new concept in the Trust, and they believed this contributed to its success, as the contractors, facilities department and ward staff were all novices and had to work together in partnership. In addition, as the SWH was implemented as a joint project between ward staff and the contractor it helped to break down barriers and established better working relationships.

The success of the role had not only raised the profile of the Trust amongst its peers but also raised the profile of the facilities and estates department in the local community with newspapers and radio stations reporting on the new role and the difference it was making in healthcare.

Table 19 - Case Study Eleven Summary

Type of Trust	**Large acute hospital Trust - approx. 900 beds**
Role	Implemented SWHs 2 years ago, including in the A & E department. Senior Ward Housekeeper role responsible for all catering and domestic ward work
Recruitment	Led by contractor with input and final decision from ward sisters
Induction	As part of 4 week training programme
Training	4 week programme. Included shadowing members of staff
Integration	Good. Allowing the ward sister to make decision on SWH helped integration
Management	Day to day by ward sister. For training, holiday, sickness and contract of employment SWHs report to contractor

4.3.3 Case Study Twelve

Case study twelve demonstrates a unique healthcare assistant model (which incorporates the housekeeping services) that had been implemented in a general hospital Trust. The Trust had continued to use a different housekeeping/domestic model in some central areas and implemented the new model across a number of other wards. As the Trust was still operating parallel systems it provided an interesting opportunity to compare the two models. For this particular Trust the senior ward housekeepers were known as Senior Healthcare Assistants (Housekeeping) or housekeeping SHA. The focus of the research was the housekeeping SHA, this role was part of the new model and by taking a holistic approach to the research the case study illustrated some interesting points. The development of the new model was driven by a senior management team who strongly believed in it. There was commitment from the Trust board and support from HR and the trade unions.

The housekeeping services were incorporated into a new healthcare assistant model which had been adopted on some wards across the Trust. The model was unusual and seemed to be fairly unique within the NHS. The ethos behind the healthcare model was to use multidisciplinary teams that could cover the work on a particular ward/unit. Diagram 8 illustrates the basic model.

The healthcare assistant model incorporated three strands of staff within an inclusive team, these were "Care Assistant - Housekeeping"; "Care Assistant - Nursing"; "Care Assistant -

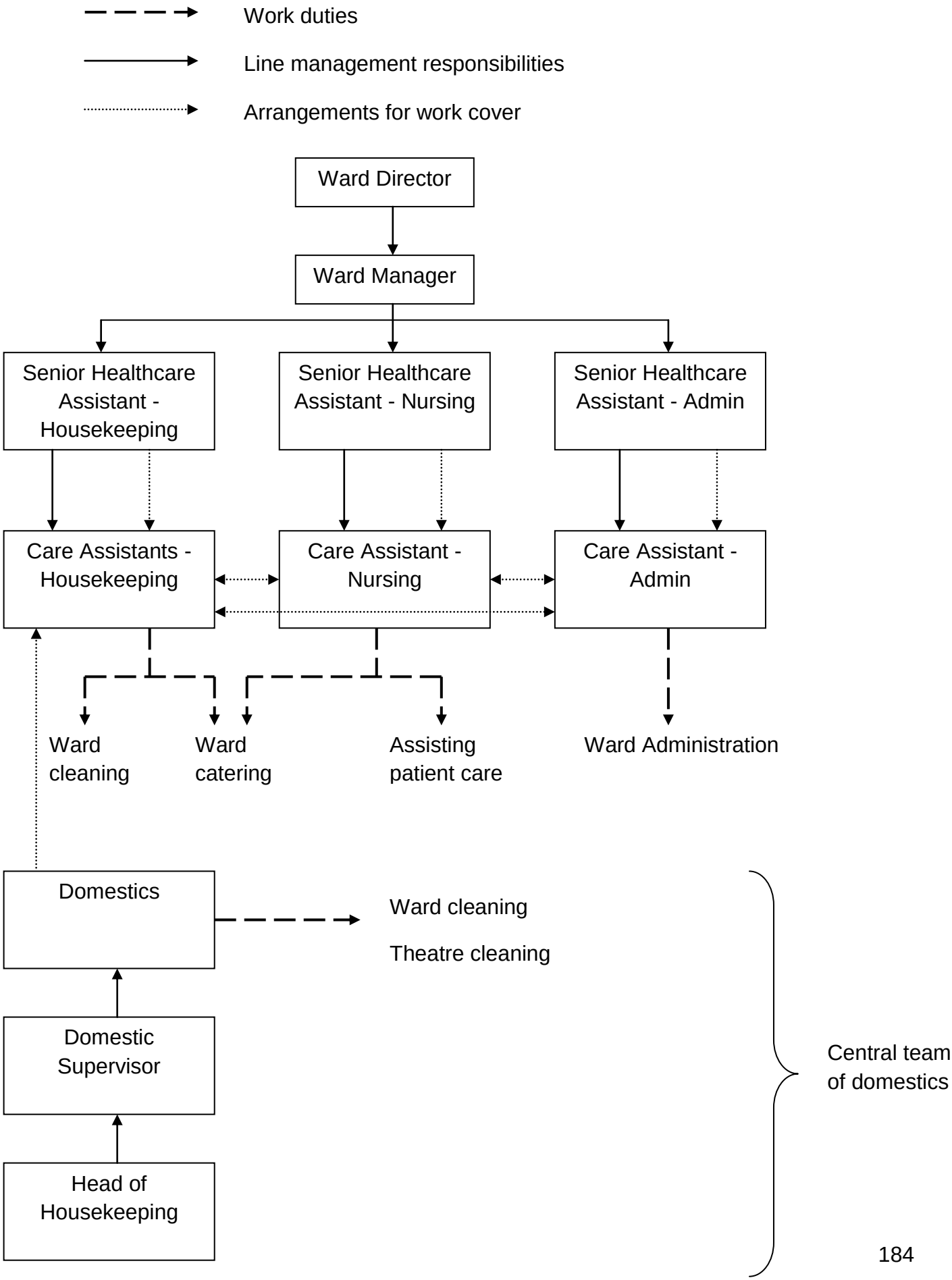
Admin/Ward Clerk." Each of the three groups of staff were managed by a senior healthcare assistant, hence "Senior Healthcare Assistant - Housekeeping"; "Senior Healthcare Assistant - Nursing"; "Senior Healthcare Assistant - Admin/Ward Clerk."

The concept was that the care assistants had a core set of duties which they performed on a day to day basis. In addition, all care assistants were also trained to a sufficient level in order to provide flexible cover across the team, hence a self-contained model. For example, in theory the housekeeping care assistants main responsibilities were ward cleaning and catering, however, if the ward was short staffed (due to sickness or holiday) then the basic workload could be managed short-term by either the nursing/admin care assistants or the senior housekeeping healthcare assistant.

Although the main focus for the case study was the housekeeping senior healthcare assistant, it is worth outlining the main duties undertaken by the housekeeping care assistants. These were to ensure all areas of the ward were cleaned according to agreed standards and attend promptly to ad hoc spillage, equipment cleaning and any other requests. Ensure the ward area was kept tidy, moving and storing chairs and equipment as required. Fetch or take patients, equipment, specimens, paperwork etc. promptly in response to a request.

The housekeeping care assistant core duties also included looking after patient drink requirements and serving breakfasts. There had been a certain degree of flexibility within the model that had allowed wards to modify the work undertaken by the housekeeping care assistants. It was the level of catering responsibility that was principally adjusted; some ward managers preferred the housekeeping care assistants to help distribute meals and even feed patients when the nursing team were short staffed, whereas on other wards they were entirely focused on cleaning duties.

Diagram 8 - Senior Healthcare Assistant (housekeeping model)



The role of the housekeeping SHA was predominately managing the care assistants and ensuring cleaning and catering standards are met. On a day to day basis the housekeeping SHA reported to the ward manager, or if the SHA was based across a number of wards they reported to the modern matron. The housekeeping SHA job description outlined the principle responsibilities for the role. The focus of the role was very much on managing and supporting the care assistants in their team. Therefore this included helping with the care assistant training, mentoring care assistants, acting as a role model and covering any work in their area when required.

The key in making the model operate successfully was ensuring that the 3 SHAs were able to cover their own area of work, e.g. this meant the housekeeping SHAs to help out with the ward cleaning and catering duties when necessary but also cover for the nursing and admin SHAs.

There was a degree of flexibility for the model whereby wards could modify the duties assigned to the housekeeping SHA. For example, on one ward the line management responsibilities for the housekeeping SHA had been removed, instead the housekeeping care assistants reported directly to the ward manager. However, within larger departments that covered several wards, the managers had found the housekeeping SHA management responsibilities useful.

For day to day management the housekeeping SHA reported to the ward manager or the modern matron if they worked across a number of wards. This new model meant the Facilities department no longer had management responsibilities for either the housekeeping SHA or housekeeping care assistants. The only formal involvement from the Facilities department with the ward based housekeeping staff was through the quality audits, however they could only advise of the results and not influence any change at ward level. When cover was required due to sickness or annual leave, the concept of the autonomous team approach should allow for one of the other two SHAs (either the nursing or admin) to manage the basic workload.

All of the housekeeping SHAs were recruited internally and had worked previously as domestic supervisors in the central team. This meant they had the basic training required for the role and already had leadership and training experience. Under the new ward based model it was now the responsibility of the ward manager or modern matron to monitor the housekeeping SHA training. The only input from the Facilities department regarding training was if new cleaning products or equipment was introduced.

The training that the housekeeping SHAs received either working within the new model or when working as part of the central domestic team included line management courses, appraisal courses, interviewing techniques and health & safety risk assessment. In addition to the basic training the housekeeping SHAs had the opportunity to complete relevant NVQs and also qualify as an NVQ assessor.

To enable housekeeping SHAs to provide cover for the nursing and admin SHAs some had been provided with the necessary training to do so. However, this had been as a result of their personal choice and not a compulsory part of the training. Therefore, the housekeeping SHAs who had decided not to take the necessary training could not provide cover for the nursing or admin SHAs.

The new healthcare assistant model aimed to encourage team working and integration across the ward through the "crossover" concept. This required the care assistants and senior healthcare assistants from the three strands to cover each others duties. While most of the staff interviewed during the case study agreed that the concept was good there had been difficulties in achieving the crossover across all of the wards. One of the key factors to cause the crossover concept to fail was the size of the ward teams - the healthcare assistant teams were too small to be autonomous and therefore unable to cover for holiday and sickness. This resulted in cover having to be arranged, sometimes at short notice, using staff from the central team of domestics.

Perhaps the most interesting aspect to the case study was the problems and difficulties that the ward based model had created, particularly in relation to the staff issues and operating a parallel system alongside the central pool of domestics. The concerns described during the case study interviews were summarised under six headings, these were: *Size of ward based teams; Staff issues; Uniforms; Recruitment and retention; Pay and conditions; Flexibility for rosters*. These six issues are now discussed in more detail below.

Size of ward based teams: The new healthcare assistant model meant that the wards were now self contained autonomous units which in theory could arrange holiday and sickness cover internally. Cover was arranged using the "crossover" concept amongst the SHAs and care assistants. The major problem with the new model was that ward teams were too small to be autonomous and did not have sufficient resources to be flexible in providing cover. The size of the central team of domestics meant they did have a certain amount of flexibility amongst staff; however this luxury was not available to the smaller units who were working

to capacity. The situation had now developed where the ward based healthcare teams had to use domestics from the central team to provide cover. The problem was often most acute during the evening and night shifts when a ward manager would take domestics from the central team leaving them short of staff. The result was that the areas (theatres, central bays, and some wards) which the central team should cover were not being cleaned. An additional knock on problem was that the central domestic team were paid significantly less, therefore being asked to provide cover for the ward staff was creating tension and bad feeling.

Staff issues: It was again the crossover concept that created a problem. When the new model was introduced, the staff that were either already in place or recruited to the new positions as senior healthcare assistants and care assistants were given improved pay and conditions. This was on the provision that they would have to work under the crossover concept and take on additional duties covering across the team when needed. However, the ward managers had found it difficult getting the staff to integrate in the crossover model, especially the admin healthcare assistants who had been keen to retain their own identity and not provide cover for domestic duties. One ward manager described the problems on the ward and provided a possible explanation for the difficulties:

> *"There is natural self selection and then when you are trying to integrate those roles it doesn't really work. I mean I've tried because one of the project leaders believed desperately in the model, but it's gradually separating out again and settling to a happy level. As it's separating out the admin care assistants now are much happier in a separate uniform just doing admin work, if they'd have wanted to work with patients they'd have come to work as nursing care assistants"*
>
> Ward Manager

Uniforms: The same coloured uniform was introduced for staff as part of the healthcare assistant model. The reason for this was to present a team approach, particularly across the three strands of care assistants who were supposed to cover for each other, and also to suggest an image of equity for the staff, especially as they were on the same grade/level. The matching uniforms had been successful in portraying a team image to the doctors, and allowed the non-clinical staff to be accepted. There had been several problems with introducing standard uniforms. The first was related to patients who have found it difficult to distinguish between the staff groups. This had resulted in frustrated patients who, for example had confused housekeepers with nursing staff and asked for help which had been

outside the remit of their duties. There had also been a problem for some of the admin care assistant staff who felt that the new uniforms took away their own identity. Consequently, they had changed to a different uniform and it was anticipated that the housekeeping and nursing care assistants would soon do the same.

Recruitment and retention: When the ward based healthcare assistant model was implemented the majority of staff were recruited internally from the central domestic team, this resulted in major implications for the Facilities department who were responsible for the central team. The pay and conditions being offered to work as part of the ward based team was preferential compared to the central domestic team. The result was that the most experienced domestic supervisors transferred jobs to work as a ward based housekeeping SHA, leaving the central team short staffed. As new ward based positions became available ward managers were aware of sickness records and the quality of work and had been able to select the best domestic supervisors who applied. The Head of Housekeeping had found it very difficult to replace the domestic supervisors especially as the ward based staff were offered superior pay. The situation was made worse if the Trust recruited at the same time for both ward based and central domestic staff. The Head of Housekeeping described the problem facing the facilities department:

> *"I have lost no end of staff, I mean at times it's quite difficult for me to cover because it's not easy to recruit. For example, I advertised for two part-time supervisors, unfortunately a ward based team at the same time advertised for a basic care assistant, which is a lower grade than my supervisor but the money is better! The first thing potential ancillary staff will look for is not what the job is doing but how much they get paid"*
>
> Head of Housekeeping

Pay and conditions: As detailed above, the pay and conditions offered to the ward based care assistants were superior to those offered to the central team of domestics. This had led to many of the most experienced staff transferring from the central team and leaving the Head of Housekeeping short staffed. The Facilities department had also found that ward based care assistants and the central team of domestics would share break times and use the same common room and would compare pay slips. This had resulted in resentment amongst the domestics who were receiving less pay for performing a virtually identical role.

Flexibility for rosters: The housekeeping SHAs had the responsibility for managing their own rosters and those of their housekeeping care assistant staff. Some of the housekeeping SHA had the option of not working weekends or evenings and fixing their hours to cover Monday to Friday daytimes only. Hence on weekends and evenings there was no supervision for the housekeeping care assistants which meant that quality standards could not be checked and no senior was available to provide short notice cover in the event of absence.

Although the focus of the case study was on the housekeeping SHA, it was important to look at the role in context of the new ward based healthcare assistant model. For this reason the case study looked at the new model and the benefits and weaknesses of it in addition to reporting on the housekeeping SHA. The implementation of the model has been a "top-down" approach and it appeared that this had caused the Trust difficulties, particularly getting the staff to adopt the crossover concept which had a number of problems (listed above).

The other major weakness with the new model was the impact it had on the central team of domestics which had continued to operate in parallel. In effect the Trust had created an internal market for its own housekeeping/domestic staff. As a result of this the Facilities department, who managed the central team of domestics, had lost out significantly, principally due to the preferential pay that the wards offered to healthcare assistants.

Both the ward managers and housekeeping SHAs working under the new model felt that it had been successful in some areas, mainly the team working. However, most believed that there would be a natural and gradual shift back towards the senior healthcare and care assistants dedicated to only their job with no crossover at all; i.e. housekeeping care assistants responsible for domestic work, the nursing care assistants focusing on patient care, and the admin care assistants only doing admin work. This was already evident in the uniforms, with the admin care assistants having changed theirs.

As outlined above one of the current problems with the ward based model was that wards were too small to be self contained and autonomous. This resulted in them having to use staff from the central team of domestics as cover, which in turn left the central team short staffed. One possible solution to this, suggested by the facilities department, was to make housekeeping SHAs responsible for a larger number of wards or units and place them onto a rota which meant cover was available during longer shifts and weekends. By allowing the housekeeping SHAs to be responsible for a larger number of wards resulted in them having

more staff meaning greater flexibility for arranging cover and thereby not having to rely upon the central team.

At the time of the case study interviews it was unclear what direction the Trust would take with the healthcare assistant model, however they were introducing a 'ward hostess' as a pilot study into one ward, with the possibility of also piloting a change in the crossover concept. The ward hostess would be responsible for co-ordinating the meals, and in the process freeing up the housekeeping care assistants to concentrate on the domestic duties. It was undecided whether a senior ward hostess position would be introduced. In addition, the pilot ward might continue with the crossover concept but with staff working in block weeks, i.e. spending one week as a hostess and then the following week as a housekeeping care assistant.

Table 20 - Case Study Twelve Summary

Type of Trust	**General hospital trust - approx. 500 beds**
Role	Operating 2 parallel housekeeping models. In the ward areas the trust has senior healthcare assistants (housekeeping) overseeing catering and cleaning
Recruitment	All recruitment was done internally and managed by individual ward managers or modern matrons
Induction	Limited as all senior healthcare assistants were internally recruited
Training	Line management courses, appraisal courses, interviewing techniques, health & safety risk assessment and relevant NVQs
Integration	Poor. "Cross-over" support model did not function well
Management	By ward manager or modern matron. Little involvement from FM department

4.3.4 Case Study Thirteen

Case study thirteen was in a large general acute hospital which, as a result of the NHS Plan, had introduced a new housekeeping model across the complete Trust. At the time, all of the Trust's hotel service arrangements were supplied in-house. The new housekeeping model was introduced on all wards apart from Oncology which continued to use the central facilities staff for housekeeping duties.

As part of the implementation of the new housekeeping model all the "staff cost" related elements of the service (including the hostesses and domestic staff), previously managed by the hotel services department, were transferred to the ward budgets. Therefore the recruitment, mandatory training, organising rotas, annual leave etc. were now managed by the ward. All the "non-staff" elements of the housekeeping services, e.g. distribution of chemicals, co-ordination of the stores and some non-mandatory training continued to be managed centrally by the hotel services department.

As part of the housekeeping model the senior ward housekeeper (SWH) role was introduced two years ago. The concept of the SWH was a fully integrated member of the ward team and responsible for the housekeeping line management duties at a local (ward) level.

Like the other case studies investigated as part of this research, the development of the SWH had to be considered in the context of the overall Trust housekeeping arrangements. After the initial housekeeping model was implemented the Trust wanted to investigate ways to support, manage and create more efficient communication channels for their housekeeping staff. The concept of the SWH was developed to be a "hands on role" under the direct management of the senior ward nurse/modern matron and fully integrated into the ward team. The SWH project was managed jointly by the hotel services manager and the deputy director of nursing; they were supported by senior nurse colleagues and directorate managers.

Before the SWH went live the project team spent a considerable amount of time designing the core role and duties and ensured that adequate planning was undertaken - particularly as they considered the SWH role to be entering *"uncharted territory"*. After a draft SWH role was agreed the project team presented three options to the Trust board with differing levels of service and associated costs.

The Surgical Ward was the first to start using SWHs and it then took the Trust a period of nine months to complete the implementation across all the planned wards - approximately 85% of the wards were now using SWHs. One of the initial problems facing the project team was the perception from nursing staff of *"just another change"* and an increase in responsibility and workload for the senior nurses. The other initial problem was how the existing domestic and housekeeping staff accepted the SWH - both problems needed careful management, particularly around the communication of the new role to staff.

The basic responsibilities for ward housekeepers were to ensure the patient catering and cleaning requirements were met. The SWH was directly responsible for overseeing the ward housekeeper duties. Each ward had SWH cover 24 hours a day apart from the weekend evening shifts. The main SWH duties included Managing sickness and holiday cover for housekeeping staff: Arranging temporary cover for housekeeping staff: Management of housekeeping shifts/rotas: Co-ordination of housekeeping staff timesheets: Management of ward stores and cleaning equipment: Weekly ward environmental audits (in conjunction with the senior nurse): Organising housekeeping staff training requirements (including keeping records): Providing support to ward hosts during mealtimes.

The concept of the ward based housekeeping model required the hotel services to be autonomous, self-contained units. Therefore in addition to the core duties listed above occasionally the SWH needed to help out the domestics/hostesses with their duties - e.g. cleaning spillages, ordering or collecting extra patient meals. The team approach model was also reflected across clinical and non-clinical staff, for example the weekly ward environmental audits were conducted jointly with the senior nurse.

After the "staff" elements for the hotel services departments were transferred over to each ward it effectively meant each ward was responsible for their housekeeping staff and therefore line management. It was essential to move the management responsibilities from the hotel services department over to the ward manager in order to achieve a successful autonomous unit. As part of the new housekeeping model the SWHs reported directly to the senior ward nurse, or modern matron if they covered more than one ward.

As outlined above, the SWH was the line manager for the ward based housekeeping staff and was responsible for organising the rotas, annual leave, sickness cover and training requirements. The Trust was very keen to stress the team approach in the new ward based housekeeping model; this enabled nursing staff to approach housekeepers, to clear up spillages for example, without first having to get the SWH permission.

Following the implementation of the ward based housekeeping model and to allow the SWHs across the Trust to communicate, a monthly team meeting was arranged. The meeting allowed SWHs, senior nursing staff and hotel services representatives to discuss any areas of concern and feedback developments across the Trust. In addition, speakers were regularly invited to the meetings to provide training presentations on various topics, e.g. recruitment & retention, occupational health and catering presentations.

The initial recruitment of the first SWHs was managed by the project implementation team and at the time of the study, nearly all of those initially appointed were still working in their roles. The new posts were advertised both internally and externally and the Trust were able to attract quality applicants by advertising at a supervisory grade. The recruitment process resulted in approximately 75% of the SWHs appointed being from external applicants. At first the internally appointed SWHs found it difficult to shake off the label of being a "domestic". The other disadvantage had been a lack of management experience from the internal recruits, as one senior nurse pointed out initially it was not unusual for her to have the new SWHs visiting her 3 or 4 times a day with different queries.

Most of the new SWHs underwent a two week induction period. One week was spent going through the standard Trust induction and the second week was a localised department/ward induction. As part of the localised ward induction the SWHs spent time shadowing the existing housekeeping team and the senior nurse. The induction also allowed the new staff to familiarise themselves with the ward environment and systems, for example where the chemical stores were, how to complete the time sheets etc - however the implementation project team felt it important to allow each ward manager or senior nurse the flexibility to build the induction (and training) programme to suit their local needs.

In terms of training, SWHs received the standard requirements for housekeeping such as food hygiene, COSHH etc. The Trust made use of their in-house practice development team who were able to organise training courses and shape them to the needs of each ward - thus allowing ward managers to tailor their training programmes to suit their individual needs - for example the SWHs recruited internally (from the hotel services teams) had experience gaps in managing staff so wards arranged additional sessions looking at recruitment and appraisal.

All the staff interviewed for the research agreed that the implementation of the new housekeeping ward based model had enabled a more integrated team approach. The Hotel Services Manager explained that the old model (when domestic staff were part of a central team and not ward based) was not conducive with promoting teamwork, within both the support services, and across clinical and non-clinical teams:

> *"one of the particular issues is about being locally accountable and accepted as part of the team, one of the difficulties coming under a department like hotel services was moving around. You move people around for operational reasons but that didn't help the continuity of being part of the team."*
>
> Hotel Services Manager

The SWHs were accepted as part of the team by the experienced nursing staff, however, some of the junior nurses took a while before they appreciated the SWH role and responsibilities. In addition, some of the ward based hotel services staff were initially concerned, particularly during the transitional period, when the SWHs were integrated onto the ward. Their main concerns centred on a perceived increase in supervision and the changes that took place which affected their routine such as new rotas - domestics felt there was more flexibility when they were managed centrally by the Hotel Services department.

At the time of the research, anecdotal evidence suggested the new housekeeping model and the SWH role to be successful. The initial problems during the transitional period - which focused on making sure some of the junior nurses were aware of the role and responsibilities of the SWH and allaying fears from domestic staff regarding another perceived tier of management - had been identified and resolved.

After the new housekeeping model was operational one of the major hurdles was getting the domestic staff to use the SWH as their line manager instead of going straight to the hotel services department. This was particularly acute for the domestic staff that had worked at the Trust a long time and were used to being managed by the central hotel services department. The dilemma for the Hotel Services department had been deciding at what point to step in and provide support to the wards, which had been left short staffed and unable to cover vacancies internally, and when to take a less involved position.

At the time, no formal evaluation of the new housekeeping model (and SWH role) had taken place. However feedback from the ward managers across the Trust suggested that it was an improvement over the previous service provision and should remain in place. The improved team working, particularly across clinical and non-clinical teams, since implementation was cited as one of the success factors. A consequence of the new ward based model had enabled the patients to have a regular housekeeper or for the SWH to attend to their needs and therefore facilitate a stable housekeeping service. The housekeeper contribution to

patient care was something the Trust was keen to build on and wanted to ensure all staff appreciated the impact and value of non-clinical ward based staff.

Case study thirteen was another example of where a project team, consisting of clinical and non-clinical representatives, had implemented a new housekeeping model with the Facilities Directorate (or Hotel Services department in this case) acting in an 'advisory' capacity. The project team took the approach that if the ward based housekeeper was to be successful then the budget and all management responsibility had to be transferred to ward level. After the new housekeeping model had been implemented, and to promote the concept of autonomous self-sufficient units, the Hotel Services department ceased all management and supervisory duties.

Table 21 - Case Study Thirteen Summary

Type of Trust	**General hospital Trust - approx. 500 beds**
Role	Implemented SWH 2 years ago across 85% of the Trust. Focused on patient catering and cleaning
Recruitment	Initial set of SWH recruited by the Project Implementation team
Induction	Two week induction period. One week was the standard trust induction and a second week was a localised department/ward induction
Training	Food Hygiene, COSHH. In-house practice development team tailored training course to individual ward needs
Integration	Good
Management	Management and budget of SWH devolved to wards

4.3.5 Discussion

The first set of guidance notes from NHS Estates (2001a) suggested a management structure where the ward sister (or equivalent) was responsible for day to day management of the ward housekeepers and the facilities department was responsible for the more "strategic" elements such as recruitment, training, performance monitoring and sometimes organising sickness and holiday cover. The housekeeping models investigated during the SWH case studies indicated a shift towards a more autonomous, self-contained unit where all the housekeeping responsibilities are handled at a local level (i.e. ward) - however this may not be representative of the NHS as a whole. Using the autonomous units with a

devolved management model, the dilemma for the Hotel Services department - when managing the remaining pool of central housekeeping staff - was deciding when to provide support at ward level and when to take a less involved role or "back seat". If the ward based teams were allowed to approach the central housekeeping team, without first trying to resource internally, then it facilitates the breakdown of the autonomous units. Diagram 9 below shows the autonomous ward housekeeping model integrated into the ward team.

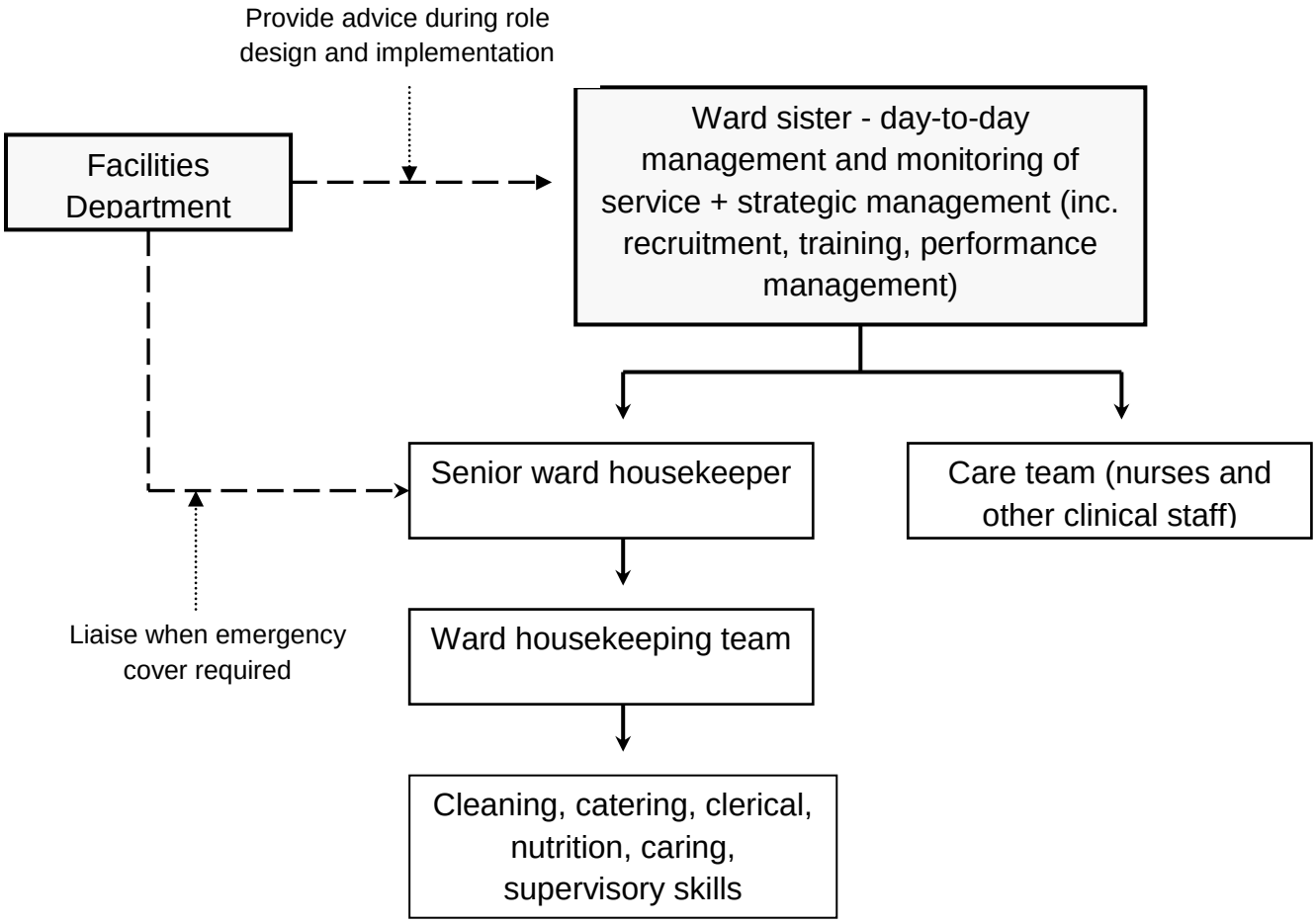


Diagram 9 - autonomous ward housekeeping unit

Table 22 provides a summary and comparison of case studies 11 to 13 and the various issues related to the role, recruitment, induction, training, integration and management. Case studies 11 to 13 revealed two problem areas which were a result of implementing the autonomous units. Firstly, some of the individual wards which operated as autonomous units were not large or flexible enough to cover for sickness or holiday absence. Secondly, when the autonomous units failed to cover absence internally and then relied on a central team of domestics - which are on different pay and conditions - it caused tension amongst these staff.

It is important for Trusts implementing the senior ward housekeeper (SWH) role to consider it in the context of their overall housekeeping arrangements which were already established. The case studies 11 to 13 clearly illustrate examples where the SWH can contribute to patient care and support, manage and create more efficient communication channels for the ward based housekeeping team. The danger Trusts face is avoiding the perceived extra bureaucracy.

The SWH implementation project team in case study 13 felt that in order to achieve a successful autonomous unit, all the housekeeping management duties should be transferred to ward level. In addition to this, the devolved management responsibilities helped promote teamwork and integration across the clinical and non-clinical staff - although the case studies indicate that it takes time for a "cultural shift" to occur before housekeeping staff stop using the Hotel Services department and accept the new line management responsibilities. The shift towards the autonomous units was also reflected during the implementation of the SWH role. The success of case study 13 demonstrated where the Facilities Department could act in a more advisory role - providing advice and consultancy to the cross departmental implementation project team - rather than leading the project.

Case study 11 demonstrated where a SWH could be successfully implemented into an A & E department. The diverse nature of patients and illnesses dealt with in A & E meant the SWH needed to work flexibly and had less routine work than SWHs based on other wards/departments. The ward catering requirements for the SWH in A & E may only be providing hot drinks and serving sandwiches, however the SWH made improvements such as adding salad garnishes to the pre-packed sandwiches and serving on plates.

Case studies 11 to 13 show where the SWH has been implemented using different housekeeping models. It illustrated how important it was to consider the SWH in the overall context of the Trust's housekeeping arrangements. In addition to the patient centred advantages respondents also highlighted some additional benefits for the Trust and specifically the facilities department:

- The facilities departments felt where the SWH had been implemented successfully it resulted in increased confidence in their hotel services department from clinical staff.

- The success of the SWH had raised the profile of the Trust's facilities department amongst its peers.

- Cross representation of clinical and non-clinical staff on the project implementation team helped to break down barriers at ward level.

- A joint project between the Trust and contractor - when the hotel services were contracted out - helped establish better working relationships.

Table 22 - Case Studies Eleven - Thirteen Summaries

Case Study	Eleven	Twelve	Thirteen
Role	Senior ward housekeeper. Responsible for catering and cleaning	Senior healthcare assistant. Responsible for catering and cleaning	Senior ward housekeeper. Responsible for catering and cleaning
Recruitment	Led by contractor. Final decision with ward sister	Ward managers or modern matrons	Through Project Implementation Team
Induction	4 week programme	Limited	Two week induction - standard trust and ward induction
Training	4 week programme. Included shadowing staff	Focused on management issues	Food hygiene, COSHH. Led by practice development team
Integration	Good	Poor	Good
Management	Joint. Day-to-day ward sisters. Training, holiday, sickness contractor	Ward manager or modern matron	Management and budget devolved to ward sisters

4.4 Evaluation of role

4.4.1 Introduction

The longitudinal evaluative case studies (14 and 15) relate to the senior ward housekeeper role (case study 14) and the basic ward housekeeper role (case study 15). Please see Table 3 for a summary of the case study selection.

In summary case study 14 is a repeat visit to the Trust investigated during the original research - case study 11. Case study 15 is a repeat visit to the Trust investigated for case study 3. As already outlined in the research methodology chapter, the primary research method utilised was the in-depth, semi-structured interview.

In order to make comparisons with previous housekeeper research the questions for discussion during the interviews were based on the themes that emerged during the previous study. These were designed to explore the ward housekeeper core role/duties, management of the role (operationally and strategically), recruitment and selection, pay and conditions, funding of the role, training, team integration, problem areas, suggested improvements, evaluation of the role and the value of the role.

In addition to this, questions were included that explored the long term impact of the role and how things had developed since the initial implementation of the role. A copy of the interview guides used can be seen in appendix 2. As with the previous research various stakeholders from the Trust were selected to be interviewed. This included housekeepers, nursing staff, modern matrons, ward managers, facilities managers/directors and if appropriate representatives from the domestic contracting company.

Table 7 below summarises the type of Trust/Organisation used in the case studies and the main characteristics of the senior housekeeper / housekeeper.

Table 23 - Summary of case study type and main characteristics of the NHS Trust

Case study	Trust
14	Large acute hospital Trust - approx. 900 beds. Implemented SWHs, including in the A & E department, as a pilot study in 2001.
15	Large acute hospital Trust. Supervisory role, responsible for overseeing all non-clinical work on the ward.

Following the presentation of the findings from case studies 14 and 15, a chapter is dedicated to the discussion. The discussion includes a narrative and analysis from the longitudinal evaluative case studies. In addition to this, the discussion chapter pulls together and aggregates the main findings from the earlier case studies. The findings presented below are split up for each case study by theme. The themes have emerged from a grouping of codes. For a full list of themes and codes please see appendix 7.

4.4.2 Case study 14

The Trust investigated as part of case study 14 was a large acute hospital. The Trust had initially implemented a senior ward housekeeper role as a pilot after the NHS Plan. They had continued with the senior ward housekeeper role and introduced it across the Trust. Case study 14 is a repeat visit to the same Trust from case study 11. The senior ward housekeeper was responsible for managing a team of domestics and hosts (caterers) on wards. Throughout the case study they were often referred to as "housekeepers." This term was applied to mean the "senior ward housekeeper." Therefore, read any reference to housekeeper or senior ward housekeeper as the same position/person. The findings from the evaluative case study are aggregated together under the following themes:

- Audits
- Communication
- Dedicated ward housekeepers
- Duties
- Perception of ward housekeeper
- Management tensions
- Managing staff
- Modern Matrons

- Perception of ward housekeeper
- Recruitment
- Service level
- Team integration
- Training
- Value to patients

Audits

One area that a lot of respondents discussed was related to audits. The importance of audits was clearly an area that had become more significant since 2004. In general respondents felt that the spotlight now on audits was a result of a national drive. An audit of all clinical areas was conducted at the Trust every week using a national toolkit. Non-clinical areas, for example offices, were done less frequently (monthly). The domestic services were contracted out to a third party supplier; therefore it was the Trust's contract manager for domestic services who completed the audits. The Trust's domestic contracts manager also alluded to the perceived pressure from various external regulatory bodies and inspections, for example the Quality Care Commission and the PEAT inspections. This, she suggested, had shifted the focus for the housekeeper services, and therefore the ward housekeeper from catering to cleaning.

In addition to the mandatory audits, the Trust had also implemented their in-house bi-weekly audits. These audits were done in partnership with the relevant associate directors, matrons and housekeeping, portering and Estates representatives. These extra bi-weekly audits were in response to a drive by the Trust to improve environmental cleaning standards. The ward housekeepers interviewed for the research recognised the increased focus on environmental cleaning audits. However, recently they had been getting more involved in the bi-weekly audits, and this they felt was beneficial. Prior to their involvement they would be a passive stakeholder in the audit process, and usually receive non-specific instructions afterwards on what was required. Being involved in what they called "the walk-arounds" meant they could fully understand what actions were necessary to comply with the standards. One senior Modern Matron was quite clear that the ward housekeepers had an important role to play in maintaining cleaning standards *"their role is to oversee the housekeeping staff; to make sure that all areas are scrupulously clean; that all the cleaning standards are maintained."* While this Modern Matron recognised that ultimately it was her role to maintain cleaning standards, she felt that the ward housekeepers had a part to play in supporting her to achieve this.

One senior ward housekeeper also reported other benefits that came about as a result of doing the bi-weekly. She stressed that completing the audits allowed her to have regular contact with the Trusts facilities staff as well as her own line managers in the contracts team. Yet many of the audits were unannounced which meant she had to stop any work she was completing in order to undertake them.

Other respondents confirmed how the emphasis had shifted for the ward housekeeper, for example representatives from the domestic services contractor referred to the importance of monitoring and maintaining high standards of cleanliness and *"its all about checking, checking and checking."* Although one of the Domestic Services Contractors did suggest that the Trust appeared to undertake a lot more audits than other Trusts he had worked for. While he proposed that this was good in that it helped keep a focus on high cleaning standards, there was concern that some senior ward housekeepers felt it was a hindrance. This was due to the volume of paperwork which resulted from each audit.

There was also a secondary issue that emerged related to the importance of cleaning. This was from the perspective of the domestic staff and if they realised how crucial their role was in keeping the hospital clean. One of the Senior Ward Housekeepers questioned whether some of her domestic team appreciated the impact of their role in relation to cleaning:

> *"but I can see that some of the House Keepers (domestics), sometimes, they think they are there to clean, or they don't understand how important is what they are doing, because in a hospital, you are not just cleaning anywhere. So, they say, 'yeah, it's clean', and it's not actually clean. Not what you want them to do. And you ask again, you ask again, you ask again, and sometimes, I get a little bit frustrated, 'cos it doesn't depend on me. Sometimes, I just want to be there and go and do it myself, but I know I can not do that."*
>
> Senior Ward Housekeeper

As reported above, all staff recognised there was a definite shift toward cleaning standards and auditing, and on the whole this had been a positive move. There were others, however, who also had reservations about how resource intensive they were becoming. The Trust's Domestic Contracts Manager who completed the mandatory weekly audits and the bi-weekly trust audits acknowledged that it meant she was working on inspections every day *"because we have to do a re-check the following day, so, effectively, it's every day."* At first each

building was taking 2 ½ hours to complete for the audit, although this was now down to 1 hour.

Communication

Although communication was not a distinct discreet theme reported on during the original research, it did appear throughout. For example it was frequently discussed during the setting up of the role and during the induction and training. It was also crucial in ensuring the integration of the ward housekeeper into the ward environment. The first set of case studies found that failing to communicate effectively with both the clinical and non-clinical ward based staff caused problems when trying to integrate the new role.

Therefore it was not surprising that communication emerged as an important theme during the evaluation case study work. Some of the communication issues centred on basic tangible factors such how the ward housekeepers could get in contact with staff in the Facilities department or their own line managers with the contractors. While this might have appeared a mundane issue, it needs to be put into context. In a busy large acute hospital site, it was sometimes difficult for the ward housekeepers to contact their line managers via phone. In addition to this, the ward housekeepers did not have access to a PC or email account. In spite of this, the ward housekeepers did mention that their recent involvement in the bi-weekly audits (the *"walk-abouts"*) had allowed them to meet the Trust's domestic contracts manager on a regular basis.

There was a slight feeling of separation from the Facilities department. As one Senior Ward Housekeeper mentioned *"Some days we can come up here and not speak to anyone in the office for a couple of days."* Although the same Ward Housekeeper felt this wasn't necessarily a bad thing because *"if they're not speaking to you, nothing's going wrong."*

The Trust was one of the first in England to implement the senior ward housekeeper role. Therefore any issues to do with communication and integration into the ward should no longer have been a factor. This was not the case. On one level there were problems with communication related to the matrix management approach. At the time there appeared to be a breakdown of communication between the modern matrons who were reporting cleaning related issues and faults to the Trust's Domestic Contracts Manager. However, these were not then reported to the senior ward housekeepers. Frustrations were also reported by one Senior Ward Housekeeper who stated that modern matrons could

communicate directly with them over cleaning issues. However, they felt that matrons still did not fully understand their role and responsibilities.

Dedicated ward housekeepers

The importance of having dedicated ward housekeeping staff allocated and assigned to wards was again stressed during the case study. One member of staff made a direct comparison between wards where they had dedicated permanent housekeepers and other areas where they had to rely on agency staff on a regular basis.

On one hand there was the obvious preference for permanent dedicated ward housekeepers based on wards. But, in addition to this the advantage of having dedicated housekeepers was also referred to in relation to the domestic and cleaning staff. One experienced Modern Matron placed a great emphasis on the advantages of having a dedicated permanent ward housekeeper within a team with a traditionally transient workforce. The Modern Matron explained why he held this view:

> *"You know, they're absolutely lovely, they really are (the housekeepers). But, I think, what contributes to that is their permanency. They're not transient. They're not, what's the word, relief. Actually having regular people, a regular team, makes a huge difference."*
>
> *"You know, because, the standards can, actually, drop. When you have, actually, got temporary staff, and none of them know, the policies, the procedures, any routine. The standards do, actually, sort of, drop, so, we're quite aware of that, so, having a permanent team."*
>
> Modern Matron

Here again, when discussing the issue of having dedicated ward housekeeping staff and other domestic services there is a reference to standards and audits.

Duties

A large part of the early case study work focused on the development of the role and the associated duties. This was to be expected with a new emergent health care role, particularly with the way the implementation was handled nationally. A large degree of

flexibility was promoted; therefore different trusts managed the role according to their needs. This was then reflected in the different roles and duties assigned to the ward housekeeping role. Part of the later evaluative case study work asked how the role and duties of the ward housekeeper had changed since the original project implementation. It was inevitable over 10 years the role would change and morph to the needs and requirements of a changing health service.

A number of key themes emerged from this case study in terms of the changing focus for ward housekeepers. One was the attention now placed on maintaining standards, particularly standards of cleanliness (see the discussion on Audits). This resulted in a shift in terms of the ratio of time spent between catering and cleaning. The original role saw ward housekeepers split their time between these two core activities. In fact some viewed the original ward housekeeper focus much more on catering and patient feeding. However the focus was now much more on cleaning. As the Trust Facilities Contract manager explained that they were still present during mealtimes, but the majority of their time was now spent engaged with cleaning related activities. Although to put this into context, one of the representatives from the domestic services contractor did feel that the importance placed on cleaning and maintaining cleaning standards across the Trust had become so high profile that it was now everyone's responsibility.

This shift in responsibility was further evidenced when one experienced Modern Matron was asked to describe, in their opinion, what the role of the ward housekeeper was:

> *"Their role, I think, is to oversee the House Keeping staff; to make sure that all areas are scrupulously clean; that all the cleaning standards are maintained; to deal with any, sort of issues, with their House Keeping staff; to make sure the ward is staffed, or sort out their annual leave; to make sure that if somebody wants the day off, that it's covered seven days a week. They also have a responsibility to make sure that the Host or the Hostess is competent in managing the management of food. They are also responsible for making sure the patients are happy with the delivery of the food, the content, the heat etc, and if they haven't, if they're not, then they make some other provision for the patients to have; food, drink, whatever it is they need. I think their role is to support me in keeping the standards as they should be."*
>
> Modern Matron

Here the Modern Matron first makes reference to the cleaning duties for the ward

housekeeper. This is then confirmed through the standards of cleanliness they are responsible for. The second area for the ward housekeeper role is that of supervision. The focus on catering is now relegated to the third area.

This additional focus on supervision is worth exploring. When asked a similar question, for example "please describe a typical day?", the ward housekeeper first referred to her supervision duties:

> *"I've found on my main day I would, obviously, first, come in, check, make sure my staff are, during week days and make sure they are all in doing the jobs. Then, making sure that everything in the kitchen is ready to go, that there's food in there. Things like that, no foods that are out of date. I, then, have cleaning duties to do, myself. I'd then be checking out all my staff, to make sure they are doing their check lists. And, obviously, any problems that they have, deal with them as they come up."*
>
> Senior Ward Housekeeper

The Trust Facilities Contract Manager was more functional in her description of the role stating that *"they're a point of contact for the Ward Manager/Matron, for any support services i.e. catering, housekeeping, portering, maintenance issues."*

It was unsurprising that the ward housekeepers in this case study had the supervision responsibilities that they did. The role from the beginning was labelled as a "senior ward housekeeper." Therefore they duties included doing things such as appraisals, work schedules, food/stores orders and providing leadership, guidance and quality control for the domestic and housekeeping (ward based catering) staff.

Perception of ward housekeeper

This theme relates to how others viewed the ward housekeeper role. The "*others*" related to two groups; 1. Patients; 2. Other healthcare professionals. From the patient perspective, it appeared that their understanding of the role had not changed from the original studies. The feeling was that patients misunderstood what the role was. Perhaps more worrying was that nurses saw the ward housekeeper as *"just another cleaner."* The Trust's Facilities Contract Manager speculated that one reason for the unawareness was due to their reliance on so many nursing agency staff *"they're not around long enough to find out what all the roles and*

responsibilities of everyone are." Despite this they felt that the Trust Board still had commitment to the role, who despite having to make savings each year, never considered the option to remove the senior ward housekeeper role from the Trust.

Management tensions

One of the complexities highlighted when the role was originally implemented was the dual line management responsibilities, or in some cases the unclear lines of management for the housekeeper. This case study had the added dimension in that the housekeeping duties were subcontracted out to a third party supplier. This naturally left the situation open to any tensions between the various stakeholders. Particularly when the level of housekeeping service was defined in a SLA, and therefore a commercial contract with an external company driven by profit. Furthermore, there was also the tension that the ward housekeepers potentially felt being "in the middle" between what was asked from the ward staff and what the contractors had agreed they would do. Paradoxically, this tension was one of the key responsibilities for the ward housekeeper - to be a point of contact between the ward team and the facilities team.

Hence, in addition to the multiple and sometimes unclear reporting lines for the ward housekeeper, there was also the conflict in terms of what they were asked to do. For example the Trust's Facilities Contract Manager stated that:

> *"in the past, I've found them making beds, which we're not supposed to do, cleaning commodes, which we're not supposed to do, cleaning medical equipment, which we're not supposed to do. 'Cos the Matron what has asked them to do, and they've done it, thinking, 'Oh, I'd better do it'"*
>
> Facilities Contract Manager

One of the Ward Housekeepers confirmed that they were occasionally asked to do work by nursing staff or their modern matron which wasn't included in their job description. However the need to work within a team and contribute to the success appeared to override any constraints in their job descriptions:

> *"No, it doesn't happen very often, and half the time, we all work as a team up here, anyway, so half the time, I'd probably just go in and do it anyway"*
>
> Senior Ward Housekeeper

The same Housekeeper also referred to the lack of skills that nurses had in relation to cleaning. This meant that even when they were asked to do some cleaning that was outside of their remit, and declined, they usually had to follow up afterwards:

> *"it has happened a few times, and if I really thought that we shouldn't be doing it, I would say to the nurse, 'I don't think we're meant to be doing that'. And most of the time they're, 'Oh, that's fine, I didn't know who was meant to do it', and they will do it themselves. But, then, obviously, we'd go in afterwards, and clear up after what they've done anyway."*
>
> Senior ward housekeeper

This perhaps demonstrates a willing on behalf of the ward housekeeper to contribute to the overall team's success and conduct work above what was required and their own remit.

When housekeepers had been asked to carry out work that fell outside of their job description, the Contract Manager felt this might in part be due to the lack of awareness. This lack of awareness was from nurses and modern matrons over what the housekeeper could and couldn't do (see Perceptions theme). Therefore regular weekly meetings had been arranged in order to clarify the level of service and what could be expected from the housekeeping service provided by the contractors. However, the problem went deeper than that and some staff felt the lack of involvement from the ward sisters or modern matrons during the ward housekeeper recruitment contributed to this lack of understanding and ultimately the tension over work duties. One of the Modern Matrons made the point that they ultimately were responsible for cleaning on their wards. They were also responsible for the ward teams. Therefore if a ward housekeeper, who was there to support the cleaning, and who also needed to be integrated into a ward team, was to be recruited, then they (the Modern Matron) should be involved in the recruitment and selection process. This did not happen at the Trust.

Managing staff

The focus for this particular case study was a "senior ward housekeeper." The Trust made the decision to implement the role at a level that included clear supervisory responsibilities for the ward cleaning and catering staff. In order to differentiate from the domestic staff - which the Trust called "housekeepers" - they introduced the role as the "senior ward housekeeper."

The amount of staff each senior ward housekeeper was responsible for varied from ward to ward and was largely dependant on the size of the ward. In some cases it was as little as two staff, on other large wards it could be a team of 12 domestic staff. The line management responsibilities were mainly focused on staffing levels and rotas and ensuring there was enough staff to cover all housekeeping work.

It was reported by several senior ward housekeepers and other ward staff and modern matrons that the biggest issue they faced, in relation to managing their staff, was being able to get adequate cover when people were off ill or on annual leave. In order to arrange cover for their own ward the senior housekeeper would initially liaise with the management team for the contract cleaning company (this team was based on-site).

Like all hospital sites, in addition to the ward areas, there were also general public areas that needed cleaning. The Trust employed domestic staff to clean these areas. This meant the senior housekeepers were able to second staff from the general areas to cover. The justification for this was that the patient areas, i.e. the wards, took priority for cleaning over general public areas. In order to request staff to be moved from a different ward, the senior housekeeper would need to go through the Contractor to arrange this, they did not have it in their power to approach other wards and move staff without first getting approval.

Actual staff absence rates were not disclosed, however one Senior Ward Housekeeper did allude to high sickness rates in one area. As discussed above, one difficulty was getting cover for the domestic cleaning staff. However, getting cover for the ward catering staff (hostesses) was more problematic. Unlike the general public areas where a central team of domestics cleaned, there was no similar situation for the hospital catering. Hence, if a ward hostess was absent there was no central pool of catering staff that could be called upon to cover.

Other staff management factors related to supervising the domestic team and resolving

clashes between members. As one Senior Housekeeper reported that *"my main problem is not even between me and them, it's between themselves….. they clash."* For an experienced and confident member of staff, this type of situation may be something they felt comfortable in managing, however, as one Modern Matron pointed out *"some of them are able to manage them if they have got a strong character, you know, and others found it more difficult."* Two of the modern matrons interviewed for the case study also questioned the level of leadership/management support and training that the senior housekeepers were given when they took over the roles. One of the Modern Matrons commented that it was difficult to manage sickness cover. If the senior housekeepers were given more support from the Contractors it would enable them to feel confident when leading their teams. Furthermore, the matrons also suspected that the senior housekeepers' time was often taken up with basic cleaning and catering duties that meant it was difficult for them to spend time dedicated to leading their teams:

> *"What I see in practice is them doing a lot of the House Keeping, and not spending enough time supervising people. And, actually, when you do, I spend quite a lot of time talking to them about various individuals that we have, and it doesn't seem to be that it's within their gift, they don't seem capable in managing some of the people they have to manage"*
>
> Modern Matron

There were two areas that were absent from the senior housekeeper role in relation to managing and leading their teams. The first was the recruitment of new staff and the second was conducting appraisals with existing staff.

In terms of recruitment of new hosts or domestics, the modern matron, ward staff or senior housekeeper were not involved in this process. The issue of modern matrons not being involved in recruitment is discussed within the "Managing Tensions" theme. With regards to the senior housekeeper being involved in recruitment, there was a different opinion. The view from one senior housekeeper was if they avoided being involved in the recruitment process then should any problem occur due to the staff appointment they would be free from any responsibility:

> *"The Host is probably a very hard job to fill up here. But, sometimes, it is nice not to do recruiting, because if they don't do well, because we would get blamed, 'You hired them, you're stuck with them', kind of thing. So, sometimes it is nice, because if they don't do okay, you can say, 'Well, you chose them, not us'."*
>
> Senior Ward Housekeeper

At the time it was the Contractors who were responsible for recruiting and appointing domestic and catering staff. The second area of management responsibility omitted from the senior housekeepers' duties was conducting appraisals for the ward domestics and hosts. Conducting appraisals was again an area handled by the Contractors. One Modern Matron challenged this and felt the senior housekeeper should complete the appraisals for their staff, and not doing this compromised any potential succession planning:

> *"And also, they should do their appraisal. 'What are you going to do, John? Are you going to be cleaning East for the rest of your, the next twenty years?' 'Oh, no. I'd like to be one of you.' 'Really? Then I'll train you to be one of me. Let me show you what I do.' You know, so you're a good role model. And, actually, on a day, say to them, 'Guess what? I'm going to clean East today, and John, you're going to be the Senior Ward House Keeper'. You know, there's none of that nurturing, growing in to roles, succession planning. You don't see that."*
>
> Modern Matron

To conclude this theme; the senior housekeepers did have some line management responsibilities for their team, however this only extended to certain work. It seemed that the senior housekeepers were offered some level of training in how to supervise staff, but this was not sufficient to meet their requirements and provide them with the confidence they needed to manage effectively. At the time of the case study a review had been undertaken and leadership training was identified as an area that needed attention.

Modern Matrons

The role of modern matrons in the context of the ward housekeepers was highlighted several times during the case study. The modern matron was also as a result of the NHS Plan and re-introduced as a key role in many Trusts at the same time as ward housekeepers. Unsurprisingly the modern matron was significant in relation to the ward housekeeper, as

ultimately part of their remit was to oversee items such as the cleanliness of wards and the quality of hospital food served to patients.

The modern matrons interviewed as part of the research confirmed their own input was key in making the ward housekeeper role a success. They also confirmed that they saw the ward housekeeper in a support role to them and the team and in keeping high standards of cleaning and catering.

One Modern Matron raised the issue of visibility with their own role and how important it was in making their team work:

> *"I think, it's an interesting thing what you talk about because I think the role of the Ward Sister has changed hugely, in the last ten years. And I think more and more people are not visible as Ward Sisters. They are stuck in offices doing paperwork, and all sorts of rubbish, that, basically, we shouldn't be involved in, because, actually, you need to be out there seeing what's happening, and that's, those that, you know, if you're out on the floor you can see what happens, you can work with your nurses, work with your House Keeping staff, whatever. You can maintain your standards."*
>
> Modern Matron

Representatives from the domestic Contractors also confirmed that the commitment from the modern matrons was so important in making the ward housekeeper role a success. Where the modern matron had accepted and understood the ward housekeeper role made an impact on how well they were utilised. This then lead to potential variations across the site where other modern matrons had not supported the new role in the same way.

Despite the general feeling over the importance of the modern matron in making the ward housekeeper role a success, they were not included in the recruitment process for new housekeepers. This has already been discussed elsewhere within the findings (see the Managing Staff theme). At the time, the recruitment of new housekeepers was managed entirely by the domestic Contractors. The duty manager, healthcare cleaning manager and operations manager were often involved in the recruitment process, but no ward staff or modern matrons were represented. Sometimes the modern matron or ward manager would be invited to meet a new member of staff working on their ward, but this would be after they have been appointed. The view from the modern matrons interviewed during the case study

was that either they or the ward managers should be involved during the recruitment. When the original pilot scheme was set up 10 years ago the ward sisters and ward managers at the time were involved in the recruitment of housekeepers.

Notwithstanding their lack of involvement during the recruitment process, the modern matrons, who were committed to supporting and utilising the ward housekeeper role, did have the scope to tailor and develop the housekeeper once started. This degree of flexibility was one of the key features of the ward housekeeper role advocated in the original guidance from NHS Estates (NHS Estates, 2001a). Any adaptation would need to have been within the scope of the SLA agreed with the domestic Contractors, but it did allow some level of ownership for those modern matrons and wards that wanted it.

Patient Perception

During the case study interviews, participants were asked about how they felt patients perceived the ward housekeeper role. The reason for this line of inquiry stemmed from the original research where some housekeepers felt patients were unaware of their role and associated duties.

When asked again how patients viewed the ward housekeeper role the view was that there was a general lack of understanding. The most common misconception was the housekeeper was a domestic. The Trust had introduced a separate uniform for the senior ward housekeepers, yet patients struggled to differentiate the different groups of staff.

In one ward (maternity), the domestics didn't wear uniforms, this then led to patients to confuse the housekeepers with nursing staff. For example, patients would request medicines from the housekeepers.

Recruitment

The issue of modern matrons not being involved in the recruitment process has already been covered elsewhere (see the Modern Matron theme). In summary, the recruitment process was co-ordinated by the Domestic Contractors. Specifically, the Duty Manager would conduct the initial interview, followed by a second interview with the Cleaning Manager. Following these interviews, the modern matrons or ward managers were invited to informally meet the new senior ward housekeeper; however they were not formally part of the recruitment process. While the modern matrons suggested they should be formally

involved in the recruitment process, the view from the Domestic Contractors was different. Initially when the senior ward housekeeper pilot scheme was set up ward staff such as the modern matrons and ward managers or ward sisters were included during the interviews. One representative from the Domestic Contractors explained this was due to the initial focus for the role being more towards supporting nursing[2] which led to a number of healthcare assistants applying. They also felt that the focus for the housekeeper role was now focused on cleaning and catering that it was correct they would co-ordinate all aspects of the recruitment process:

> *"But I think, nowadays, because we control all the experts in house-keeping and catering, it makes sense to maintain that recruitment process. I think, I may be speaking out of turn here, but I don't think the nurses have a problem with that. They are quite happy for us to recruit, because it is a success story already, and they would be happy"*
>
> Domestic Contractor representative

Clearly the last sentence illustrates that there was a misunderstanding from the Domestic Contractors surrounding the involvement of the modern matrons and ward sister during the recruitment process.

In general, participants recorded that there was no problem attracting good candidates to apply for senior ward housekeeper jobs when there were vacancies available. Data on the local pay and conditions for the senior ward housekeeper were not collected. Nor were data on the pay and conditions for nursing staff. However, the Trust's Facilities Contracts manager reported that senior ward housekeeper pay was more than the basic nurse rate. Additionally, with overtime rates paid for weekend work, senior ward housekeepers were able to earn more than their duty managers. This had caused some upset with the duty managers.

When senior ward housekeeper roles became available most vacancies were filled by internal applicants. These were usually domestic staff looking for a promotion. The Facilities Contracts manager could only recall two occasions over the last eight years when they had to recruit externally. One participant during the case study, from the Domestic Contractor, confirmed this by stating they *"quite like to promote them from within, and give people an*

[2] The initial purpose and associated guidance of the role did not suggest the focus of the housekeeper to support the nursing staff in this way.

opportunity to develop, so a lot of our senior wards arrive as a cleaner or a hostess."

However, there was some concern - from one Modern Matron - with the ability of domestic staff to cope with the responsibilities of undertaking a senior ward housekeeper role. Specifically, it was the ability to manage and lead a team of staff that domestics, having not had previous experience, might find it difficult to make the transition. The same Modern Matron also pointed out she felt that during the interview stage the Duty Manager (from the Domestic Contractors) should be highlighting to potential candidates how demanding the senior ward housekeeper job could potentially be. This would enable them to make sure they were selecting the best candidates for the position, and those were also able to deal with the pressures of working on the ward and managing the team of domestics.

The importance of past experience was discussed by one of the Senior Ward Housekeepers who was previously a ward hostess. She felt that even though being a host meant she just worked on the food service within the ward environment, the experience of being on the ward was valuable:

> *"But a Host on, especially, this ward is a very demanding job, so I think that helps you, that helps a bit, because, obviously, it proved I could cope with the stresses and strains of being a Host on this ward"*
>
> Senior Ward Housekeeper

Ultimately, the two Modern Matrons both agreed that regardless of previous experience, it was the personalities of the senior ward housekeepers that determined whether they were a success or not within their jobs:

> *"Firstly, you've got to get the right person, and I know we all make mistakes, I mean, I do, too. You know, I recruit people, and you think, you're not right, you may be a good nurse, but you're not the right nurse for this area."*
>
> *"They're really good. And, I think what contributes to, as we were just saying, the nature of the people they are. They are just two lovely people, and nothing is too much trouble. They really do actually, sort of, take on board any particular issues we have."*
>
> Modern Matrons

Service Level

The Trust investigated for this case study had contracted out their domestic and housekeeping services to a third party. This included the senior ward housekeeper role. The Trust had invested a considerable amount of money to fund the contractor's recruitment of a senior ward housekeeper. Potentially this was money diverted from other budgets, for example nursing.

The housekeeper service level for each ward was decided on by the actual size (number of beds). Therefore the number of ward housekeepers on each ward was dependant on the number of patients that required looking after.

The housekeeper role was also tailored to the needs of the particular ward or department. For example there were different needs from patients from endoscopy, gynaecology and general medical wards. The flexibility of the ward housekeeper and tailoring the needs of the service was one of the key concepts when the role was originally introduced in the NHS.

One housekeeper did point out that on some very small wards the allocation of one housekeeper was more than required to meet the needs. Yet there was no mechanism for making use of any under utilised housekeeping staff onto wards where the current service was being stretched. Each ward has its own cost centre and budget, therefore they were reluctant to share resources - i.e. staff - with other wards. This resulted in cover for sickness and holiday absence for domestic staff being taken from a central team of domestics. Yet cover for senior ward housekeepers were not available in the same way. This frustrated some of the senior housekeepers and modern matrons.

Team Integration

Team integration of the housekeeper into the ward structure was a key theme from the original research. For this reason it was an area that was again explored during the evaluative case studies. The original case studies highlighted areas such as failing to communicate effectively the role to both clinical and non-clinical ward based staff. This was reported as a significant barrier to team integration.

Participants were asked specifically whether there were still issues over team integration for the ward housekeeper. Most reported that this was no longer an issue. One potential explanation for this was the actual length of time that ward housekeepers had been utilised

at the Trust. The role was no longer new, novel or unique and ward staff understood their role and accepted them as part of the team. This time period simply hadn't elapsed when the first research studies on housekeepers were conducted.

Instead the influence of the modern matron or ward manager was raised as integral when trying to integrate new senior ward housekeepers into the ward team. This was confirmed by both the Domestic Contractors and the Modern Matrons themselves. When asked how well the senior ward housekeeper integrated into the ward team, one representative from the Domestic Contractor stated *"I think it will depend on the ward manager, and the person in charge up there….. But you will, possibly, go to another area where they won't feel so involved."* Additionally one Modern Matron added that:

> *"You know, when I actually did employ them, they said they felt part of, that I was actually part of it, and they would become a part of our team, which, of course, they are. You know, they're not separate. I know separate people pay your salary, but, at the end of the day, yeah, we're all here to make the patients comfortable, and make sure that their passage through the hospital is a safe one. And that includes them doing their bit. We can't do it without them."*
>
> Modern Matron

It was clear from the above statement that the Modern Matron highlighted how important the senior ward housekeeper role was to the patient experience. This would have been motivating to the member of staff and aided any integration into the ward team.

Another Senior Ward Housekeeper explained the problems when they weren't fully accepted as a team member on a ward due to the lack of involvement and commitment from the modern matron:

> *"for example on A&E, from day one they were part of the team, even invited to their team days, and Christmas meals and things, you know, the matron there, they were part of the nursing team, so to speak, the whole team. Other wards are not like that at all, as I say. But they wouldn't even know, some of them, 'Who are you?' they just think they're another cleaner. You know, an additional pair of hands to help with cleaning."*
>
> Senior Ward Housekeeper

Training

A key theme concluded from the original set of case studies was around the training programmes introduced for the housekeeper role. Naturally, one of the concerns for the early implementer Trusts was how to train their new staff as housekeepers. Training programmes were initially pragmatic and covered basic skills such as food hygiene and cleaning procedures. Some Trusts had designed more advanced training programmes that included customer care guidance. At the time of the original research there was no national training programme, although many trusts were waiting for the introduction of a Ward Housekeeper NVQ through the UK "Skills for Health" agency. Some trusts had already lined up with local FE colleges and sent their housekeepers through customer-care NVQs. Unfortunately the planned introduction of the Ward Housekeeper NVQ never got to the implementation stage.

Training issues was explored as an area of questioning during the evaluative case studies. Of particular interest was the training provided to new staff on leadership and management. The reason was because the senior ward housekeeper had management responsibilities for the ward based domestic and catering staff.

It appeared that at the time of the case study, any training or guidance on leadership/management was not offered to the senior ward housekeepers. This was an area that disappointed both the housekeepers and the modern matrons. Both agreed it was needed to help prepare them for the role. One Modern Matron suggested that the sickness rates amongst the ward domestic staff could be improved if the senior ward housekeepers were more confident about managing their staff. They believed that this was one area that could be picked up and tackled through training. They also felt that in general the senior ward housekeepers were not adequately trained to provide effective line management to

their domestic and catering staff. A Senior Ward Housekeeper admitted that they relied on the Duty Manager (with the Domestic Contractors) for advice on managing staff.

The basic training offered to the senior ward housekeepers appeared to be similar to that reported during the original case studies. This included customer service, food hygiene and health and safety. In addition new housekeepers spent time shadowing other staff outside the ward team they would need to liaise with during their work. For example, the porters and staff based in the kitchens.

The training programme was managed by the Domestic Contractor who had a member staff responsible for delivering the training packages. There was a separate training scheme specifically for the senior ward housekeepers. This was arranged into 12 modules and covered the areas listed above. The senior ward housekeepers interviewed for the research all replied that they were happy with the basic training provided, it was only the lack of leadership and management guidance that caused them concern.

Value to Patients

There has been a gradual acceptance by the medical community and the Department of Health over the impact non-clinical services can have on patient care and health outcomes. This had accelerated since the NHS Plan, and arguably one of the areas that had both benefited from and contributed to this impact was the ward housekeeper role.

The value and the impact of the ward housekeeper role was explored during the case study. Participants were asked how they felt the role contributed to patient care. One Modern Matron focused on the customer service aspect during the food service. They pointed out that it was the small things like being able to offer alternative food to a patient rather than just taking a tray of food away that was uneaten.

As part of the domestic contract, some housekeepers were aware that they were not employed directly by the Trust. However, they felt this irrelevant and felt part of the team to care for patients, as one Housekeeper explained *"we're all here to make the patients comfortable, and make sure that their passage through the hospital is a safe one."* Part of the impact and contribution they made was through the one-to-one contact they had with patients. This was something raised during the original case study research. Their input was valued as patients viewed the housekeeper as separate from the nursing staff. They were

able to show empathy with patients and patients were able to connect with them and discuss mundane, day to day things with the housekeepers that were not related to their treatment in any way. One Senior Ward Housekeeper described this contact in her own words:

> *"Obviously, the food and the cleaning does help the patients, but I think the one-to-one contact with the patients helps them. Sometimes, they feel a bit left out, because, obviously, the nurses are really busy. And, even if you just spend five minutes with them. ….. Like when you are doing the food orders, you have, spent five minutes with them. So, I think that one-to-one contact sometimes helps patients."*
>
> Senior Ward Housekeeper

Although another Senior Ward Housekeeper felt that she had lost contact with patients since taking the new role. She viewed her own team of domestics and hosts as having a closer relationship with patients. This may be a reflection of the different ways in which the housekeepers were used on different wards and the resulting level of patient interaction:

> *"But, now, being a supervisor, I don't have a really close relationship with the patients. I am more with the domestics, you know, who are my staff. Before, I was much closer."*
>
> Senior Ward Housekeeper

The housekeepers interviewed during the research could see the impact their role had on patient care, either through the value of providing good food or a clean safe environment. They were also aware of the importance of spending time, where possible, with patients and giving them some one-to-one attention. Having the right person in place as a housekeeper was key to this and the resulting impact on patients. It was clear that individual personalities had a part to play, and the success of the service was down to the passion and care that they brought to the role:

> *"It's not boring at all. And, I really like to deal, you know, like, I love to deal with people, especially with the patients. And, I like to deal with people. These are, like, my customers."*
>
> Senior Ward Housekeeper

Table 24 - Case Study Fourteen Summary and comparison

	Case Study 14	**Case study 11**	**Change / development**
Type of Trust	Large acute hospital Trust - approx. 900 beds	Large acute hospital Trust - approx. 900 beds	No change
Role	The Senior Ward housekeeper responsible for managing a team of domestics and caterers on the ward	Implemented SWHs 2 years ago, including in the A & E department. Senior Ward Housekeeper role responsible for all catering and domestic ward work	More attention on cleaning, particularly standards of cleanliness and auditing. Focus is now on supervision/management of staff rather than basic cleaning and catering duties
Recruitment	Managed by the Domestic contractors who would interview candidates. Ward sisters/modern matrons would meet new staff but not formally part of process	Led by contractor with input and final decision from ward sisters	Less input from ward sisters/modern matrons. Initial focus was on supporting nursing. Now focus is on cleaning (and catering), therefore ward sisters not involved in recruitment
Induction	As part of 4 week training programme	As part of 4 week training programme	No change
Training	Customer service, food hygiene and health and safety. Shadowing element still included	4 week programme. Included shadowing members of staff	No change in training programme. Lack of leadership/management training cited as an omission from training programme
Integration	Good integration. Modern matrons / ward sisters integral influence in facilitating staff integration	Good. Allowing the ward sister to make decision on SWH helped integration	Integration no longer an issue when recruiting a new Senior Ward Housekeeper
Management	Day to day by ward sister. For training, holiday, sickness and contract of employment SWHs report to contractor	Day to day by ward sister. For training, holiday, sickness and contract of employment SWHs report to contractor	No change in management arrangements. SWH had little contact with the Trust's FM department, mainly through the cleaning audits

4.4.3 Case study 15

The Trust studied as part of case study 15 was a repeat visit on case study 3. The Trust was one of the first in England to implement the ward housekeeper role, and at the time was viewed by its peers to be a pioneer in the area. For this reason they were included as part of the initial series of case studies. The Trust was a large acute hospital based in the North of England. Ward housekeepers had been implemented gradually since 2002 across most of the Trust. The co-ordination for the project had been guided by a proactive and forward thinking Director of Facilities.

The findings from evaluative case study 15 were aggregated together under the following themes:

- Audits
- Change in WHK role
- Duties
- Flexibility
- FM tension
- Management
- National Support
- Patient Care
- Recruitment
- Resources
- Skills needed
- Team integration
- Training
- Value of WHK role

Audits

Audits and the ward housekeepers' involvement in the auditing process was explored again during this case study. Case study 14 had shown that auditing was now an important part of the ward housekeepers' duties at that particular trust.

During the interviews for case study 15 it was apparent that ward housekeepers did not have the same level of involvement in the cleaning audits compared to case study 14. The Trust conducted weekly non-mandatory cleaning audits, which the ward housekeepers were not involved with. However, there was the national cleaning audit conducted annually. This involved a team of staff including representatives from the Estates Department, Infection Control and the ward housekeeper.

In addition to this the ward housekeepers would be involved in the PEAT inspections should they be on duty when the audit was conducted. They were also responsible for monitoring and auditing the waste produced from the ward. Compared to case study 14, the ward housekeeper had relatively little involvement in the cleaning audits. However, in spite of this there was a general recognition that the ward housekeepers had a large part to play in infection control - through keeping the ward environment clean and tidy - and by working with colleagues in the facilities department to maintain non-clinical standards.

Change in ward housekeeper role

Of particular interest during this case study was how the ward housekeeper role had evolved over the period since it was implemented. Some participants also discussed how the development of the role had led to a tension between the ward teams and the FM department. This perceived tension is discussed in depth during the "FM tension" theme. This section deals with the changes made to the ward housekeeper role since the implementation. It also details the future changes that staff - mainly nurses and modern matrons - would like to see introduced in the future.

In some ward areas, respondents felt that the ward housekeeper had been a victim of its own success. Where it had been successful the nursing staff had fully embraced the role and realised the value of having a ward housekeeper. In some of these situations, the nurses had then taken a lead in developing the ward housekeeper role and asking them to undertake additional duties. Some of these duties included tasks that were outside the original remit set for the ward housekeeper role. One example of this included asking ward housekeepers to put away the controlled prescriptions in the ward storage area. There was a mixed response to being asked to do this from some of the ward housekeepers. One Housekeeper interviewed was keen to take on-board new and additional duties. However, another Housekeeper had a contrasting opinion:

> *"The only thing I did say I wouldn't particularly, didn't want, I won't have to do, actually, you know when we have stores come up, drugs, and controlled drugs? And, one of the ward helpers puts them away, and I didn't know that she'd started to put them away. And, I would have to do it, and I said, 'No'. That's not in my role. I mean, I would do certain things, but controlled drugs....I didn't want to be responsible in case anything...it's got to be done....., but I went to my manager, and I said, 'I don't want to take that role'."*
>
> Housekeeper

Other duties given to the housekeepers which were additional to the original role included ordering medical consumables such as drains and syringes and being responsible for the storage of this equipment. The housekeepers interviewed during the research agreed that the role had evolved and changed since the original implementation. The feeling was that under the guidance of the nursing teams they had gradually taken on more duties. When questioned about what exactly the new additional duties were, apart from the examples given above, the housekeepers were limited in their recollection *"When I first started, yeah, I think I did half as much as I do now. And, gradually, over the years, I've taken on more. Diane has said, 'Maggie, could you take this on, maybe? Do you mind?'"*

The interviews also revealed plans to transform the ward housekeeper role further in the future. These changes were being driven by the nursing team, therefore they centred on patient care. For instance, helping patients eat and drink was referred to on more than one occasion. On one Trauma ward the Modern Matron had patients who depended on helpers to eat and drink, and while a team of non-staffing volunteers could help patients the ward housekeepers were unable to support in eating and drinking. Her view was that the ward housekeepers could help patients feed. Additionally, a further suggestion from the same Modern Matron was to allow the nurses to have a bigger role to play during the food distribution rather than just supporting patients to eat. The ward housekeepers would support patients to eat instead. The rationale was that nurses would be able to monitor the nutritional element better when helping to distribute meals.

The development of the role and the perceived "shift" in management away from the FM department to the nursing staff, led to the ward teams starting to recruit new housekeepers without the involvement of the FM department. This had led to the FM department questioning its responsibility to the ward housekeepers, as the FM Hotel Services Manager explained:

> *"they're recruiting without even telling us. As if they want to go it alone. Do we leave them to go it alone, and see what happens to this House Keeping role, or, you know, do we, you know, do we insist that we're still very much involved?"*
>
> FM Hotel Services Manager

Furthermore, the Hotel Services Manager also went on to explain that if future modifications were made, then there may be an argument for having a complete transformation of the housekeeper role, although they were not in favour of this wholesale change. This view was also shared by the Director of Facilities who didn't foresee significant changes in the future *"I don't expect it'll change a great deal, no. I think it's recognised that we need to have someone responsible for the standards on the ward."*

The changes and modifications made to the role had clearly created tension between the FM department and the ward teams utilising ward housekeepers. There was no dispute over the effectiveness of the role, if anything the role had been so successful in supporting patients that the nursing teams wanted it to evolve further. The tension was centred on the nature of the role, what the ward housekeepers should be doing and ultimately who should be responsible for the recruitment and line management. This is explored in further detail under the "FM tension" theme.

Duties

The core duties were explored during the case study to review how the housekeeper role had evolved since its implementation. The key changes are discussed under the "Change in WHK role" theme. The section discusses the duties undertaken by the housekeepers at the time the research was conducted.

The main housekeeper responsibilities included overseeing all the non-clinical duties. The Trust had a team of domestic contractors who would carry out the day-to-day ward cleaning, this meant the housekeeper would not physically be cleaning. Instead they would check the cleanliness and tidiness. This led, to some extent, to uncertainty over particular areas that needed cleaning. For instance, equipment such as keyboards and computers located around the ward station area would normally in the past be cleaned by nurses. The ward housekeeper, in order to support nurses, would carry out this cleaning. Keeping the ward area tidy was not something to be underestimated and the nurses valued this contribution

from the housekeepers. For example, one Modern Matron referred to keeping the day room tidy and in acceptable state as a space for patient relatives to use. Other responsibilities for cleaning saw the housekeeper involved with the deep cleaning team.

On wards where hot food was not served the housekeeper would make sure the relevant supplies were readily available. For example, the kitchen area might require cereals, porridge, bread, toast, jam and tea and coffee. Where hot food was served to patients on wards, then the housekeeper had a similar role to play as they did with the cleaning element. They would be responsible during the mornings for distributing and collecting menus. This included discussing if patients had any special dietary requirements and then a subsequent liaison with a dietician. The Trust had in-house catering staff that would provide the meals from the kitchen. The housekeeper would oversee the distribution of meals, make sure the food was presented in an acceptable way, make sure cutlery was available and if appropriate encourage patients to eat.

The issue of auditing is covered under the "Audits" theme. The housekeepers did have some limited responsibilities linked to monitoring and standards. They would liaise with the PEAT inspection and the domestic cleaning monitoring teams and receive feedback from both audits. They also monitored and audited the waste produced from the ward.

The housekeeper was the contact liaison point for the estates department. They would also do any "trouble shooting" related to any equipment that was broken. Often they would work with porters to direct any patient movement and support nurses by doing ad-hoc tasks such as photocopying.

The housekeepers were not qualified to carry out clinical duties such as moving patients and taking patients to the toilet. In spite of this one housekeeper did report getting commodes for patients if the nurses or auxiliary nurses were unavailable. A number of the housekeepers had undertaken training to allow them to feed patients. Some wards now wanted to allow housekeepers to routinely support patients when eating and drinking, however the FM hotel services manager explained that *"it's not something we would encourage."*

Despite this, there was recognition that a large part of the ward housekeeper role was supporting patients. As one Modern Matron explained due to the housekeeper spending a lot of time in wards, the patients found it easier to talk to them and more comfortable stopping them rather than the nurses. The Modern Matron felt this was crucial and cited the type of complaints received always had an element of "communication." Therefore having a

member of staff who could meet and greet patients would reduce these related complaints. This area is explored further under the "Patient Care" and "Value of the WHK role" themes.

Flexibility

The concept of flexibility and allowing wards - within reason and the boundaries of the terms of reference - to modify the housekeeper role was included in the original NHS Estates (2001a) guidance issued. The degree of flexibility still evident in the role at the Trust was again explored during the evaluative case studies.

The FM Hotel Services Manager explained that they tailored the role to the ward needs during the initial discussion with the ward manager or modern matron. This could include a negotiation on the hours required for the housekeeper cover which would impact on what meals they oversaw. The modern matron or ward sister would then be able to modify the job description - within the boundaries of the role definition - before the FM hotel services department would recruit.

The FM Hotel Services Manager described why it was important that they first decide what was required by each ward before recruiting the correct person to fit those requirements:

> *"I think the key to the House Keeper role being successful is if we've got the right people, and not just really fast-recruited staff. We've not recruited a whole load of people, and then decided what wards they're going on. We've recruited them for each individual ward."*
>
> FM Hotel Services Manager

Some wards adapted the role after the housekeeper started by changing some of their duties after observing how they worked and interacted with other staff. As one housekeeper explained:

> *"So, I was, kind of, a trial, before, really. And, then, she decided what else she wanted me to do."*
>
> *"Charge Nurse wants the House Keepers to do different things, and she wanted me to take over the menus for her auxiliaries, so that they could spend more time caring for the patients"*
>
> Housekeeper

FM tension

During the initial case studies the interviews explored how the ward teams and FM departments worked collaboratively in order to implement the ward housekeeper role. Participants did not report any significant conflict or tension between the ward team and FM department related to the implementation of housekeepers.

At this Trust, since the initial implementation of the ward housekeeper, the role had evolved and developed. This had led to a degree of tension between the FM department and ward teams who were wanting to develop the role further, and subsequently move away from the original housekeeper description.

Some of the tension between the two teams appeared to have been a result of the ward staff requesting housekeepers to undertake clinical related duties. For example, this was illustrated by asking the housekeepers to put away the controlled drugs into the stores. Furthermore, some housekeepers reported to help the nurses with making beds, and even supporting patients to use commodes - although the housekeeper did clarify they would only do this if the nurses or auxiliary nurses were busy. The FM department were clear that the ward housekeepers should not have been doing any clinical duties, including anything that involved physically touching a patient.

The flexibility of the role to meet individual ward requirements was one of the key concepts behind the ward housekeeper. At this Trust it was evident that the ward teams had embraced this concept and wanted to further extend the flexibility of the housekeeper role. It appeared this had led to conflict. One Modern Matron referred to how their desire to amend the housekeeper role was in conflict with the view from the FM department - they felt that there was a resistance to change from the FM department. The Director of Facilities, when asked for their opinion on the ward teams taking more control and ownership of

housekeepers with less involvement from the FM department responded *"And so it's down to us, then to rein that back, and do something about it."* The FM Hotel Services Manager had a similar view and questioned if the FM department needed to intervene so the housekeeper role didn't become completely devolved.

The issue of housekeeper recruitment is discussed in more detail under the "Recruitment" theme. It did, however, lead to a disagreement between the FM department and the ward teams where the latter had started to recruit housekeepers without involving the FM department. The FM Hotel Services Manager referred to this *"We've not been informed, and somehow, they've got through HR, even though we've got measures in place to try and stop that, and the ward have gone it alone to try to recruit a House Keeper."* The FM department clearly felt they should be still involved in recruitment, as their view was that it was a non-clinical role. Additionally, they justified their involvement in the recruitment as they *"know what we're looking for"* and they also co-ordinated the training.

The tension between FM departments and the ward team also looked to filter down to the relationship the ward housekeepers had between the two. One Housekeeper reported that they never get to see representatives from the FM department on a day-to-day basis. Another Housekeeper stated that *"if there was a problem. I think I'd go to the Ward Manager first."* This was in contradiction to the view from FM Hotel Services Manager who revealed the following:

> *"the House Keepers are a little bit confused at times, who their manager is. They that they work on here, you know, for a Ward Manager, and a Matron, but, when they've got a problem, they often come to us, Facilities, because we can get things done for them."*
>
> FM Hotel Services Manager

Initially when the role was first set up there was a monthly meeting co-ordinated by the FM Hotel Services Manager. This was a meeting for all housekeepers across the Trust to raise issues related to their role. The meeting had since stopped being held, this may have contributed to the feeling of separation reported by some of the housekeepers.

Management

The original ward housekeeping guidance (NHS Estates, 2001a) provided a number of frameworks for how trusts could line manage the housekeepers. The management of ward housekeepers was also explored as a theme during the first set of case studies completed. The initial case study findings suggested it was necessary to define clear lines of management for all involved in the housekeeper role. For many trusts the Hotel Services/FM departments took the lead role in setting up the housekeeper posts - including recruitment. Once established the ward manager / sister or modern matron was given responsibility for the day-to-day management of the housekeeper. However, in most cases the FM department would still have involvement with the housekeeping services, including things like training, induction and recruitment of new staff.

During this case study the development of the role had led to the line management responsibilities shifting - without consultation or agreement from all stakeholders - this subsequently resulted in tension over who was accountable for managing the housekeeper. This section deals with two issues related to the management theme. The first is the actual line management of the housekeepers and associated concerns. The second is the management responsibilities the housekeepers had with the catering staff and domestics.

When asked about whom their line manager was, all the housekeepers identified either the charge nurse or ward sister. If the ward charge nurse wasn't available then the housekeeper would approach any of the senior nurses. The funding for each housekeeper was provided locally through ward budgets. This caused problems when arranging sickness or holiday cover for housekeepers. The individual wards - through the ward sisters - would manage the staff absence. In the case of housekeepers, where for most areas there was only one per ward, it resulted in no cover being available when they were absent. One Ward Housekeeper illustrated the extent of the difficulty through the lack of cover when *"jobs galore when I get back and the wards look a total mess. They really miss me."* With regards to arranging cover for the housekeepers, the Facilities Director corroborated the above view *"it would be better that we come clean about it, because we can not do without them, because there isn't any, if they're off, they're off."* There were no line-management responsibilities from the FM department on a day-to-day basis for the housekeepers. The management involvement from the FM department was focused on the recruitment of housekeepers. This included liaising with the wards in advance and agreeing job specifications and providing advice on the role. The development of the housekeeper role by some wards had recently seen them start to recruit new housekeepers without involving the

FM department. This had led to tensions between the wards and FM department - this is explored in more detail in the "FM tension" theme. There also appeared to be either confusion or a misunderstanding as to the role the FM department thought they had in the day-to-day management of the housekeepers. All the housekeepers interviewed during the research were clear that their line managers were the charge nurses or the ward sisters. Yet, the FM Hotel Services Manager argued they still have a role to play during the day-to-day support for housekeepers.

This theme also deals with the line management responsibilities that the housekeepers had with the catering and domestic staff. The above illustrates there were issues over the supervision of housekeepers. In addition, the line management of catering and domestic staff had similar unresolved concerns. The FM Hotel Services manager suggested that the housekeeper was a supervisory role. The housekeepers also reported undertaking work that could be seen as supervisory, for example reporting and managing absence for domestic staff. Whilst there were no formal line management responsibilities for the domestic staff, several participants interviewed felt that the housekeepers did have a role:

> *"In the early days there were some difficulties with the contractor because the poor domestic on the wards felt she had two lots of bosses because she had a supervisor, and then she had the Ward House Keeper. That now works, as far as I am aware, it works really well. They get on well together."*
>
> Director of Facilities
>
> *"Well, it's a grey area, really. If I've got anything, then they have their own supervisor, who'll come on the wards. I have to say, the Domestic Supervisor comes on to the ward every day. Caterers not so much, Catering Supervisors, I have to say. But, if I've got any problems, then I'll have a word with the Domestic Supervisor or the Catering Supervisor, or the Catering Manager, if I don't get satisfaction. 'Cos, ultimately, patient care is top of my list, really."*
>
> *"They have their own supervisor, but, half the time, they do come to us more than their own supervisors, because we have a good relationship, you know, like them. And it's same, like, with the volunteers. They always come to us, and never go to....."*
>
> Housekeepers

Where it was reported that the housekeeper role had been successful, it appeared to be from wards where the Ward Sister had fully embraced the role and encouraged a sense of team working. Importantly the concept of team working embraced both the housekeeper into the ward team, but also the housekeeper as a team working with the caterers and domestics. This wasn't achieved instantly but evolved over time. One housekeeper now reported they felt comfortable and confident in asking the domestics to re-clean areas should the standards not be acceptable.

National Support

The national support available to Trusts on all matters related to ward housekeepers emerged as a new theme during this case study. The initial implementation of ward housekeepers was co-ordinated nationally through the now defunct NHS Estates. This government arms length body was an agency from the Department of Health. They were responsible for publishing the guidance that complimented the implementation programme - *"Housekeeping: a first guide to new, modern and dependable ward housekeeping services in the NHS"* (NHS Estates, 2001a).

In the year 2000 it saw the release of the NHS Plan (Department of Health, 2000) and ward housekeepers were featured as part of the Chapter Four that outlined the investment in healthcare facilities. Following the NHS Plan, and as part of the national implementation for ward housekeepers the NHS Estates co-ordinated a series of workshops and training events aimed at educating and supporting Trust staff - both clinical and non-clinical - in achieving a successful execution of the new role. As part of the review of arm's length bodies, the NHS Estates was disbanded in 2004. This is discussed in more detail in the Introduction section to this thesis. Since then there has been little activity to provide support or co-ordination on a national level. This provides an explanation behind some of the issues raised during this case study.

The theme on "National Support" specifically relates to the lack of national support and the subsequent issues participants from the FM department reported in relation to this. A number of concerns were raised and these are described below.

The lack of guidance was cited as a problem, along with conferences or training courses which were unavailable. The Trust investigated for this case study viewed themselves as an exemplar site and in the past either visited or had other Trusts visit them to share best

practice. They also felt this was no longer possible because of a lack of national co-ordination. In a similar vein the Trust also wished to learn from other Trusts who were identified as exemplar, but had been unable to do this recently.

Other specific issues raised were a lack of a nationally recognised career structure for ward housekeepers. This is something the NHS Estates had been advocating before being abolished. There was also no national monitoring completed. An initial target was to have 50% of Trusts to have housekeepers in place by 2006. There had been no audit of this target.

In general it appeared the Trust felt nationally there was no vision to move the initiative forward. This had led to the ward housekeeper programme on a large scale to either stand still, decline or develop into a role adopted, owned and driven by clinical teams.

Patient care

The impact on patient care wasn't a prominent feature during the first set of six case studies. The themes were more operational around the implementation and the role design, rather than looking at the impact on patients and patient care in general. Some of the case studies conducted in the second phase looking at housekeepers in mental health environments did focus on the contribution that they could make to patient care.

It is unclear whether it has been the development and subsequent ownership of the ward housekeeper role by the nursing community or the awareness of patient care and the contribution that non-clinical services can have patient outcomes that resulted in this theme being discussed by participants.

It was reported that patients viewed the housekeepers as nurses and they were routinely confused for part of the clinical team. One housekeeper stated that:

> *"Usually, they think I'm in charge! I think it's just the uniform 'cos it looks quite formal, but, yeah...sometimes they'll ask, 'Nurse, can we take this out, Nurse, I need these tablets'. And, I'll always say to them, I'm strictly non-medical, you must see your Nurse in Charge."*
>
> Housekeeper

As the above demonstrates, patients clearly viewed the ward housekeepers as part of their care team. There were also specific duties the housekeepers undertook where they felt they contributed directly to patient care. For instance, helping to manage patients with special dietary requirements (diabetic etc.). The housekeeper involvement in this case may have been through managing the patient case history / information or liaising with the relevant departments (catering) to ensure the correct menus and food were supplied. Sometimes the value to patients was from the housekeeper spending time with each individual discussing what they would like to eat from the menu. It was this "relaxed" time that nurses felt they did not have during their work schedules to spend with patients. Some of the housekeepers also on occasion helped patients to feed.

Although not strictly clinical patient care, one Modern Matron described how valuable the housekeepers were when liaising with porters over patient movement. Other involvement, although not related to patient care, did extend to supporting patient visitors and family. One Modern Matron described how they used the housekeeper in a visitor liaison role, particularly with visitors who had a very sick relative on the ward.

The concept of a liaison role was also mentioned by another Ward Sister who employed their housekeeper in a "meet and greet" way to aid communication with patients:

> *"The biggest part about it, is meeting and greeting, and talking to people. If you look at the complaints in the Trust, they're all to do with, there is always an element of communication in them. And, if you can have somebody who will even, even if they're just walking round, you know, every day, and saying, 'Is everything all right?'"*
>
> Ward sister

The patient contact was also reported to be an area that the housekeepers enjoyed with their work. As one Housekeeper said, we *"get to know patients from all walks of life"* and *"to go and meet any new patients that we have."*

The Director of Facilities agreed that the housekeeper role had a large communication element within their remit. Similarly, one Ward Sister confirmed findings from the earlier case studies, where she felt patients were more at ease when talking to housekeepers rather than

nurses. The reasons behind this were a) nurses appeared very busy and "*rushed*" and b) housekeepers were *"on the shop floor all the time."*

Recruitment

How the ward housekeeper was recruited was a key theme during the original case studies. This was due to the role being new and Trusts wanting to describe and learn from others the best practice with regards to recruiting new staff. Some Trusts had been very successful when retaining their ward housekeepers and had therefore had to do little recruitment since the initial staff started. Other Trusts had a very buoyant local employment market and had a waiting list of potential applicants wanting to become ward housekeepers.

The original findings stressed the importance of involving ward managers or nurse representatives during the recruitment of housekeepers. Getting the ward managers and nurses involved in the recruitment process (including the job design) helped get commitment from ward teams. The success of the role at this Trust meant that gaining commitment from ward staff was not an issue. In reality the success of the ward housekeeper role had caused different problems. The recruitment of new ward housekeepers was the source of conflict between some of the wards and the FM department. This has been covered elsewhere under the "FM tension" theme. The core of the problem appeared to be with wards now recruiting new housekeepers without involving the FM department within the process. The Director of Facilities stated that ward teams needed to be involved in the recruitment process to make sure they got the "right" personality to fit into the ward teams. However, representatives from the FM department did feel that wards recruiting without their involvement were not appropriate.

The Trust had found the ward housekeeper role was popular amongst the domestic staff who viewed it as a promotion. One Modern Matron stated that for every housekeeper post advertised they had 15-20 people applying. The FM Hotel Services Manager confirmed that they were able to be very selective about who they appointed. They were in a position to go out to re-recruit if they felt the first round did not attract the calibre of person they required.

Resources

This theme related to issues surrounding the resourcing of the housekeeping service, including the domestic support on the ward. The resource concerned both the hours the

housekeepers and domestics covered on the ward and the actual number of housekeepers per ward and how they were funded.

The issue of funding for the ward housekeepers was straightforward. Across the Trust the FM department had no finance to support housekeepers operationally on the wards. The budget for employing housekeepers was devolved to each ward. This meant individual wards having to make decisions about reducing funding from other areas to support the housekeeping service. The FM department did provide support through helping with recruitment, advising on job descriptions, training and organising meetings for all the housekeepers to get together.

Most wards employed just one housekeeper. As discussed elsewhere, this caused difficulties through a lack of support for cover when the housekeeper was absent through annual leave or sickness.

The shift patterns for each housekeeper were decided by individual wards, but typically housekeepers worked a 36 1/2 hour week. Their shift would start around either 7am or 7.30am and then finish mid afternoon, between 3pm - 4pm. The housekeeper shifts were confined to week days and not weekend work. Although one Ward Housekeeper did admit to being asked occasionally to work weekends in order to *"catch up"*. The FM Hotel Services Manager did suggest that a new framework for housekeeper cover should be considered. Weekend and 24 hour cover had not been discounted as part of this review.

The focus of the case study was not on the domestic and catering staff, it was however important to understand the level of resource provided by these staff/services as they had a direct impact on the housekeepers/housekeeper service.

The ward domestic services were provided by a third party contractor. The catering service was in-house. The domestic and catering staff both had their own supervisors, however, as discussed in a previous theme, the housekeeper would frequently have to get involved in co-ordinating either the staff or the services they provide. The catering service shifts and cover appeared to vary from ward to ward. Some had split shifts using two members of staff, others relied on just one member of the catering team. The domestic's shifts were arranged on a similar pattern, split with one member of staff covering 7am until 3pm, then a second member of staff to cover from 3pm to 7pm. Overnight there was no dedicated domestic staff based on individual wards. Instead there was an emergency service that would respond when needed.

Skills needed

As a discreet theme, the skills required to become a successful ward housekeeper were not reported during the original case studies. That is not to say they were not discussed. Instead the skills required were referred to across other themes, for example the role and training.

The skills required for housekeepers at the Trust investigated in case study 15 were highlighted, and although they were often in relation to other aspects - for example training or recruitment - they are now presented in a new theme called "Skills needed."

It was evident that all respondents viewed the soft skills and interpersonal awareness as the key to operating successfully as a ward housekeeper. The FM Hotel Services Manager was clear that during recruitment it was the individual's experience in customer care and customer service that took precedent over any qualifications they might have. The respondent also alluded to the resilience of housekeepers as an important attribute *"so it's someone who, you know, has got to understand they're going to be hard-working."* She also said they looked for someone who would *"be a caring sort of person"* and *"to understand patients and all sorts of nationalities."* This implies that during housekeeper recruitment the Trust was considering the impact and contribution to patient care.

Two Housekeepers demonstrated how they came from very different backgrounds. This confirms that it might have been the individual personality as the key to becoming successful:

> *"I was a House Keeper at the Royal Hotel, which is 155 bedrooms. Prior to that I worked for the university as a similar role."*
>
> *"I haven't. Totally different when I came here. I worked in, you know, Aunt Bessie's.....food,...Yorkshire Pudding factory. I'd worked there for 15 years, I was a team leader there."*
>
> Housekeepers

The original case studies touched briefly on getting the "right personality." Again during case study 15 this was mentioned by the Director of Facilities, although what constituted the type

of personality was not explicitly described *"at ward level' it's about personality, and getting on with people."*

The housekeepers being able to fit in with the ward team and communicate with a broad range of stakeholders was mentioned on more than one occasion by participants. As one Housekeeper explained, it was their ability to communicate and form relationships with other departments, such as the Estates team, that allowed them to *"get them (work / job requests) done a bit quicker."*

Team integration

Integration into the ward team was one of the core findings from the original case studies. Some of the early case studies demonstrated problems for the early implementer Trusts when trying to integrate the housekeeper into the ward teams. This area was explored again during this case study. In general, participants reported no such problems of team integration. There were some initial issues, but long term the housekeepers had been successfully integrated into their respective ward teams.

One Ward Housekeeper described how when she started the nursing auxiliaries viewed them as a "threat." The auxiliary nurses were asking the housekeepers to undertake duties and alter their allocated workloads. Another Housekeeper indicated that it was a simple lack of understanding due to miscommunication that led to the auxiliaries being unsure of the role the housekeepers had. The same participant stated that the initial threat soon disappeared when the auxiliaries realised the extent to which the housekeepers could support them and free up their time.

There had also been some conflict between housekeepers and the ward domestic staff. The nature of the responsibilities for each member of staff naturally resulted in them having to work very closely, particularly with the ward cleaning. The Trust had outsourced its domestic services, and the domestic staff had their own team supervisor (who wasn't ward based). One Housekeeper described this:

> *"I think, at first, when the House Keeper started, there was conflict between, us and the domestics, because, basically, I don't think they liked us, really, saying, 'Could you do this, could you do that?'…… and, along the way, I think they've realised that we're not going away, and there's lots more of us now"*
>
> Housekeeper

These initial problems had appeared to have been resolved, as one Modern Matron stated *"We don't have any of that now. I'm seven years down the line, …… they've really settled in."* A simple indication of integration into the ward teams was shown through asking participants to identify the line manager for the housekeepers. All were clear that it was either the ward sister or ward manager who managed the housekeepers on a day-to-day basis. The integration of the role and ultimately the success of housekeepers was again demonstrated through the impact of the Modern Matron. One Matron describes this:

> *"I used to have House Keeper meetings when I was first in post, but I was a generic Matron then. And, they used to come down to my office and have a cup of tea, and, you know, they used to chat to me 'cos I felt they needed it then."*
>
> Modern Matron

The Trust used to have a regular meeting where all the housekeepers were brought together to discuss common problems and try to instil a sense of community and teamwork amongst them. This meeting was organised by the FM department and specifically the hotel services team. Participants reported that the meetings had gradually become less regular and less well attended - due to a number of reasons, for example a general lack of interest from housekeepers, and some felt the meetings were too large to be productive. The loss of the team meetings co-ordinated from the FM department seems to have re-enforced the housekeepers as part of the ward team who care for patients. The Director of Facilities admitted the person the housekeeper worked most closely with was the ward sister as they had the shared responsibility for the ward environment:

> *"I think they work with, the closest people they work with, or should do are the Ward Sisters. That was always the plan as far as I was concerned. To be, like, to work quite closely, because the Ward Sister has a responsibility for the environment."*
>
> Director of Facilities

Training

The ward housekeeper training was one of the core themes explored during the initial case studies. As a theme and a specific series of questions, training was again discussed as part of case study 15.

As discussed elsewhere, the Trust had been an early implementer of the ward housekeeper project and had therefore had time to develop their training programme over time. The relative success the housekeeper role across the Trust was in part due to the commitment from the FM department during the initial implementation and the resulting ward teams embracing the role.

The Trust had a generic induction programme which all new staff, including the housekeepers, went through. The generic induction programme had been recently introduced and included elements that previously were covered in-depth during the specific housekeeper training, for example infection control. The FM Hotel Services Manager felt this had compromised the effectiveness of the housekeeper training. In spite of this the housekeeper training was three weeks long and participants felt overall, it was still effective.

One area the housekeepers did feel was lacking in relationship to training was around leadership and managing staff. Although the FM hotel services manager did state that during the training programme they prepared housekeepers to deal with potential conflict with their job. Other areas suggested for improvement as part of the training was the shadowing housekeepers undertook. Housekeepers would spend time with other departments to help inform their own work and see how their role fits in with other service departments. Feedback from housekeepers indicated the issue was over the timing of when the shadowing took place - with there being too much of a delay since their initial training and starting their job before commencing the shadowing. Routines had already been established by the time they started shadowing other departments, sometimes six months later.

It was the FM department who were responsible for designing and co-ordinating the initial housekeeper training package. The Trust had a policy that each individual was responsible for making sure they complied with the mandatory training, for example fire safety and equality and diversity. Several participants made reference to housekeepers completing NVQ level 2 and 3 in customer service.

Value of WHK role

Case study 14 demonstrated that since the original research the value of the ward housekeeper role, and specifically the value to patients, is now recognised in a number of ways. The value of the ward housekeeper was also explored by participants during this case study.

From the perspective of the FM department, the value of the ward housekeeper was demonstrated in two ways. Firstly it was through the housekeepers freeing up nursing time to concentrate on clinical duties. This meant the housekeepers were doing non-clinical work that previously had been undertaken by nursing staff. The second area highlighted by the Director of Facilities, in relation to the value of the housekeeper, was the ability of them to maintain appropriate standards in relation to the ward environment. While it could be argued that both of these points would directly benefit the patients in some way, it is worth noting that participants interviewed for the research from the Facilities Department did not cite the value to patients as a direct contribution from the housekeeper.

After the initial implementation of the housekeeper, the Director of Facilities had completed a study to assess the benefit of the role. As part of this they had looked at and measured a number of key performance indicators related to the housekeeper role. Two of the KPIs mentioned by the Director of Facilities were a reduction in clinical waste and a reduction in sick absence levels for wards were the housekeeper had been implemented compared to wards were it had not.

There was also wide spread recognition from the ward sisters and modern matrons interviewed that the housekeeper had made a large impact since being implemented across the Trust. The value of the role was also demonstrated through the difference they had made by freeing up nurse time:

> *"I think they've made a massive difference. I think on busy wards, it's changed things, dramatically, for the better, in that, it's taken a lot off the nursing staff, and they do the hospitality, hotel parts of the job, which wouldn't be done as effectively, if we just relied on the nursing staff."*
>
> Ward Sister

One Ward Sister also referred to the impact the housekeepers had on patients through their ability to spend time with them on a one-to-one basis:

> *"They chat to the patients a lot, they're out on the shop floor all the time. I think patients sometimes find it easier to talk to the House....'cos they think they're not bothering people as much if they talk to the House Keepers about things, rather than stopping nurses, who seem to be very busy, and rushed."*
>
> Ward Sister

Despite the value of the role, the commendation and recognition they received during the interviews, two of the Housekeepers still felt they were undervalued by the ward staff for their work:

> *"I think, sometimes, I don't think we are praised enough for what we actually do. I think there's a few feel like that. I don't think they realise how much we actually do."*
>
> *"You feel as though you're a bit devalued sometimes. Definitely"*
>
> Housekeepers

Although this view was not shared by all housekeepers:

> ***"Do you ever get any recognition from the ward sister?***
> *Ward Sister does, yeah. She refers to me as her right hand woman."*
>
> Housekeeper

The ability of the ward housekeepers to help with ward communication was mentioned throughout the study. In spite of being busy, the housekeepers discussed making time to speak to patients, in some cases it was related to their needs whilst on the ward, for example finding out their food preferences and trying to accommodate these. In other examples it was the housekeeper's ability to care that impacted on patients:

> *"And then the qualitative side of stuff with the patients. We had a patient, actually, who wrote in to the local newspaper because the House Keepers take time to speak to patients, and the nurse was going off, the House Keeper was going off the ward and said, 'I'll see you tomorrow. (And the patient said) 'It is my granddaughters birthday, I can't get her a card', and so, the Housekeeper went, got a card, brought it back, got her to sign it, posted it, and it meant such a lot to her. She actually wrote to the Paper and said, you know, 'It has made such a difference'. So, it's the qualitative type of stuff which is important."*
>
> Director of Facilities

Other examples of the contribution of the ward housekeeper through their ability to communicate with others have been discussed elsewhere. They include meeting and greeting patients and visitors onto the ward and liaising with other service departments such as the estates team and portering staff.

Table 25 - Case Study Fifteen Summary and comparison

	Case Study 15	**Case study 3**	**Change / development**
Type of Trust	Acute	Acute	No change
Role	Supervisory role. Overseeing all non-clinical duties. Storage and ordering of some medications, controlled prescriptions and consumables. Helping nurses to make beds	Supervisory role, responsible for overseeing all non-clinical work on the ward	More focus on supporting patients and work typically undertaken by nursing staff. Future duties could include helping patients to eat and patient movement
Recruitment	Ward managers now recruiting new housekeepers without the involvement from the FM department	Ward managers and the Hotel Services Manager conduct the interviews	This was a change since the original case study. The FM department no longer being involved in some ward housekeeper recruitment had led to tension
Induction	Standard trust and department induction programme included for new housekeepers. Staff shadowing also included	The mandatory trust and departmental training incorporated safety induction (fire, H&S, manual handling, COSHH and NAPPI)	Trust programme had recently been updated to include infection control. This was previously just offered to staff involved with cleaning
Training	Some housekeepers had undertaken training in helping patients to eat, otherwise standard training offered as before	Training included ward based, non-ward based and mandatory training. Training manual put together	Additional training offered to housekeepers in helping patients to eat. Lack of training on leadership/management cited
Integration	No problems with integration. Long term housekeepers had been successfully implemented into the ward teams	Successful integration through the ward managers being involved in designing the role, recruitment and on-going management	Successful integration of housekeepers reported during the original case. Integration no longer viewed as a problem
Management	Day to day management through ward managers. Little involvement from FM department apart from some recruitment	Day to day management through ward managers. Hotel services department oversaw the implementation of the project	The ward managers had now taken almost complete ownership of housekeeper. FM department felt they still had a role to play, this was leading to tension

5. Discussion

5.1 Introduction

This chapter will discuss the main findings from the complete set of case studies conducted for the study. A particular focus will be on the findings and discussion from the two evaluative case studies - case study 14 and case study 15. Much of the discussion and key points arising from the original individual case studies have already been covered. This discussion is embedded at the end of the relevant sections and chapters to the related case study. For this reason the overall discussion chapter presented here will primarily focus on the last two evaluative case studies. The findings will be discussed and contextualised with reference to various literature drawn from the body of work presented in the literature review. The chapter concludes with two models (Model A and Model B) which are presented as a consequence of the analytical review of the data.

The nature of qualitative data, particularly data derived from a grounded theory type approach to analysis, means that the presentation of findings and discussion is integral and intertwined. Hennink et. al. (2011), argues that a good results section weaves together the issues considered important by participants and that commonly the research context is presented when writing up. Stake (1978, page 5) states that the kind of commentary presented during a case study report is appealing to the reader because it is *"epistemologically in harmony with the reader's experience and thus to that personal natural basis for generalisation."* In relation to presenting case study research there are conflicting views which lead to criticism. For example, conclusions based on a case study seem to be self-evident and, as such, are more directly based on lay knowledge or prejudices than on empirical data (Swanborn, 2010). Thomas (2001) presents a standard structure for a research study outlining a separate findings chapter followed by an analysis and discussion. However, he does recognise that the fieldwork, findings, analysis and discussion may be merged together for interpretative case studies. He explains this due to the simultaneous reporting of observations and discussion.

The logical place to start the discussion for this study is to revisit the underlying key principles for the ward housekeeper role in the context of the NHS Plan (Department of Health, 2000) and the subsequent NHS Estates Guidance (NHS Estates, 2001a) issued in response. Returning back to the original frameworks will help inform the discussion of the findings and key points resulting from this study.

Chapter 4 of the NHS Plan outlined the investment pledged by the Department of Health into hospital facilities. This included the new ward housekeeper role. Other investment outlined was an extra 7000 beds, over 100 new hospitals by 2010, and a pledge to invest in clean wards and better hospital food. It was these last two points that the introduction of the ward housekeeper was designed to achieve. Within the NHS Plan there were two key phrases related to the new role:

> *"Hospital domestics will be fully part of the ward team – and respected for the important work they do."*
>
> (Department of Health, 2000, page 46)
>
> *"Half of all hospitals will have new 'ward housekeepers' in place by 2004 to ensure that the quality, presentation and quantity of meals meets patient needs; that patients, particularly elderly people, are able to eat the meals on offer; and that the service patients receive is genuinely available round-the-clock."*
>
> (Department of Health, 2000, page 47)

The NHS Plan also planned for the return of the matron - now known as the *Modern Matron*. As the findings from this study show, the modern matron was crucial in the longer term development of ward housekeeper role. This is discussed in further detail later in this chapter. The NHS Plan identified the role the modern matron had to play in "Leadership" within hospitals:

> *"Action needs to start in hospitals. The public consultation provoked a strong call for a 'modern matron' figure – a strong clinical leader with clear authority at ward level – and we will do it. The ward sister or charge nurse will be given authority to resolve clinical issues, such as discharge delays and environmental problems such as poor cleanliness. By April 2002 every hospital will have senior sisters and charge nurses who are easily identifiable to patients and who will be accountable for a group of wards. They will be in control of the necessary resources to sort out the fundamentals of care, backed up by appropriate administrative support. In this way patients' demand for a 'modern matron' will be met."*
>
> (Department of Health, 2000, Page 86)

"Ward sisters and charge nurses will have the authority to ensure the wards they lead are properly cleaned."

(Department of Health, 2000, Page 46)

Shortly after the NHS Plan, the NHS Estates published a document outlining the principles behind the ward housekeeper role. This was known as *"Housekeeping – a first guide to new, modern and dependable ward housekeeping services in the NHS"* (NHS Estates, 2001a). The guide was aimed at staff involved in the ward housekeeping services, including ward nurses, facilities managers, ward housekeepers and patients, their relatives and carers. The guidance outlined how to set up the ward housekeeper role, or where it was already in place, improve services. The guidance interpreted the statements from the NHS Plan (Department of Health, 2000) and introduced the key standards for the role. These were that the ward sister would be supported by the ward housekeeper to manage the ward environment; ward housekeepers must be ward based; housekeepers must be multi-skilled and flexible; and their main tasks would be focused on the cleaning services, the food services and maintaining the environment. The guidance also made reference to ward housekeepers being patient-focused and able to react quickly and sensitively to a range of differing needs. There was a clear statement within the guide that the ward housekeeper had to meet the needs of patients and respond to patient needs. NHS Estates had also made it clear that there was no single model; Trusts were free to implement the role, within the framework, to suit their needs. This left it open for Trusts to be flexible. The resulting research and findings collated throughout this study showed that there were multiple models adopted either implemented as new, or applied to existing services. There were mixed results and levels of success.

The history of ward housekeepers also needs to be understood in relation to the changes that were being made by the government at the time. A review of the Arms Length Bodies (ALB) in 2004 resulted in the NHS Estates being disbanded and the services they were previously responsible for being divided across the Department of Health and a number of other ALBs. The impact of this on the development of ward housekeepers is discussed further in this chapter.

The chapter starts with a summary discussion of the key findings from the original case studies. It revisits the initial themes and provides a commentary as to whether they are still relevant in light of the new findings from the evaluative work. This is succeeded by a number

of key discussion points which have emerged through an analysis of the original and evaluative case studies. The following areas are examined, the impact of the modern matron role; the importance of auditing; the shift in emphasis from catering to cleaning work; a developing tension between FM and ward staff over the housekeeper responsibilities and line management; support the ward housekeepers required; lack of national support and co-ordination of the initiative; and the value to patients and contribution to patient care.

5.2 Initial themes revisited with the evaluative work

It is important to revisit the original themes from the first set of case studies and make a judgement as to whether they are still relevant and appropriate based on the findings from the evaluate case studies. The evaluation and longitudinal nature of this research justifies this decision. One of the main objectives was to investigate the same themes from the phase one case studies. Therefore summarising and then making a statement on their applicability and appropriateness to the phase two case studies plays a significant part in validating this research.

The first six case studies generated the original key themes. The following emerged as the themes: Role; Recruitment; Induction; Training; Integration; and Management. These key themes formed the basis of many of the questions during the subsequent case studies and interviews. Hence, they were explicitly covered during the interviews.

Were the findings and resulting best practice suggested under the headings of the original themes still relevant and appropriate? The answer is 'yes.' However, exploring these themes did uncover how the role had developed and in some cases how other problems that only started to occur over a long period of time. Before reviewing the new developments, it is worth summarising the original themes individually and their respective appropriateness in the context of the findings from the evaluative case studies.

Initially the role supported the guidance and framework from the NHS Estates, insofar as each Trust had modified the housekeeper role to meet their own requirements. There appeared to be no trend or pattern suggesting an emphasis towards the cleaning or catering on the ward. Some Trusts implemented a totally new role, while others tried to adapt existing services to meet the national guidance. This level of flexibility and adaptability was still evident during the evaluative case studies. However, there was a further shift from the Trust level adaptability to a ward level adaptability/flexibility. One consequence of this was a greater ownership of the housekeeper by the ward teams to such an extent that it had

created a tension between ward staff and FM departments. This was especially evident in case study 15. This is explored later in this chapter under the heading *"A developing tension between FM and ward staff."* The impact of the modern matron is also important within this context of the ownership of the ward housekeeper. The modern matron's introduction onto wards needs to be understood in relation to the tension between ward and FM departments and the nature of the ward housekeeping services. Again this is explored in more detail in the next section "Impact of Modern Matron Role."

Another key finding from the original case studies that related to the role was the need for a dedicated permanent ward based housekeeper. The importance of this was still evident during case studies 14 and 15. Most Trusts had continued with this model, yet found it difficult to provide cover when their dedicated ward housekeeper was on annual leave or away due to sickness. The value of the housekeeper was clear to ward staff who said how difficult it was to operate and cover the ward housekeeper's duties while they were absent.

The second core original theme was on the recruitment of ward housekeepers. Some of the initial Trust participating in the case studies reported having difficulties recruiting ward housekeepers, with the main issues around unsociable hours and pay. Neither of two Trusts acting as the evaluative cases studies had problems recruiting. In fact it they both stated having waiting lists for potential housekeeper recruits. Although, it has to be remembered that the economic environment in 2011 was very different to 2004. A recurring theme from the original cases studies was the importance of having ward staff, nurses or ward sisters involved during the recruitment in order to get "buy-in" from ward staff. Due to the ward housekeeper role being new at the time, and to many staff they were initially unaware of their place on the ward, then this was important. However the evaluative case studies demonstrated two different approaches to the recruitment of housekeepers. The ward sisters and modern matrons in case study 14 were initially involved in the recruitment of the housekeepers. But more recently they had found themselves to be less involved and the recruitment handled solely by the domestic services contractor. The ward teams felt they needed to be still involved in the recruitment process for the reasons stated above.

Case study 15 was different in that the FM department had, in some cases, been excluded from the recruitment of ward housekeepers. Due to the success of the role, the ward teams had fully embraced their housekeepers and were starting to recruit new or replacement staff without involving the FM departments. This had created tensions on both sides. Again this is explored later in this chapter under the heading *"A developing tension between FM and ward staff."*

The next original theme to revisit is the induction programme for ward housekeepers. During the original case studies this was a high priority area for many Trusts due to the innovative and largely untested nature of the role. Trusts used the induction to integrate their new staff, but also to communicate the housekeeper role within the fabric of the organisation. The evaluative case studies seemed to show that this was no longer such an issue. Trusts and staff, naturally over a period of time, were accustomed to the housekeeper role which was no longer new or novel. They had also had time to develop extensive induction and training programmes for their housekeepers.

The training of housekeepers was an original theme. Once more this appeared to be an area that Trusts had developed during the period up to the evaluate case studies. For this reason most participants didn't raise this as a priority area. The only element related to training was how some housekeepers and modern matrons felt they required more support around leadership and management. This didn't come through during the original case studies as particularly important.

Trusts were acutely aware of the need to support all staff in order to successfully integrate the housekeeper into their respective ward teams. The importance of integration could be seen as a symptom of the relatively early stages of the ward housekeeper project during the original case studies. Although participants during the evaluate case studies still felt integration was important, once again it wasn't so much of a priority due to the period of time elapsed since the original project inception. Instead during the evaluate case studies it was apparent the role the modern matron had on the success of the integration of the ward housekeepers. This is discussed in more detail in the next section.

The last of the themes from the original case studies was focused on the management of ward housekeepers. The findings were just centred in isolation on the line management of the housekeepers. Most of the original case studies followed the guidance suggested by the Department of Health. This was for the ward teams to manage the housekeeper on a day-to-day basis. The FM department would provide an advisory role during the setting up and recruitment of housekeepers. They would also support ward teams if cover was needed for staff absence. The evaluative case studies continued to support this model - although case study 15 showed the success of the housekeeper meant the ward teams had fully embraced the role leading to the FM department being excluded from decision making on recruitment. An area the original case studies didn't report on, in relation to management, was the line management responsibilities the housekeepers had over the team of ward domestics and

catering staff. This continued to be a grey area and potentially a contentious one as in some cases there were multiple stakeholders involved in the line management of domestic staff. Clearly the housekeepers had responsibility for cleaning and catering on their wards and would need to work closely with domestic and catering staff. In most cases the working relationship appeared to have evolved over a number of years where each party were mutually content with the arrangements, without the lines of management ever formally being recognised between the groups of staff involved. While this may have allowed for a practical working understanding to be established, what it didn't permit was for the housekeepers to be prepared for managing staff. For example, during the evaluative case studies, housekeepers felt unsupported through a lack of relevant leadership training when managing staff. The six key themes (Role; Recruitment; Induction; Training; Integration; and Management) form the basis of Model B presented in section 5.10. The themes are placed under either "emotional" or "functional" based concerns and a suggested method to oversee these themes is proposed using Model B.

5.3 Impact of Modern Matron Role

As discussed during the introduction to this chapter, the modern matron role was introduced into the health service after the publication of the NHS Plan (Department of Health, 2000). Modern matrons were advocates to improve the patient experience. As well as improving patient care, they were there to make hospitals cleaner, more comfortable and provide patients with better information and more choice. They were senior ward staff who would work alongside sisters and charge nurses to ensure good, visible clinical leadership (Department of Health, 2003d). The Department of Health and the Royal College of Nursing constructed a 10 point list outlining the matron's key responsibilities. These were 1) Leading by example; 2) Making sure patients get quality care; 3) Ensuring staffing is appropriate to patient needs; 4) Empowering nurses to take on a wider range of clinical tasks; 5) Improving hospital cleanliness; 6) Ensuring patients nutritional needs are met; 7) Improving wards for patients; 8) Making sure patients are treated with respect; 9) Preventing hospital-acquired infection; 10) Resolving problems for patients and their relatives by building closer relationships (Department of Health, 2003d, pg. 5).

The role of the modern matron was, and still is, clearly intertwined with that of the ward housekeeper. The modern matrons were explicitly named as being responsible for improving hospital cleanliness and ensuring patients' nutritional needs are met. There were other aspects of their role that also overlapped with areas that housekeepers were undertaking at some Trusts. For example improving wards for patients could be interpreted

as maintaining the environment. Similarly point 10 refers to resolving problems for patients and relatives by building relationships. A number of Trusts were utilising housekeepers in this way to liaise and communicate with patients and relatives over various issues to make their (patients) stay as comfortable as possible.

The dependency between modern matrons and ward housekeepers was recognised by the Department of Health through their guidance, which at least demonstrated some "joined up thinking" amongst the quangos responsible for issuing best practice. The following year the Department of Health (2004a) would publish the Matron's Charter: An action plan for cleaner hospitals. This has already been discussed in detail in this thesis during the literature review. The main purpose was to set out a broad list of ten points of commitment based on cleaning principles. A year earlier, within their *"Modern Matrons - Improving the Patient Experience"* best practice guidance, the Department of Health (2003d) had already referred to some of the ideas that would form the ten points of commitment. At the same time they set out the role the modern matrons would have in the PEAT inspections and how they were also key to the introduction of ward housekeepers and stated how they would have *"significant improvements in ward cleanliness as well as more help for nursing staff with non-clinical tasks"* (Department of Health, 2003d, pg. 12). Whilst the original case studies did show that modern matrons and ward sisters were important during the introduction of the ward housekeeper role, it would be a little unfair to exclude the impact from the FM departments who throughout each case study were the teams behind the operational implementation plans.

During the original case studies, apart from the involvement from the modern matron role during the recruitment and induction/integration of the ward housekeeper, there was little discussion as to their impact. Even during the discussion centred on recruitment, induction/integration, it was largely cited as the ward sisters and/or ward managers who would be representing the ward teams rather than modern matrons. At the time of the original research the modern matron was still very new, and in some hospitals had not yet been introduced. For this reason it was unsurprising how little reference was made to modern matrons.

What was then surprising, perhaps due to the fact there was relatively little said during the original case studies, was how important participants reported the modern matron role to be during the evaluate phase of the research. One obvious explanation would be due to the time period that had elapsed and the modern matrons then having adequate time to find their own position within the Trust. This would have allowed them to then establish their

authority on the cleaning, catering and ward environment responsibilities that overlapped with the housekeepers. Subsequently, it was only after a period of time that the full impact of the modern matron on ward housekeepers became clear. The participants in case studies were unequivocal when it came to discussing modern matrons. It was not just during the recruitment of housekeepers, but the commitment they showed longer term to allow them to be successful and flourish in their positions. Participants from the FM departments were able to compare where they felt the commitment wasn't as strong from some modern matrons and reflected on the utilisation, and ultimately the success of the housekeeper in these areas. To investigate this topic further, and in extra detail using more than anecdotal evidence, additional research could be completed. This study was a holistic approach to the ward housekeeper role, the impact of modern matrons emerged as a key theme during the evaluation phase. Therefore, practically it was difficult to comment on this in any more detail.

5.4 The importance of auditing

One shift in emphasis for the ward housekeepers worth discussing is the importance of the role in auditing. Ward housekeepers and other participants during the evaluative case studies reported how they felt the significance and overall profile of conducting audits, and specifically cleaning audits had increased. The shift in emphasis from catering to cleaning is discussed in the next section, but it is worth noting that the auditing referred to was focused on cleaning.

The original case studies did not uncover the same significance in relation to auditing. This however, may have been another symptom of the relatively new nature of the role. It could be argued that before utilising any new member of staff to conduct the audits, their role and position would first need to have been clarified through an informal probation period.

The relative importance of cleaning and the resulting auditing that would take place across NHS Trusts may have been another explanation for the increase of auditing. In general, during the evaluative case studies, participants felt there was an increased focus across the NHS. Therefore, the impact of auditing on the ward housekeeper's duties may have been an indicator of the broad renewed interest in auditing, and specifically the cleaning audits.

5.5 Shift in emphasis from catering to cleaning

This chapter has already revisited the ward housekeeper best practice set out by the Department of Health (NHS Estates, 2001a). The original guidance discussed how Trusts

could determine the mix of tasks. It made clear that, in line with the concept of flexibility and meeting the needs of individual ward, tasks will vary from ward to ward. For example, in an elderly care ward the time spent on providing food and keeping the environment clean may be similar. Whereas a housekeeper on an A&E ward with a higher patient input may spend more time cleaning and less time of the catering duties.

The guidance provided indicative advice on four different skill mixes: a baseline ward; an A&E ward; an elderly ward; and an ICU ward. The baseline ward had an even mix of 25% of time spent on maintenance, food, cleaning and other duties. The A&E ward had a suggested skill mix of 44% of time spent on cleaning, 25% on other duties, 17% on maintenance and 14% on food. An elderly ward skill mix was 33% of time spent on cleaning, 24% on food, 24% on other duties and 19% on maintenance. The ICU skill mix was 44% of time spent on cleaning 28% on other duties, 21% on maintenance and 7% on food. It was unclear how the Department of Health came to these calculations for the skill mix. The assumption was that there was no empirical evidence to justify the suggested skill mix. But the guidance did not set out to make this claim and readers had to assume they were indicative examples. The baseline ward split the work evenly between the four areas. The other three examples provided had the cleaning duties as the priority set of duties, while food had the lowest priority in two of the examples.

How does this compare with the reported skill mix from housekeepers during the case studies? Unfortunately it is difficult to get an accurate picture. The research study did not set out to measure or test aspects of the housekeeping service, it was exploratory in nature. This does not mean that the skill mix couldn't have been assessed in some way as part of the research. This could have been completed in a number of ways. Using a semi-scientific approach and through structured observation a measurement of the housekeeper skill could have been achieved by means of a "time and motion" type of exercise. To have any validity this would have to be conducted over a relatively long period of time - for example a full shift over a complete week. Another similar approach would be through asking housekeepers to keep a self recorded diary of their time spent undertaking various duties. A less precise method to record the skill mix could have been through the housekeepers retrospectively reflecting on their time spent undertaking various duties and recalling this during the interviews.

During the original case studies, anecdotally, there was a general feeling that no one area of skill mix dominated the daily routine for housekeepers. The focus for participants responses were usually on the catering and food related duties. There was relatively little discussion on

their maintenance responsibilities or other sundry activities they undertook. It has to be remembered that it was under the heading of "improving the hospital food" in the NHS Plan (Department of Health, 2000) that housekeepers were first cited. The Trusts did appear to use housekeepers across both cleaning and catering functions on the wards and attribute equal weighting to the percentage of time spent undertaking these two tasks. What was noticeable during the evaluate case studies was the rhetoric surrounding cleaning. At the time participants discussed the impact of cleaning and the significance from the Trust, at a senior level, on this service area. This clearly had an impact on the housekeeper role. Specifically housekeepers considered that cleaning was now their priority and core work. Further work in this area would be useful to measure the skill mix over a period of time.

5.6 A developing tension between FM and ward staff

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

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

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

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

Instead, there was however, a new tension. This time it was not centred on the actual role itself, but because of the role. The two evaluative case studies illustrated an undercurrent of tension between ward teams and the FM departments, both for different reasons. One Modern Matron in case study 14, who was a key proponent of the housekeeper role, was unhappy at their lack of involvement during the recruitment of key housekeepers. They had originally been a member of interview panels and had an interest in *"getting the right person for the job."* They were no longer involved at this level. The Domestic Services Contractor and their on-site management team were responsible for recruitment and once appointed would take new housekeepers to meet their modern matron. This was causing resentment. During the same case study there was further strain put on the relationship between ward teams and FM department over requests made to the housekeepers which were not included as part of the SLA. Housekeepers reported feeling "in the middle" as a result of requests made by nursing staff to complete work that fell outside of the SLA. They also had a sense of obligation to their employers - the Domestic Services Contractor - who had a commercial arrangement with the Trust.

Case study 15 revealed a tension between the ward teams and the FM department due to a different set of circumstances. Participants reported that the housekeeper role had been fully embraced on the wards where it had been implemented. This appeared to be a combination of strong clinical leadership from a set of modern matrons who had demonstrated a commitment to the role and also a clear direction from a pioneering Facilities Director who had a passion and vision for housekeepers. The success of the role had lead to the ward teams taking full ownership of their respective housekeepers and starting to recruit new staff without involving the FM department. Representatives from the FM department and Domestics services were uncomfortable with this and considered they had an important part to play during the recruitment of new housekeepers. They could provide FM related advice and specialist knowledge that ward teams were unqualified to do.

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

The proposed Model A listed in section 5.9 suggests a matrix mapping out the tensions between FM and ward staff over the ownership of ward housekeeping services. It suggests four possible alternative segments in which FM and ward staff can operate.

5.7 Lack of national support and co-ordination

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

The aim of this study wasn't to focus and discuss the national situation. However, it did provide an important context to the study and worth reflecting on for future developments. Case study 15 demonstrated that FM departments and Hotel Service teams were concerned at the situation nationally.

The NHS Estates were responsible for overseeing the implementation of the housekeeper project and supported trusts during this period. It was widely acknowledged at the time to be a success from the agency. During the initial period training events, conferences and workshops were organised, along with the publication of the Housekeeping Guide (NHS Estates, 2001a) to support Trusts.

As part of the review of ALBs, the NHS Estates was abolished in 2004. Since then, there has been relatively little attention given at national level to the ward housekeeper project. This was the focus for concern from participants in case study 15. The concern was centred on the lack of guidance, training events, career structure and general national level support for the housekeeper initiative.

It could be argued that without an invention nationally to support or act on behalf of FM departments for the cause of ward housekeepers, then there is a danger of seeing the role fragment. This was already evident in case study 15, where the success of the project had lead to the ward teams fully embracing it and therefore excluding the FM department from decision making. There is also the risk that trusts will move away from the original role description and develop new models without any involvement from FM departments.

The ward housekeeper role should be viewed as a success, and FM departments in NHS Trusts should use this to raise their profile and demonstrate their impact and contribution to patient care. Unfortunately, in some trusts there is evidence that the ward teams are taking complete ownership of housekeepers, and this would be to the detriment of the FM departments.

5.8 Value to patients and contribution to patient care

The last area to discuss in this chapter is the value to patients and contribution to patient care from the housekeeper. It is pertinent to finish with this topic, as ward housekeepers should be viewed as having an important part in patient care. Yet, often during the research, and in other publications related to housekeepers, this element was either missing or secondary to some of the other points and issues raised.

The need for FM departments to raise their profile and demonstrate their impact on patient care is crucial (May and Pinder, 2008). The ward housekeeper role can play a large part in doing this for the FM departments. However, as already discussed above there is now a real danger, due to a growing tension in some Trusts over the role, that the ward teams take full ownership. Coupled with a lack of national support, FM departments could miss the opportunity presented through an on-going co-ordinated housekeeper campaign.

During both of the evaluative case studies, the value to patients and impact on patient care emerged as a key theme. There was a lack of discussion on this topic from the first set of case studies. Again further research could be completed to support the anecdotal evidence presented here. Nevertheless, there was a strong feeling amongst the participants during case studies 14 and 15 regarding the contribution to patient care that ward housekeepers could make. This type and level of feeling was not evident in the original case studies. Paradoxically, the reason for the rhetoric and perceived increase in reference to patient care, could be due to the fact that ward teams and the nursing community were taking ownership of housekeepers and establishing their authority. Naturally this would bring an increased awareness of contributing to patient needs. Conversely, it could reasonably be argued that FM departments had also realised the need to discuss their services and impact on patient care - this was manifesting itself through their involvement with ward housekeepers.

What about the view from patients? This study did not engage with them as a stakeholder. However, the perception from housekeepers was that the patients did view them as part of the ward team. Their own awareness also hinted towards a self-appreciation of the impact

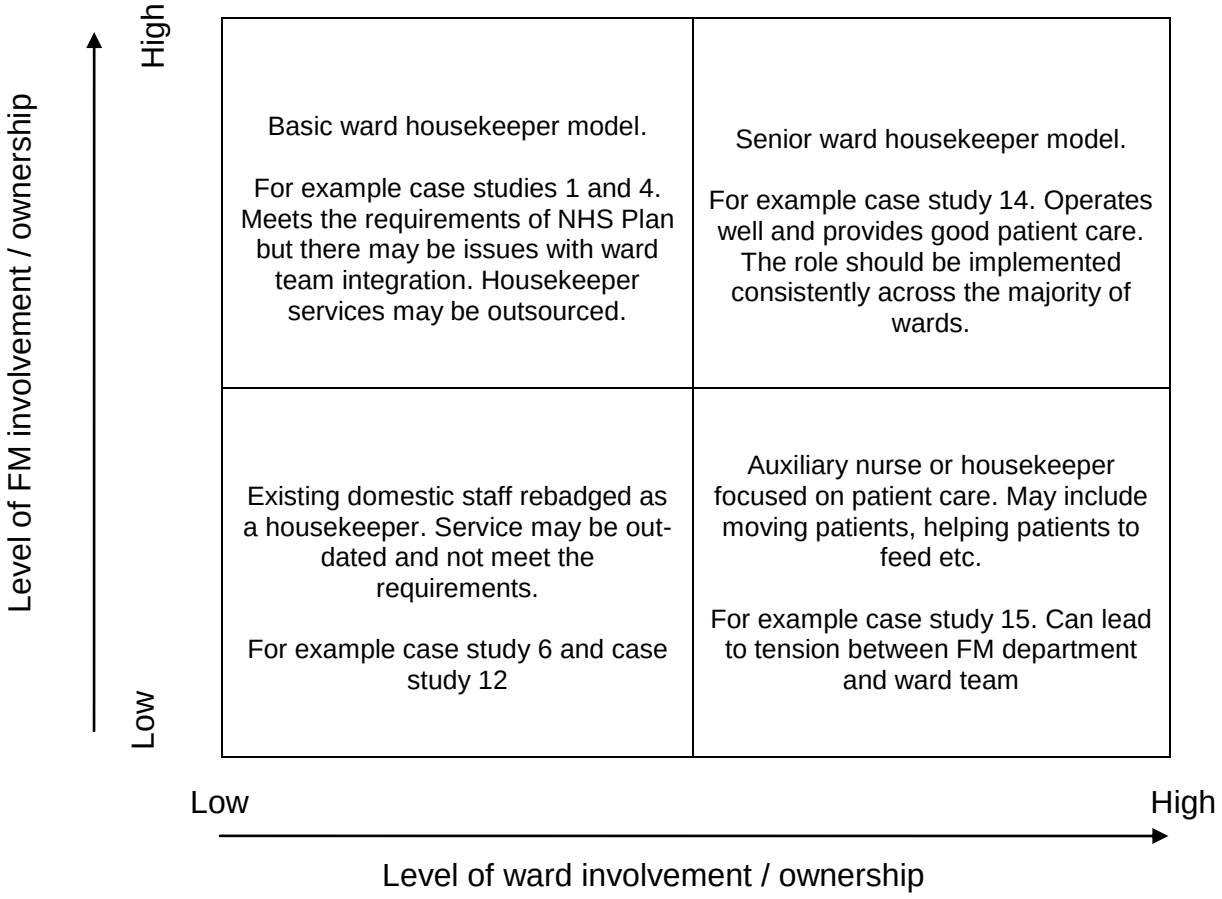
they had and ultimately their value. Specially, participants during the evaluative case studies cited examples such as managing patient dietary requirements, liaison and communication with patients and visitors and an informal one-to-one relationship with patients as areas where the housekeepers made the biggest difference to patient care.

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

A number of key concepts can be constructed to form a suggested model for housekeeping services in the NHS. The first one creates a model to suggest a level of involvement from FM departments and ward teams when managing the housekeeper role. This model has developed from the case study findings, analysis and discussion. It should be noted that these models are untested, but do provide the opportunity for future research. In addition, as the models are yet to be tested, they cannot be proposed as best practice. Instead, NHS trusts should view the models and associated ideas as a template to implement the housekeeper role and then experiment with the effectiveness and efficacy within the local environment.

Model A infers a template which NHS trusts may wish to consider when either implementing the housekeeper role or re-designing their existing services. The model interprets the various case studies and summarises the level of involvement from the FM departments and ward teams in relation to the ward housekeeper role. It also draws upon literature already discussed in the theoretical framework. The areas of power, conflict and overlapping authority are relevant for the suggested model. Power, in the sense of how groups and departments exert power over others (French and Raven, 1958). Conflict is relevant for Model A as NHS trusts are pluralistic organisations (Fox, 1966; Fox, 1973) and consist of a collection of groups with their own interests. The concept of overlapping authority is also evident in the model which leads to demarcation disputes (Huczynski and Buchanan, 200&). Model A is illustrated below in diagram 10.

Diagram 10 - FM department and ward team involvement in ward housekeeper services: a proposed model (Model A).



Where there has been low involvement or ownership from FM departments and a low level of engagement from wards then the housekeeper is placed in the bottom left segment of the model. Trusts operating in this area may encounter poor levels of integration from their housekeepers into ward teams. Case study 6 demonstrated where a Trust had rebadged an existing domestic role. Here the reported level of integration into the ward teams was poor. Case study 12 demonstrated where potentially a lack of engagement from the FM department had lead to parallel and inconsistent housekeeping models being implemented. The housekeeping staff in this case study were not dedicated to any one ward, which could also impact on integration. It could be argued that ward housekeepers implemented in this situation do not meet the requirements of the role and are out-dated and little more than a rebadged domestic.

Trusts that had low levels of engagement from FM departments and high levels of engagement from ward teams will have their housekeeper role situated in the bottom right segment. A housekeeper role reflecting the characteristics in this type of environment may

be closer to a typical HCA or nursing auxiliary. The housekeeper may still undertake and be responsible for the tasks suggested in the NHS Estates skill mix - food, cleaning and maintenance. In addition it is likely that the ward staff or teams will have asked them to do other duties that are not classed as "non-clinical." For example:- moving patients, helping patients to feed and taking patients to the toilet. Trusts using housekeepers in this segment may see their model move away from the original guidance set out by the NHS Estates. Additionally, because the involvement from the FM department is relatively low, there may be tension and conflict created between the FM department and ward team regarding the housekeeper role. This can be seen in case study 15. Here the involvement from the FM department is not low - in any absolute manner - however it is relatively low compared to the involvement from the ward team. This had led to a tension between the two after ward teams starting to ask their housekeepers to undertake work that was considered to be of a clinical nature. The ward teams were also starting to recruit new housekeepers without involving the FM departments, again leading to tension.

The segment in the top left hand corner of the model shows a Trust where the level of involvement from the FM department is relatively high and the involvement from the ward teams is low. Trusts implementing ward housekeepers within this environment do meet the requirements set out in the original guidance set by NHS Estates. The housekeeper role may have been successful, yet due to the relatively low involvement and engagement from the ward teams there might have been problems with integration. It is also likely that in these circumstances, there is less management from ward teams on a day-to-day basis. The housekeeping services in this model may be outsourced to a third party, therefore SLA arrangements in place and a less flexible approach to the services provided by the housekeeper. There may also be less scope to change the role or add additional services in the future. Case study 1 is an example of this. A lack of commitment from some wards resulted in only a partial integration of housekeepers. The role was also poorly communicated to some ward teams which did not help the problem. Case study 4 is another example of this, the housekeeping and domestic services were outsourced at this Trust. The day-to-day management of the housekeepers were conducted at ward level, yet issues surrounding recruitment, training and induction were handled by the contractor. Any strategic decisions made related to the housekeeper role were the responsibility of the Facilities team.

Model A proposes that the optimum place for the ward housekeeper role is in this top right segment. This is where the level of involvement and engagement from both the FM department and the ward teams are high. This should be trust wide, and the housekeeper role implemented consistently across the majority of wards, including A&E. There should be

commitment from both FM departments and ward teams, yet no one stakeholder should dominate thereby making the other a relatively low engaged partner. Although not explicit in the NHS Estates guidance, the concept of a senior ward housekeeper role has demonstrated good practice. This is illustrated in case study 14. The FM department were responsible for overseeing the implementation of the new role. Following this the day-to-day management of housekeepers had been taken by ward sisters and modern matrons. The housekeeper worked at a "senior" level and had a group of domestics and ward catering staff they viewed as part of their team. The Trust in case study 14 had also implemented the senior ward housekeeper across the majority of their wards, including within A&E.

5.10 Emotional and function based housekeeper concerns (Model B).

A second model is also suggested. This discriminates the key themes/findings into two distinct areas of concern that enables the housekeeper role to be successful - emotional based concerns and functional based concerns. This model also proposes that the two groups of concerns should be the responsibility of either the FM department or the ward teams. The concerns are not divided according to their strategic nature versus day-to-day operations nature, but instead on the appropriateness of responsibility. Again it should be noted that these models are untested, but do provide the opportunity for future research. NHS trusts implementing or re-designing their housekeeper role or the housekeeping services may wish to consider Model B and the principles. However, it should not be treated as best practice until tested. Table 8 below illustrates the indicate themes (based upon the findings from the empirical data) and the respective teams responsible for managing / implementing.

Table 26 - Emotional and function based housekeeper concerns (Model B).

Emotional based concerns	**Functional based concerns**
Managed by ward teams	*Managed by FM departments*
Integration	Role (basic description and Trust wide model)
Management (on a day-to-day basis)	Training
Value to patients	Induction
Patient care	Recruitment
	Flexibility

Some of concerns have joint responsibility, for example induction, recruitment, and flexibility. These have been placed under the responsibility of FM departments, who should design how these concerns will be managed across the Trust. Yet in practice these concerns will be implemented by many teams and departments. Using recruitment as a case in point.

Evidence from the case studies shows that in most cases the FM department have co-ordinated the recruitment of ward housekeepers, yet they need to work in conjunction with the HR department and ward teams to put together the job description and conduct the interviews.

The model proposes that NHS trust should consider managing the functional based through their FM departments within NHS Trusts. These are operational based decisions, usually they need to be made before or prior to the housekeeper starting. The following are examples of functional based concerns that could be managed by the FM departments: role; training; induction; recruitment; flexibility. The findings from the case studies suggest that NHS trusts considered and in some areas agreed the functional based concerns pre-implementation of the ward housekeeper.

Model B proposes that NHS Trusts should consider managing the emotional based concerns through the ward teams. These are non-functional issues and include: integration; management; value to patients; patient care. These issues are intrinsic, fundamental concerns that are related to providing patient care and ensuring the housekeeper is equipped to work as part of an efficient team. They are related to meeting the needs of patients and allowing the housekeeper to demonstrate their impact on health outcomes. The emotional based concerns are more likely to be considered (or measured) post-implementation of the ward housekeeper.

6. Conclusions

Whilst this study has been conducted, there has been a shift in power and responsibilities between the FM discipline and clinical based teams related to the focus of the research - the housekeeper. This shift of power is reflected at both the national level and Trust level through ward environments. The changes occurring have already been discussed in the previous chapter. Shift in ownership, from FM departments to ward teams, for catering and cleaning services and consequently the housekeeper role can also be seen through the impact of the modern matron.

But is this a good thing in the long term for FM departments? The increased focus on facilities services and the relative success of the ward housekeeper role appeared to raise the profile of FM departments across NHS Trusts. FM departments were also supported and had an identity nationally through NHS Estates. At a ward level, the evaluative case studies have indicated a shift towards ward teams taking ownership over the housekeeper role. This potentially leaves FM departments with a purely advisory role. The lack of an advocate at national level further supports this perilous position. Instead, FM departments should have been looking to consolidate the successes achieved through the ward housekeeper role.

The Models A and B propose a solution to this and could help Trusts re-establish their role within ward based housekeeping. The models are based upon the findings grounded through the empirical data. However they are untested and this forms the basis as one of the recommendations for this study (see below).

Where does this leave the future for housekeepers and potential research? In terms of moving forward, new work to test the two models suggested above, would provide a deductively credible partner to complement this study. The importance of qualitative work in the discipline of facilities management, and specifically in the context of health environments should not be underestimated. Traditionally medical research uses the experiment as the gold standard for empirical based research. Yet, interpretive work does have a role to play. The aim of the study was to complete an interpretive and evaluate based enquiry, it was not looking to test a hypothesis or model, and therefore this should be left for future work.

6.1 Recommendations

Based on the findings and conclusions from the original and evaluative case studies, the following recommendations are suggested:

Recommendation 1: National Level Support

NHS Estates were the government agency responsible for overseeing the national implementation of the ward housekeeper role. They supported trusts during the project roll out by organising training events, conferences and publications. This included the publication of the Housekeeping Guide (NHS Estates, 2001a). NHS Estates was still operating as an executive agency of the Department of Health during most of the original case study research. Following a review of arms length bodies, the NHS Estates was abolished in 2004.

At the time the National Patient Safety Agency (now also disbanded with responsibilities transferred to the NHS Commissioning Board Special Health Authority on 1st June 2012) took over responsibility to support NHS Trusts in the delivery and implementation of cleaning, catering and safe hospital design. However there appeared to be little direct focus on supporting trusts in the ward housekeeper role.

Evidence from the evaluative case studies - specifically case study 15 (please see the discussion section for case study 15) - suggests that NHS trusts would benefit from a national level organisation who would act as an advocate for ward housekeepers. The lack of national support and co-ordination is also referred to during the Thesis Discussion chapter. This recommendation is made to the Department of Health, the NHS Commissioning Board Special Authority Trust and the Health Estates and Facilities Management Association (Hefma). There is no longer a dedicated team at the Department of Health focused on facilities and estates. Instead there is a "Patient Safety" department/section which has taken the lead on areas including infrastructure. The NHS Commissioning Board Special Authority Trust also refers to part of their work agenda looking at "Patient Safety," but there is no reference to estates, facilities or estates. Hefma is a member association that represents estates and facilities professional in the NHS. The Hefma Business Plan 2010-2013 (Hefma, 2010) makes reference to their aims in the current period including: striving for quality healthcare facilities while recognising that the patient is

key; representing views of estates and FM in the NHS; promoting professional management of healthcare facilities; promoting innovation; providing a forum for the exchange of relevant information; and sharing matters of common interest. It could be argued that Hefma is the natural stakeholder to promote and continue to champion the ward housekeeper role for NHS trusts.

The recommendation is that one of the above named organisations is identified and nominated as an advocate for ward housekeepers. This should be considered as it would reinstate a national focus for ward housekeepers and provide support and guidance for NHS trusts wanting to either implement a new housekeeper role or re-design their existing services. A series of workshops and supporting material (either printed or through other media such as web resources) would be available through the national body overseeing ward housekeepers.

Recommendation 2: NHS trusts to consider Model A and Model B in their ward housekeeping services

Model A and Model B have been proposed following the review of the evidence presented in the case studies and the analysis of the data. These models are as yet untested (see recommendation 3 below). Therefore until empirically proven by testing through further research they need to be treated as unverified. However despite this, the models have been developed through observation and would prove useful for NHS trusts wanting to either implement a new housekeeper role or re-design their existing services. The models present a useful framework that instead of being generalised from sample to population can be adapted and applied between cases.

Model A is the FM department and ward team involvement in ward housekeeper services. It proposes that for the ward housekeeper role to be a success there needs to be a high level of involvement from both the FM department and ward staff/managers. The involvement from both stakeholders is relative to each group. Without the equal and high involvement from both parties then the potential consequences include conflict/tension, poor integration and a poor/out-dated service delivery. For further discussion on Model A please see section 5.9 and diagram 10.

Model B illustrates the emotional and function based housekeeper concerns. This model divides the key themes/findings into two areas of concern which are labelled either "emotional based concerns" or "functional based concerns." It proposes that the two groups

are the responsibility of either the FM department or the ward teams. For further discussion on Model B please see section 5.10 and table 8.

The recommendation to consider the two models is made to NHS trusts and specifically either individual staff or project teams responsible for ward housekeeping services. This could apply to either a new ward housekeeper role being implemented or an existing service provision being reviewed. By taking into account the proposals suggested in the models it would potentially aid decisions around the role which emerged as a result of previous projects.

Recommendation 3: Future research to test Model A and Model B

The last recommendation concerns the scope for further research. This primarily comes from the need to test the two proposed models A and B. These models are untested and this provides scope for further research. One proposal would be to adopt a deductive approach using multiple methods to measure the impact of the two models. Again a pluralistic attempt to engage with multiple stakeholders might be considered. Patients, as stakeholders, could be engaged to assess patient care, value to patients and the impact on health outcomes. This work would provide evidence for FM departments in order to demonstrate their contribution to patient care.

Further work to investigate the housekeeper skill mix options - for example the percentage of time spent on catering, cleaning, maintenance and other related duties - implemented by trusts would show where the current priorities are situated. This could be tested over a period of time to look for shifts in priorities. Other KPIs may be identified to use as markers to measure success or otherwise of the proposed models. For example infection rates, food wastage, patient complaints and bed occupancy. An attempt to design some type of experimental study might be difficult but should not be ruled out for future research.

This recommendation is made to the Centre for Facilities Management Development at Sheffield Hallam University. It could also apply to other individual researchers or research teams that have an interest in how non-clinical services can contribute to patient care. The further research suggested above would enable the work, findings and models presented in this thesis to be tested and presented as best practice.

6.2 Contribution to knowledge - Concluding discussion

The significance of this study emerges through the advancement of methodology within the context of facilities in healthcare and through the contribution to knowledge and practice by way of suggesting two original models.

The central question was of importance for two reasons. Firstly, it was the first type of study to look in detail at ward housekeeping models, using an interpretive approach over a relatively long period of time. 15 in-depth case studies were completed to construct a representation of the ward housekeeper role across the UK since its introduction from the NHS Plan. Such a study had not taken place.

The second reason why it was worth conducting the study was the growing emergence of the need for NHS facilities and estates departments to demonstrate their contribution to health outcomes - i.e. their value to patient care. It could be argued that the profile of food services and cleaning in the NHS is at an all time high. Furthermore, there is a case to make that the food and cleaning services are the two areas where the facilities departments in NHS Trusts can really make a difference to patient care. The ward housekeeper plays a crucial role here. Therefore, by understanding in better detail and greater depth how the role should be designed and implemented, it gives facilities departments in the NHS a better chance to appreciate where they can make a difference to patient care.

Methodologically, the study was important as it was the first of its kind to apply an interpretive approach to investigate the ward housekeeper in the NHS. There have been other studies looking at the role. However these have been either mixed methods - with a focus on measuring impacts through quantitative based work - or practice based designs. The size, scale and interpretive nature of this work makes it unique. The longitudinal nature of the work should also be considered when reflecting on the contribution to knowledge. Much of the evidence and thinking for the suggested models comes from the development of the role over a relatively long period of time. Without this some of the significant findings would not have been uncovered.

The findings from the study are of significance for NHS facilities and estates departments and clinical stakeholders who have a responsibility for ward catering, cleaning and the environment. The original set of case studies provided important guidance and best practice related to the role, management, recruitment, induction integration and training (most of

these are categorised as functional based concerns in Model B). The evaluative case studies will be of interest to NHS FM departments to raise awareness of the involvement/engagement between them and the ward teams. This point is demonstrated through Model A. The ability to generalise the findings to a wider population is limited, but this was not the aim of the study. However, as already discussed above, the findings can instead be generalised to other settings - i.e. the best practice can be applied to other NHS Trusts.

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

Already the study has produced three publications. A first paper was produced presenting the core findings from the original case study. This was followed by a paper looking specifically at ward housekeepers in mental health environments. A third paper was a literature review on cleaning in the NHS since the NHS Plan. A fourth paper is currently being completed. This complements the cleaning paper by way of a literature review of catering in the NHS. In addition to the papers produced, as a result of the work completed during the study on ward housekeepers in mental health environments, the author was invited to sit on the Department of Health's "Ward housekeepers in Mental Health" steering group.

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Appendix Contents

Appendix 1 - Role Description from NHS Estates Guidance

Appendix 2 - Semi-Structured Interview Guides

Appendix 3 - LJMU confirmation of ethics approval

Appendix 4 - Participant Information Sheet

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Appendix 6 - Example of interview transcript

Appendix 7 - List of codes and categories for case studies 14 and 15

Appendix 8 - Senior Ward Housekeeper responsibilities from case study 11

Appendix 1 Role Description from NHS Estates Guidance (NHS Estates, 2001a).

Title: Ward Housekeeper
Responsible to: Ward Sister
Accountable to: Dependent on organisational structure

Role Summary

The postholder will work as an integral part of the ward team. He/she will be responsible for the co-ordination of all patient facilities services in the ward area and ensuring a clean, safe and comfortable environment.

The main elements of the role are ensuring the delivery of cleaning, catering and minor maintenance, together with other specified tasks to meet individual patient needs as determined by the ward sister/charge nurse.

The postholder will be required to work closely with contractors and support service departments. He/she will monitor quality standards, report deficiencies and take appropriate action.

Essential Tasks

Cleaning

- To assist in monitoring and maintaining cleaning standards on the ward.
- To carry out spot cleaning to ensure spillages are dealt with swiftly and efficiently.
- To ensure general and specialist equipment e.g. drip stands, incubators and commodes are cleaned as per cleaning policy.
- To ensure the ward is safe and tidy at all times e.g. remove clutter, tidy notice boards, signage etc.
- To maintain upkeep of patients' bed areas.
- To identify any problems with cleanliness and report to the ward sister.
- To ensure specialist cleaning of surfaces and furnishings.
- To ensure isolation nursing areas are cleaned appropriately.

Catering

- To assist patients to order food, where necessary taking into account special needs and medical requirements.
- To ensure people have any assistance they require to eat and drink and to monitor food intake in conjunction with the ward nurse.
- To prepare and serve hot/cold snacks (e.g. toast) as requested - offering a 24 hours snack service.
- To serve meals in conjunction with the nursing team, ensuring patients intake is known and that their dietary needs are met.
- To provide eating assistance, e.g. cutting up food, placing food within reach, encouraging patients to eat.
- To prepare hot/cold beverages including appropriate trolley/equipment.

- To regenerate meals as per policy.
- To ensure all food and beverages are served at the correct temperature according to food hygiene regulations.
- To prepare areas where food and beverages are served/consumed to ensure a pleasant environment for patients.
- To wash all equipment/utensils used in preparation, regenerating, serving and consuming food and beverages.
- To take responsibility for the ward kitchen, ensuring it is clean at all times e.g. discarding out of date food, stock rotation.
- To ensure refrigerated food is labelled and stored correctly as per policy.
- To ensure that discharged and newly admitted patients' meal requirements are actioned in conjunction with the ward nurse.
- To co-ordinate extra meal requirements that may arise.
- To ensure patients whose fluid intake is not medically restricted have access to fresh water (e.g. jugs and glasses).

Maintaining the environment

- To carry out monitoring of service delivery especially related to cleaning, food, linen and the environment at agreed frequency.
- To inform the ward sister of outcomes of monitoring and agree action plans ensuring action is taken.
- To manage the ward's defect call log book, ensuring all defects are logged, reported, recorded and closed down as appropriate.
- To monitor and co-ordinate other ad hoc maintenance, liaising with the support service helpdesk as required for other services.
- To provide household maintenance duty in line with local policy.
    - replace light blubs, clock batteries etc.
    - unblock sinks etc.
- To carry out regular equipment monitoring in accordance with procedures.
- To transport and dispose of clinical, domestic and confidential waste as per the policy e.g. taking waste to the ward disposal area.
- To clean and prepare beds and handle linen.
- To monitor the access and security and use of premises and facilities.
- To ensure the patient's space is respected including attending to patients' fruit, flowers etc.
- To respect the privacy and dignity of patients whilst carrying out housekeeping duties.
- To maintain the safety of people's property and belongings.
- To minimise the potential for adverse behaviour and security breaches.
- To use communication skills to manage any aggressive and abusive behaviour.
- To ensure equipment to be returned for reprocessing is stored safely.

General

- To receive, welcome and guide visitors on the ward, liaising with other ward staff as appropriate.
- To transport equipment, consumables and written information as required.

- To maintain and update paper based records and information as required.
- To respond to requests for general information.
- To receive and pass on information to others, maintaining confidentiality.
- To handle complaints and take appropriate action.
- To assist with training of staff involved with ward housekeeping services into ward routines to achieve required standards.
- To be aware of any new food hygiene standards, changes to waste categorisation etc.
- To be aware of any new food hygiene standards, changes to waste categorisation etc.

Working practices and relationships

- To ensure their own actions reduce risk to health and safety and to promote a health and safety culture within the workplace.
- To respond to emergencies as appropriate.
- To maintain effective working relationships.
- To foster people's equality, diversity and rights.
- To provide an effective customer service.
- To maintain environmental, food hygiene and personal hygiene.
- To maintain complete confidentiality with regard to all patient issues.

Support of people

- To ensure patients have adequate supplies to meet their basic needs e.g. toiletries as required.
- To ensure the ward has sufficient stocks to meet patient and staff needs.
- To assist people with accessing and interpreting written information e.g. cards and letters.
- To explain the correct use of equipment to people e.g. nurse call.
- To communicate effectively with people.
- To respond to health emergencies as appropriate.

(NHS Estates, 2001a, page 41 - 43).

Appendix 2 Semi-Structured Interview Guides

Potential interview questions/ areas for discussion with Director of Facilities (or equivalent)

- General introduction to research and interview.

- Purpose of the research.

- Check that participant information sheet has been received and understood. Request for informed consent.

- Alert participant to the tape recorder.

- Explain confidentiality agreement: All names and references to individuals and Trusts will be removed during transcription.

- Time constraints for interview.

TURN ON TAPE RECORDER

1. **Ward Housekeeper role**

    - Can you briefly describe what the Ward Housekeepers' job entails?
    - What have been the positive outcomes of using the Ward Housekeeper?
    - Are there any elements where the service is not as good as it should/could be?
    - Has an evaluation of the current system been carried out? If so, what did it show?
    - Do different wards/hospitals in the Trust have different systems? How do these compare re: standards of service, patient satisfaction etc.
    - How does the Ward Housekeeper system compare with the previous system? e.g. cost, staff morale, patient satisfaction, standards of service?
    - Is there a commitment from the Board to the importance of improving the work of the Ward Housekeeper (patient focussed care, etc)? How is this commitment shown?
    - Do you learn from good practice on Ward Housekeeping from other wards/hospitals/trusts (e.g. Ward Housekeeper model, changing/ altering the systems)
    - How is the operational quality of the service monitored?

2. Service delivered to wards

- Who determines the level of service (SLA?) for wards and how do you determine the level of service patients should receive from the Ward Housekeeper - for catering, cleaning, drinks, patient movement?

3. What happens on the ward

- Are support staff working on the wards regarded as members of "Facilities" or "Wards"?
- Who is responsible for tidiness on the ward e.g. tidy appearance?
- Are Ward Housekeepers regarded as part of the ward team by Sisters, Nurses and Doctors?
- Communication between facilities and wards regarding Ward Housekeepers, staffing issues, absence, recruitment - does it happen?
  how does it happen (e.g. regular meetings)?

- Is this method of communication successful? who considers it successful?

4. Management of staff

- Briefly describe your Ward Housekeeper training programme
- Do Ward Housekeepers have any training alongside the nurses and other staff from the ward (patient-focussed training; health and safety; lifting and handling)? Who organises this?
- What incentives are there for staff to undertake the training?
- Who does the training of the Ward Housekeeper?
- Are Ward Housekeepers trained in communication and interpersonal skills?
- Who does the recruitment of Ward Housekeepers?
- Who is responsible for organising cover for Ward Housekeepers sickness/holidays absences etc.?
- Who is responsible for the day to day management of Ward Housekeepers
- Who is responsible for the strategic management of the Ward Housekeeper service?

5. The staff

- Do Ward Housekeepers have the ability to assess and rectify problems as they occur day to day?
- What incentives exist for the Ward Housekeeper to do a good job?
- Does a clear career paths exist for the Ward Housekeeper? What is it?
- Are there any improvements that need to be made to the Ward Housekeeper service?

6. Critical review

- Discuss reflection of the role over the last 5 years
- Does it still meet modern ward needs?
- How will the role evolve in the future?
- Are there other models that need to be considered and developed?

Semi-Structured Interview Guides

Potential interview questions/ areas for discussion with Nursing Staff or Modern Matron

- General introduction to research and interview.
- Purpose of the research.
- Check that participant information sheet has been received and understood. Request for informed consent.
- Alert participant to the tape recorder.
- Explain confidentiality agreement: All names and references to individuals and Trusts will be removed during transcription.
- Time constraints for interview.

TURN ON TAPE RECORDER

Questions for Nursing staff

What services do the senior ward housekeepers provide?

How do the senior ward housekeepers and basic ward housekeepers interact? Do you know what responsibilities each role has? Is it clear or are you clear about the work responsibilities that each role has?

What do think of the quality of the service the senior ward housekeeper provides, e.g. what is particularly good and could be improved? And what in your opinion is the value of the senior housekeeper role?

While at this Trust have you experienced a different housekeeper model (to the current one)? What were the lines of management for the housekeeper before the introduction of the senior ward housekeeper? Do you now find it easier/more helpful since the introduction of the senior ward housekeeper.

Could the Senior Ward Housekeeper take more work off you? What could they do? or are they starting to encroach on areas of work you consider yours?

Have areas of responsibility blurred between the senior ward housekeeper and the ward sister or ward manager?

Who does the recruitment of the senior ward housekeepers? Are you involved in the recruitment process? If not do you think it is important that you are involved Alternatively if you are involved in the recruitment why is this important or how do you positively contribute?

What is the morale of the senior ward housekeeper like in your opinion?

How do you work together with the senior housekeeper to provide patient centred care?

Do you consider the senior ward housekeeper to be part of the ward team?

Do you think they could become part of the ward team more?

Do you actively encourage team work with the senior ward housekeeper? How?

Do the senior ward housekeepers attend ward meetings?

Do you communicate with the Facilities/Hotel Services department regarding the senior ward housekeeper?

On a typical "ward night out" either officially or informally organised would the nurses/doctors invite the housekeeping staff along?

Are you aware of the training that the senior ward housekeeper receives. In your opinion are there any gaps in the training plan?

Are there any improvements that could be made to the service?

Critical review

- Discuss reflection of the role over the last 5 years
- Does it still meet modern ward needs?
- How will the role evolve in the future?
- Are there other models that need to be considered and developed?

Is there anything else you'd like to add?

Semi-Structured Interview Guides

Potential interview questions/areas for discussion with housekeepers / senior ward housekeepers

- General introduction to research and interview.
- Purpose of the research.
- Check that participant information sheet has been received and understood. Request for informed consent.
- Alert participant to the tape recorder.
- Explain confidentiality agreement: All names and references to individuals and Trusts will be removed during transcription.
- Time constraints for interview.

TURN ON TAPE RECORDER

Questions for ward housekeepers / senior ward housekeepers

1. Your job

What are your duties, what do you do in a typical day?

What is your job title? Do you think it is important that you are recognised by other members of staff as a different grade/position to that of a housekeeper and is this reflected in your job title?

Where did you work before becoming a senior ward housekeeper? How did this job/role help you in your current job? What skills did you bring with you into your current role?

What do you do which makes the service good?

Where does the service fall short? how could you improve it?

Are you happy with the variety of tasks you undertake?

Would you like to take on new areas? if so what

Are there areas you have been given responsibility for that you do not consider appropriate? - is this a training issue.

Are you supplied with appropriate tools and equipment to do your job? e.g. cleaning equipment, PC etc.

What opportunities exist for promotion and pay increases for you?

Are you happy with this?

How varied is your day, how interesting is your day - how important are these to you?

Do you communicate with the facilities directorate/department? If so what are the channels available to talk?

Do you think you have a clear job description -do you know what you are expected to do?

Are there clear boundaries between where your responsibility starts and ends and others take over. Or is it blurred with areas that fall outside your duties but you do if you have the time available or the situation arises?

Do you have the flexibility for decision-making? If so can you assign extra tasks to others without first gaining approval from others, or alternatively does the role allow you to be flexible in the tasks you do during the day or week?

What do you like about your job?

What do you dislike?

Do you have a uniform that clearly identifies you from other staff?

How much say did you have in its design?

Was this/would this be important to you?

Does the uniform identify you from other housekeepers?

2. Management

Who is your immediate line manager? Is this for both day-to-day matters (operational) and more strategic matters such as training, appraisals etc.

If there are dual lines of responsibility what impact does this have on you? Does this ever cause confusion?

How much support (dealing with any problems, suggestions) do you get from the Facilities Directorate, Sister, Nurses, other Ward Housekeepers?

Who would you like more support from?

Do you experience any role conflict between what your FM managers/ nurses tell you to do/expect you to do and what patients would like you to do?

Does this effect your job performance?

What are the lines of management or responsibility between you and other housekeepers? Is your management responsibility for operational and strategic

issues? Do you have management responsibility over any other facilities staff (e.g. domestics or catering assistants) or ward staff (e.g. HCA, nursing assistants)? Does this include organising cover for support staff sickness/holidays absences etc? What about recruitment?

Similarly do you experience conflict between what you ask the housekeepers to do and what other members of staff may ask?

Who is responsible for organising cover for support staff sickness/holidays absences for you etc?

3. Training

What training have you had for the senior ward housekeeper role?

Are you happy with this training?

Have you received any training in people management or leadership?

Have you been trained in customer service?

Have you had any NVQ training? how useful was it?

Do you have any training with other members of the ward staff i.e. nurses etc. Would you like this?

4. Teamwork/Integration

Do you feel part of a ward team, Facilities team or both/neither? Do the Nurses, Sister and Doctors treat you as belonging to the ward team?

Do you consider there to be a "housekeeping" team? Do you feel there is a sense of teamwork between you and other housekeepers?

What help did you have to aid integration into the ward team? Was integration a problem or issue, of so what could have been done to overcome this?

Are you invited on "ward nights out" with the nurses etc? Are these officially or informally organised?

Do you have the opportunity to meet and discuss issues with other senior housekeepers? Do you have the opportunity to hold regular meetings with the housekeepers who are part of your team?

Are you encouraged to work as a team with other groups of staff e.g. nurses, domestics?

5. Suggestions

Are your suggestions/complaints listened to?

How are your views, ideas, suggestions sought?

6. Communication

Who is your immediate manager?

How easy is it for you to take problems to them?

Do they listen to you and take action?

Do you receive recognition and feedback from nurses, patients, FM managers?

Critical review

- Discuss reflection of the role over the last 5 years
- Does it still meet modern ward needs?
- How will the role evolve in the future?
- Are there other models that need to be considered and developed?

Anything else you would like to add?

Appendix 3 LJMU confirmation of ethics approval

By email

Wednesday 22nd July 2009

Dear Daryl,

With reference to your application for Ethical approval:

Facilities Management in Healthcare: A Critical Review of Recruitment and Retention for Estates and Facilities Staff and the Introduction of the New Ward Housekeeper Role
Ref.: 09/BUE/008

Liverpool John Moores University Research Ethics Committee (REC) has reviewed the above application at the meeting held on Thursday 16th July 2009. I am happy to inform you that the Committee are content to give a favourable ethical opinion and recruitment to the study can now commence.

Approval is given on the understanding that:

- any adverse reactions/events which take place during the course of the project will be reported to the Committee immediately;
- any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately;
- any substantive amendments to the protocol will be reported to the Committee immediately.
- the LJMU logo is used for all documentation relating to participant recruitment and participation eg poster, information sheets, consent forms, questionnaires. The JMU logo can be accessed at www.ljmu.ac.uk/images/jmulogo

For details on how to report adverse events or amendments please refer to the information provided at http://www.ljmu.ac.uk/RGSO/RGSO_Docs/EC8Adverse.pdf

Please note that ethical approval is given for a period of five years from the date granted and therefore the expiry date for this project will be July 2014. An application for extension of approval must be submitted if the project continues after this date.

Yours sincerely

PP:

Brian Kerrigan

Chair of the LJMU REC

Appendix 4 Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

PARTICIPANT INFORMATION SHEET

Facilities Management in Healthcare: A critical review of recruitment and retention for estates and facilities staff and the introduction of the new ward housekeeper role.

Daryl May, School of Built Environment

" You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not."

1. What is the purpose of the study?

The aim of the project is to critically review the ward housekeeper role, specifically focusing on the impact since 2004 when an initial piece of research was conducted. As part of the study it will aim to analyse current recruitment and retention issues for facilities and estates staff. The study will form part of a student PhD thesis.

2. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

3. What will happen to me if I take part?

If you agree to take part in the study you will be asked to participate in an interview that would last approximately one hour. The interview will take place at your work/office and will be arranged in advance for a convenient time for you. You will be asked questions about the hotel services department, the role the ward housekeeper plays in the department and you will be asked to reflect on the changes made to the role since 2004. In addition, you will be asked relevant questions relating to general recruitment, retention and workforce issues for your staff.

4. Are there any risks / benefits involved?

There are no anticipated risks to taking part in the research. There are also no immediate benefits, although the findings from the study will suggest some areas of best practice which you may find useful.

5. Will my taking part in the study be kept confidential?

All names and references to your organisation will be removed from the final report. Some direct quotes may be included from participants, however these will be fully anonymised. Data from the interviews will be stored electronically using a password protected file.

Contact Details of Researcher

If you require any further information please contact the principal investigator:

Daryl May
Senior Lecturer
Sheffield Hallam University
Room 7329 Stoddart Building
City Campus
Sheffield
S1 1WB
Direct line: 0114 225 4106

Email: d.may@shu.ac.uk

Appendix 5 Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

Facilities Management in Healthcare: A critical review of recruitment and retention for estates and facilities staff and the introduction of the new ward housekeeper role.

Daryl May, School of Built Environment

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential ☐
4. I agree for the interview to be audio recorded and for fully anonymised direct quotes to be used in the report ☐
5. I agree to take part in the above study ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Name of Person taking consent Date Signature

(if different from researcher)

Note: When completed 1 copy for participant and 1 copy for researcher

Appendix 6 - Example of interview transcript

DM	**Can you just go over what the Ward House Keeper, Senior Ward House Keeper role is, on your ward or across the site**	
JK	No, well, I only know it from a ward point of view, to be honest. Their role, I think, is to oversee the House Keeping staff; to make sure that all areas are scrupulously clean; that all the cleaning standards are maintained; erm, to deal with any, sort of issues, with their House Keeping staff; to make sure the ward is staffed, or sort out their annual leave; to make sure that if somebody wants the day off, that it's covered seven days a week. They also have a responsibility to make sure that the Host or the Hostess is competent in managing the management of food. They are also responsible for making sure the patients are happy with the delivery of the food, the content, the heat etc, and if they haven't, if they're not, then they make some other provision for the patients to have; food, drink, whatever it is they need. I think their role is to support me in keeping the standards as they should be.	
DM	**The standards are the ward environment standards, and the food?**	
JK	Yes, I am yes. So, that, essentially, in a nut shell, is their role, but, obviously you can break it down in to.....	
DM	**Yeah, well I wanted just to ask you, in terms of, for example, the cleaning, is their role to actually do the cleaning?**	
JK	Depending on how big an area they've got, erm, and how complex it is depending on what type of patients you've got, whether you've got lots of infections, rooms etc, then I think they can do, sort of, small areas, like they can do this sort of area, because they just, sort of, put a Hoover round dust, and, it doesn't take much work, but, essentially, I believe that their job should be to supervise, well be part of the training, make sure that they are able to do the job, and also then work with them, to make sure that, actually, they have done the job. That's not what I see in practice, but that's what the job should be.	
DM	**Can I ask you what you see in practice, then?**	
JK	What I see in practice is them doing a lot of the House Keeping, and not spending enough time supervising people. And, actually, when you do, I spend quite a lot of time talking to them about various individuals that we have, and it doesn't seem to be that it's within their gift, in their, they don't seem capable in managing some of the people they have to manage.	
DM	**Yeah, okay, so you, this is in terms of the line management responsibilities between the Senior Ward House Keeper and the House Keepers. Is that because you, their, perhaps, not**	

	confident, or they haven't got the skills, or is it because.....	
JK	Yes. Yeah. They're not trained to do that. Yeah. I mean, I, when I first, I've had a few in ten years, as you would imagine, but, the people I had for the pilot, interestingly, I interviewed. And, since then, I've not interviewed any of them. They've just been chosen for me. I have to say, after the first two, I then had, the male House Keeper left. He was absolutely excellent. He knew how to supervise people, he knew how to talk to them when they didn't come up to scratch. If they didn't, he knew how to then deal with it with the other managers in the office, and all was well.	
DM	**Did he leave to go to another role internally?**	
JK	No, he retired. He also had fantastic people skills, and so, he spoke to the patients like they were part of his family, 'How was your food, Sir? Can I get you anything?'. You know, all of that. Erm, and, he worked in partnership with a female, who was about a similar age, actually. And, they complemented each other very well. One did half a week, the other one did half a week. She was tiny , he was tall. He did the curtains, she did all the lower stuff, and so, essentially, it all got done, no problem. He left, and then we got another lady in who had a background in catering, and understood about the meals, etc, understood about the cleaning, cleaned a bit herself, but could supervise other people. Since those two people who left within, sort of, six or seven months of each other, left, it's been, what I would call, unsatisfactory.	
DM	**So, what's the turnover been like, then? You said that you've had one, then you've had another....**	
JK	I had the original two, replaced by another one. And then I had a couple who filled in for a couple of months, that just didn't fit in, as it were. And then I had a man who came who couldn't do the job. And now I've got two males who, one, his personality doesn't suit the job, and the other has an incredible time off sick. So, he's hardly ever here. He's okay when he's here.	
DM	**What happens when they're off sick? Is that, whose responsibility is it, then, to cover that? Do you have to go back to IFS?**	
JK	Well, I don't. They get someone else just to pop in to see if everything's okay.	
DM	**And, what happens if, you said part of their, the Senior Ward House Keeper's responsibility is to line manage the Hosts and Hostesses, with a mixed degree of success, but, part of that is annual leave and holiday. So, if one of the Hosts or Hostesses is off sick, the Senior Ward House Keeper has to get cover?**	
JK	I think the office sorts that one out.	
DM	**The IFS office, or, 'cos they have to then go back to a central**	

	pool, 'cos it's not as though they, they haven't got other stuff they can	
JK	Yes. No, they haven't. No. I think if they're missing a House Keeper, for instance, sometimes, they don't have that person replaced. I mean, they will do if they can, but, I think, what they, obviously, at times when recruitment's been difficult, they haven't been able to. So, I think then they have to stretch, you know, once you've already got across the floor, or do some of it yourself... But, I think, most of the time, they have it, I think they struggle sometimes with Hostesses to do the' 'cos if they go off sick, there isn't somebody who could deputise, which is a funny way of running it, in a way, 'cos you'd hope that somebody on the floor, who knows the geography, who gets to know the patients, who delivers the food every day, could be trained to do that, so that they could just change roles around sometimes. It would just make the job a bit more interesting, I'd have thought. But, anyway.	
DM	**I want to come back to something you said earlier, in terms of the recruitment, because, I think a lot of the success, that we saw previously, was based upon getting the Ward Manager, or the Sister, involved in the recruitment. I'll come back to that. But, can you reflect upon other, prior to having the House Keepers, or the Senior Ward House Keepers in place, how it was before?**	
JK	Well, they just had somebody who would just pop in occasionally to supervise.	
DM	**So, this model is a lot better?**	
JK	It could be, yes. It is better. It is better.	
DM	**There's room for improvement?**	
JK	Yes. Definitely. It could be so much better. And, I think, I shouldn't be on their backs all the time about things. You know, I shouldn't go and find dirty toilets. I shouldn't go and find things not done. That, if you've got somebody in a supervisory role, they should be able to come to me and say, 'Are you ready for the inspection?' Off we go. I should be able to ask a question, 'When were those curtains last changed? Let's look at this toilet.'	
DM	**That's having confidence in your staff, isn't it? I know, yeah...you're right. That, is their role, isn't it, to do these things?**	
JK	Yeah. I think part of the problem is, what appears to me, is that most of the people here, it's a bit like anything else, I suppose. Most of the people who are Senior Ward House Keepers have been House Keepers before. And, it's almost like they see a job, more money, 'Oh, I can do that'. They apply. Why they have chosen, is not for me to say. But, just because you're a good House Keeper... It's like being a good nurse, isn't it? You can be a	

	good nurse, but it doesn't mean that you can actually manage the shift. You can be a good nurse, but it doesn't mean you're going to make a good Ward Sister. You know, it's all that sort of thing, really.	
DM	**It's not, it's nothing to do with the fact that they've got too much work on? They're not stretched in that way?**	
JK	No. No. They've got enough. If they're all working, all the time, and they're not gossiping, then, they've got enough. But, there's a lot of talking that goes on. I think one of the worst things is having a central area, such as the kitchen. I think that is, especially in the middle of the ward, because, actually, they can just slip in there, and, of course, they meet you, and they start talking. So, if you crop the talking time, you can probably save yourself some House Keepers, to be quite honest with you. And, if they're not....our House Keepers start at seven and finish at seven, and, actually, I've told them, 'That's not, I don't need that'. What I'd like them to do is start at half past eight, and finish at half past eight. Because, at seven o'clock in the morning, the breakfasts are going out, the staff here will get on and do that, because there's a structure to their day, they know the patients, put out the breakfast, they can do it. But, at the other half of the day, the Senior House Keeper goes at seven o'clock, and these people who just come and do a four 'til eight thirty slot, are left to their own devices. And so then I find that's where it becomes slack, you know, they don't empty the bins, they don't collect cups and saucers, erm, they don't clean the toilets, which I have a complete obsession with. I mean, everybody in every Trust is all, is obsessed about commodes, which is fine, you have to be, but, they forget that, actually, patients use toilets, and who's looking at the toilets? You should be like the airports, you know, where someone goes round every hour, and checks that every single toilet is immaculate.	
DM	**So, before, okay, so, a lot about cleanliness, and, is that a big concern....?**	
JK	Yes. Absolutely it is.	
DM	**Okay. And that diverts a lot of your attention from clinical, and managing the ward. Having to go round, and check things you shouldn't necessarily need to check.**	
JK	It does, yes. Absolutely. Yeah, it does. Yeah.	
DM	**Okay, going back to the recruitment. I know, you mentioned that you were, and I know that a lot of the success from the pilots was because you were, or Ward Managers/Ward Sisters were involved in, in the recruitment. So, you're not anymore?**	
JK	No, I haven't been since it.....	
DM	**Is there any reason for that? Why, 'cos it is managed by IFS?**	

JK	I don't know. Yes. They manage it.	
DM	**They manage it. If, from what you said, it sound like it, you would like to be, or...**	
JK	Yes. Yes, I would. Definitely.	
DM	**That means....**	
JK	Yes. I think it makes them feel part, I mean, I think that's what they said. You know, when I actually did employ them, they said they felt part of, that I was actually part of it, and they would become a part of our team, which, of course, they are. You know, they're not separate. I know separate people pay your salary, but, at the end of the day, yeah, we're all here to make the patients comfortable, and make sure that their passage through the hospital is a safe one. And that includes them doing their bit. We can't do it without them.	
DM	**Two factors you've cited there, one is to make sure you get the right person, that you've got the person with the right skills, and it's starts the integration of them in to the ward. You see yourselves as part of the ward team, by having you on the recruitment panel.**	
JK	Yes.	
DM	**Well, I mean, my next question is, you know, do you consider Senior Ward House Keeper part of the ward team, and you said you do?**	
JK	Yes. Definitely.	
DM	**And, I guess in the eyes of the patient, they would just see another member of the ward staff anyway. You know, the patients don't differentiate, don't see them to, they won't even realise that they're part of a contracted-out....hotel services.**	
JK	No, we wouldn't. Never	
DM	**So, you're quite happy with that then, you know, as far as your concerned, even though you're not part of the recruitment, which would help, but they are fully-integrated in to the ward.**	
JK	Yes.	
DM	**Do they attend the, do you have ward meetings?**	
JK	I have meetings with them. I have meetings with them and the team.	
DM	**Okay, do they, the ward meetings that you may have with the nurses?**	
JK	No, they don't come to those, 'cos most of the stuff I talk about is	

	clinical, usually, or giving them information about various aspects of things, yeah.	
DM	**If the, if there's an issue with their performance, or something to do with that, you would go straight back to IFS?**	
JK	The Senior Ward House Keeper.	
DM	**Oh, the Senior, yeah, but it....**	
JK	But if there's an issue, then I go back to ???????	
DM	**They're part of the contractors?**	
JK	Yes.	
DM	**It's just an example but, if there's a ward night out, or a ward social, or a social, would they be invited?**	
JK	Oh, yes.	
DM	**And they'd come along?**	
JK	Oh, yes. Some of them. They get the choice, and then, yeah, I think it's difficult these days, with finances, and all the rest of it. People don't come for various reasons, but oh yeah, over the years they've come, yeah.	
DM	**I think another success reason for the Senior Ward House Keeper is, for someone like yourself, who is fully behind the role, and sees the value of it, and the importance of it, and, if you have somebody on a, in charge of a ward, that isn't, then it doesn't work.**	
JK	I think, it's an interesting thing what you talk about because I think the role of the Ward Sister has changed hugely, in the last ten years. And I think more and more people are not visible as Ward Sisters. They are stuck in offices doing paperwork, and all sorts of rubbish, that, basically, we shouldn't be involved in, because, actually, you need to be out there seeing what's happening, and that's, those that, you know, if you're out on the floor you can see what happens, you can work with your nurses, work with your House Keeping staff, whatever. You can maintain your standards. I think people in IFS see me as a difficult person, because, in some ways, in that....	
DM	**'Cos you get involved in.....**	
JK	Because they know that if things aren't right, I tell them. And, I think I get treated as a special case, if you like. You know. However, it's interesting, a lot of the staff say to me, you know, 'You're about the only Sister in the hospital who actually takes an interest in what we do'. And, I think, for that, sometimes, I think sometimes the Senior Ward House Keepers, and House Keepers, feel that I sometimes support them more than, actually, their own	

	management structure supports them. So, I think, once they get to know what, why I'm doing all this... I mean, I'm not doing it for my benefit, obviously. I'm doing it for the patients, and for the rest of the staff. It's nice to work in a nice, clean environment. So, yeah. I see that it works in two ways, really. You know, you can make yourself a bit of an nuisance, you're seen as a nuisance. But, actually, some people can actually see that, actually, she's not trying to be a nuisance. What she's trying to do is the get the right things, for if you or I were a patient on the ward, that's what you'd want. You know, you'd want someone saying, 'Sorry you don't like that food, can I offer you something else?'. It's not just taking a tray of food away from you.	
DM	**So, do you know the, you're not involved in the training, or any training that goes on?**	
JK	No.	
DM	**So, what happens, if it's someone who came in from outside of the Trust then?**	
JK	They'd have a training package that ISS will offer.	
DM	**Do you know what that includes?**	
JK	For Senior Ward House Keeper, I don't actually. No.	
DM	**Do you know what it includes for a Hostess, or.....?**	
JK	No, well, I mean, they have to be trained on the, sort of, hygiene aspects of food, and, you know, how to do the temperature testing, and all that sort of thing. And, from the cleaning, they have to be trained how to use each buffer, and mop, and bucket, and what colours, and all the rest of it. You know, they have to go through that training. Certainly before they are let loose on the wards.	
DM	**But they don't receive anything, once they're here, from you, or....**	
JK	No, I think if they, you know, can't manage things, it's usually because they haven't got enough supplies for things, they go to their Senior Ward House Keeper, but otherwise, they could be, pretty much, independent in their roles, really.	
DM	**So, what would you like to see change, if anything, then, that perhaps we haven't talked about?**	
JK	I think the success in their ability, is about the failure....well, firstly, you've got to get the right person, and I know we all make mistakes, I mean, I do, too. You know, I recruit people, and you think, you're not the right, you may be a good nurse, but you're not the right nurse for this area. So, I think you need different things from different people. You know, you're asking a Senior Ward House Keeper to take a floor with the Barry Girls in, or a floor here. You've got to be walking the floor all the time, not tying yourself up	

	with, you know. And what I'd be doing, which I try to say to them, you know, 'You're here to supervise your team. What you need to do is...Do you know your job, John?' 'Yes', 'Lovely. I'll let you get on with it, then. It's coffee at eleven. It's lunch at twelve. And, I'll meet you at one, and we'll just go around your bays, and check that everything's okay, 'cos maybe you need a bit of a hand today, 'cos Sister wants these things moved, and she wants us to deep clean this area', and what have you. But they don't know how to work with, they don't know how to supervise. That's, as I say, my number one is. They don't know how to supervise.	
DM	**I bet if you got the right person, they would really thrive in that role.**	
JK	I'm sure they would. I'm sure they would. Yeah. And so, you beg the question as to what sort of pressure are the managers under, that the people who have currently got the posts. And, I don't, for one minute, think that IFS don't try to give me, potentially, some of the best people they have got. I do believe that they try to do that. 'Cos they know it'll just keep my quiet, from their point of view. I know they'll think, 'Oh, that'll keep her quiet, if we give her him or her'.	
DM	**I mean, I know there were, perhaps, issues last time, with wages, that the Trust can pay, but you weren't involved with that anyway, in terms of ???? work first. You know, you could get paid a lot more elsewhere, than in Brighton, for doing a similar type of job. But, that's something I'll discuss with IFS, to see if it's a problem..?????**	
JK	Yes, no. I don't know.	
DM	**Okay, just to finish off, then. Just, erm, sort of, reflecting on what's happened over the last five years. It sounds like the role does still meet your needs.**	
JK	Yes.	
DM	**Or it can do.**	
JK	It could do.	
DM	**With the right people. Bearing in mind what you've said, so it can do.**	
JK	Yes.	
DM	**Do you think, how do you think it's going to change in the future? Will it change, or, do you see it...**	
JK	I'd like to think it would. I think that one of the problems is the role of the Matron in, I mean, obviously, you know your own Trust unless you've got friends who work in other places. I would see that the Matron's role is key in this. One of the Matron's responsibilities is about the cleaning, and she'll take, you know,	

	part of her role must be to keep her eye on the ball, and to see how she, or he, can make the relationship better between IFS and the Ward Sisters, and actually influence, and say to the IFS Manager, 'Actually, my Sisters would like to take part in interviewing the House Keeping staff that are coming here'. Whether it be someone new who you're bringing in, or a current House Keeper, you know, to see whether they fit, personality-wise. Do you know what I mean? It's like anyone else, who else comes to this ward in a team that I don't interview? You know, I interview my House Keepers. I interview my Ward Clerks. I interview my PA. I interview all my trainers. Why do I not interview? And also, I think then, the Senior Ward House Keepers should interview the people who are going to work on the ward.	
DM	**Or be part of the panel, yeah, be involved in that.**	
JK	And because then they will take, why they're going to take an interest in somebody who just comes over to, and they're going to have a job for an evening, evening work, because they want to learn the language. You know, you're not going to take, I mean, I'm not saying there's anything wrong with those people. They're delightful. Absolutely, almost 100% delightful. But there is a different relationship when you, actually, you take a bit of pride, and, I employed this person, I feel responsible for making his life bearable, almost pleasant. I mean, you know, cleaning hospital toilets, I suppose, it's not a great job to have. You know, they chat to the patients, and the patients like it 'cos they're very kind. I mean, that's what the patients say to me. So, I've got no problem on that, sort of, level, at all. But you actually treat people differently if you're more involved in what they're doing, and explain to them, 'Do you understand what this job is, John? And this is what you'll be expected to do, and I will come and, obviously, inspect what you're doing, 'cos I'm the supervisor'. So, there are no great surprises when you come in to the job.	
DM	**Hhmm, and I guess, if, the Hostess has then been interviewed by that, it works the other way as well, by the Senior Ward House Keeper, they see, perhaps, that person as somebody who, or who has responsibility, you know, line management responsibilities. So, it works that way as well.**	
JK	Yes.	
DM	**It immediately says well, 'This person is, you know, my line manager'.**	
JK	And also, they should do their appraisal. 'What are you going to do, John? Are you going to be cleaning East for the rest of your, the next twenty years?' 'Oh, no. I'd like to be one of you.' 'Really? Then I'll train you to be one of me. Let me show you what I do.' You know, so you're a good role model. And, actually, on a day, say to them, 'Guess what? I'm going to clean East today, and John, you're going to be the Senior Ward House Keeper'. You	

	know, there's none of that nurturing, growing in to roles, succession planning. You don't see that. You suddenly think, 'Well, I've been here three years, I think I'll apply for that job'. I'm sure that's what it is.	
DM	**Do they do the appraisals then? Do they do them?**	
JK	I think there are...no, I don't think they do them. I think they ask them what they think, or, you know, if they've got any input. But they don't....do you see what I mean? So, someone in an office, who just clocks them in and clocks them out every day, does their appraisal. And, you know, I'm sure, on an intelligent level, you and I are, you know, we've got a few more neurons that they have, probably. But, actually, I have no time for that sort of thing. And, actually, you have little time for it anyway, 'cos usually it's, 'Gosh, I've got to get my appraisals done. Tick. I'll just tick that. I've done Jane Kingsbury's'. You know. Nobody's really interested in my development or what I do at all. You either.....	
DM	**These jobs you have to do.**	
JK	It absolutely does.	
DM	**????? useful tool, but that's the same, we have problems with the pro.....at our place, and, it's other things, it's obviously put at the bottom of the pile.**	
JK	Well, you see, I don't, I think it's very...I mean, lots of people say 'I think this is a waste of time', I say, 'Do you, why do you think that?'. And, I've actually got little questionnaires that I send round, well, certainly to my Senior Nurses. 'What difference do you think you've made to the patients in the past year?' 'Blimey'. They have to think about that one. 'How have you improved the environment on the ward?' 'How have you nurtured your team?' 'Which members of your team do you think you have succeeded in getting to a better place in the last year?' But, you can't, the bog-standard questions that HR give you have just, they're dull. I know there are a certain part of our job that you've got to meet, you know, tick the box, 'Yes, I've done that, Yes, I've done the training, Yes, I've passed all my assessments', and all that. But, it's not just about the skills that the person can do, whether they're clinical, cleaning, or whatever they are.	
DM	**A lot of my earlier work has been looking at that very thing, in terms of the impact upon the patient, for the Facilities staff. This is what I'm interested in, in terms of the Ward House Keeper, the porters, the cleaners, the caterers, that type of thing. But, looking to see the work that they're doing, and the impact upon the patient, rather than other outcomes, we'll, you know, how can these services contribute to patients getting better? Or, can they? That's what I'm interest..... The bottom line is, you're here for patient care, aren't you, so these services should contribute to that.**	

JK	Exactly. I mean, I know we're not supposed to be talking about porters, but, on another subject, you know, porters come and bring a patient to the ward. On their way back, there is a series of three things that need doing. 'Could you take that oxygen cylinder back there? Could you take this to so and so?' They can't do that without you picking up the 'phone, asking for a job number. And also, they'll say, 'No, sorry, he can't do that, he's got to do so and so'. And, in fact, one of the control people said to me the other day, 'You know, you can't do that, Sister'. I think she was ready for a fight, you know. I just said, 'Yeah, no, okay, fine, I won't do it. I won't use my...'. And the two porters are absolutely delightful, you know, they'll do anything for anybody. 'Well, we're on our way back, we'll do that for you, Jane'. 'We're told you don't do that sort of thing'. You know, it's become so bureaucratic, it's become....And, actually, it increases their work load. 'Cos if you can do two jobs every time you walk in a direction, you halve the work, the jobs, you know, you can log them if you like, but it actually takes you half the time. So, they haven't quite clocked that one.	
DM	**Is that to do with, is it, they're contracted out, aren't they, the services? It's not in-house. It was in-house, I think. Just when the Senior Ward House Keeper came in, I think it had just been contracted out, maybe,.....**	
JK	I don't know. I can't remember. To me, now, they've been here forever. It's quite difficult when you ask me the question about what happened before. I'm thinking, 'Right..'. No, a supervisors just popped in and said, 'Are you all right, Dolly?' You know, 'Everything okay?' You just listen to them if they said it wasn't, you know.	
DM	**Okay, that's all the questions for you. Is there anything else you wanted to add?**	
JK	Not really.	

Appendix 7 List of codes and categories for case studies 14 and 15

Case Study 14:

Audits Theme

Audits
Audits help maintain high standards
Benefits of walk arounds
Cleaning audits very important
Cleaning standards
Emphasis on cleaning standards
High volume of audits conducted at Trust
High volume of audits hinders other WHK work
Importance of checking and preparing for audits
Modern matron does daily checks
Preparation for audits
Resource intensive audits
Standards
Toilets need to be checked more regularly
Walk arounds

Communication Theme

Communication methods with FM
Communication with FM department
Communication with FM team
FM communication to matrons over WHK role
Liaison role between ward and FM staff
Poor communication over WHK role

Dedicated WHK Theme

Importance of having dedicated WHK staff
Importance of having permanent WHK staff
Team works better with dedicated staff

Duties Theme

Catering duties
Catering duties focused on meal times
Duties
Importance of patient focus
Matrons responsible for WHK role design
Paperwork

External Perception Theme

Feedback from FM staff
Lack of awareness of WHK role

Misunderstanding of WHK role from staff and patients
Nurses unsure who is responsible for cleaning
Raising the profile of WHK
Staff lack of awareness of WHK role
Trust board commitment to WHK

FM support Theme

FM duty manager supports WHKs
Lack of involvement from FM contract managers
Lack of support from FM dept

Importance of Cleaning Theme

Cleaning audits very important
Cleaning is now everyone's responsibility
Domestic role more than just cleaning
Domestics do not realise the importance of their role
Emphasis now on cleaning
Emphasis on cleaning standards
Shift in focus from catering to cleaning

Managing staff Theme

Arranging cover for domestic staff
Cover for domestic staff
Difficulty in covering staff absence
Domestic staff absence cover
Domestic staff clashing with each other
Domestics and hosts can be a difficult group of staff to management
Lack of leadership skills for WHK
Line management
Line management duties
Line management success depends on individual
Management responsibilities
Need for WHK to supervise team
Not all WHK have the necessary management skills
Problem covering sickness
Problems with staff cover
Recruitment of domestics
Staff go missing during shifts from ward
Supervision responsibility
Team management
Team meetings
Team meetings not happening now
Team meetings would improve the service
Ward areas prioritised for cover over public areas
WHK don't know how to supervise staff
WHK Leadership responsibilities
WHK need support from FM team for line management

WHK not confident in managing staff
WHK not within gift to manage
WHK to complete domestic appraisals
Line management responsibilities do not extend to moving staff to cover from different wards
Leadership skills would help manage sickness rates
Leadership training offered

Modern Matron Theme

Key role of matron in success of WHK
Role is to support matron
Success of role dependant on support from Matron
Success of role depends on Matrons
Support from modern matron
Ward managers not involved in WHK recruitment
Ward staff not involved in WHK recruitment
Modern matron does daily checks
Modern matron not included in recruitment process
Modern matron or ward manager big influence on WHK feeling part of the team
Matron does not interview WHK
Matron handbook for WHK
Matron key to success of role
Matron needs to influence FM to allow sisters to interview WHK
Matron not involved in recruiting
Matron or wards not involved in recruitment
Matrons responsible for WHK role design

Not yet allocated Theme

Appraisals
Certain things out of the control of WHK that leads to stress
Changing job description
Comparison between WHK system and other models at same Trust
Complaints to FM from WHK
Design of ward
Difference between WHK system and zone managers
Discipline for staff who go missing during shifts
Dislike the stress with the job
Domestic staff dedication
Domestic training
Evidence of reflection
Flexibility of role
Fm career ladder
FM team WHK role a luxury
Grey areas of responsibility have now been clarified
Inconsistency in labels used for job roles
Inconsistency in success of WHK
Internal promotion for WHK
Management reporting differences

Nurse involvement in food service
Personality clashes
Shift patterns don't allow team meetings
Shift patterns don't allow team meetings
Shift pattern not effective
Succession planning
Suggestions listened to
Thrown in at the deep end
Time wasted talking
WHK better than previous arrangements
WHK career progression
WHK enjoys the variety of job
WHK model better than zone managers
WHK patient feedback not evaluated formally
WHK team meetings
Zonal supervisors instead of WHK

Patient Perception Theme

Importance of visibility of role to patients
Misunderstanding of WHK role from staff and patients
Patients confuse WHK for nurses
Patients confuse WHK for nursing staff
Patients view of WHK
WHK views patients as customers

Recruitment Theme

Domestics not automatically making successful WHK
Good salary for WHK
Matron does not interview WHK
Matron not involved in recruiting
Matron or wards not involved in recruitment
Modern matron not included in recruitment process
No problem in recruiting WHKs
Recruitment of WHK
Ward managers not involved in WHK recruitment
Ward staff not involved in WHK recruitment
Ward staff only involved in initial WHK pilot recruitment
WHK recruitment
Recruitment of domestics
Need to stress at interview stage how tough the job is
FM department not involving matron in recruitment

Service Level Theme

In the future may be under pressure to reduce service levels
Inconsistency in WHK service levels for different wards
Role needs to be tailored to individual wards
Role tailored to size of ward

Wards utilising WHKs
WHK SLA dependant on no. of beds
Inflexibility in WHK being able to move from different areas

Shifting Focus Theme

Shift in focus from catering to cleaning
Importance of patient focus
Emphasis now on cleaning
Domestic role more than just cleaning
Cleaning is now everyone's responsibility

Staff qualities Theme

Need to stress at interview stage how tough the job is
People skills
Previous experience
Success of role is down to right person
WHK personalities

Team Integration Theme

Feel part of the ward team
Modern matron or ward manager big influence on WHK feeling part of the team
Priorities for ward team will affect integration of WHK
Team integration
Ward staff not utilising WHK effectively
WHK integration into ward team

Tension FM and Ward Theme

Conflict between nurses and FM over WHK responsibility
FM communication to matrons over WHK role
FM contracted services hinders dedicated WHKs
FM department not involving matron in recruitment
Inappropriate work requested
Inflexibility in WHK being able to move from different areas
Line management responsibilities do not extend to moving staff to cover from different wards
Matron needs to influence FM to allow sisters to interview WHK
Pressure of WHK role from FM and nurses
Sub contracted FM services may affect how ward staff feel towards WHK
WHK not trained to clean medical equipment
Ward staff not utilising WHK effectively
Liaison role between ward and FM staff
Lack of involvement from FM contract managers

Training Theme

Leadership skills would help manage sickness rates

Leadership training offered
Training does not cover management
Training provided
Training received
WHK training
WHK not trained to clean medical equipment

Value to Patients Theme

Additional services benefit patients
Patient benefit
Patient care
Patient satisfaction
Patients value the WHK role
Putting patients first
Senior WHK has less contact time with patients
WHK enjoys the patient contact

WHK qualities Theme

Domestics not automatically making successful WHK

Wider Picture Theme

Domestic staff need to understand the impact of their work

Appendix 7 List of codes and categories for case studies 14 and 15

Case Study 15:

Audits

Audits
Cleaning standards and monitoring
Infection control
PEAT inspections
WHK ensures standards are met

Career development

Staff use WHK role as a stepping stone

Change in WHK role

Asked to put drugs away not part of duties
Changing duties to improve service
Development
Development of the role since implementation
Development of WHK role
FM department blocking development of WHK role
Future developments
How role has evolved
New duties in the future for WHK to undertake
Resistance to change from the FM team
Role has developed over time with ward guidance
Ward managers wanting to change WHK roles
WHK gives out food
WHK role not to change much
WHK role now evolved away from FM dept
WHK role would change if FM department not involved

Communication

Communication from FM dept to WHK

Duties

Catering duties
Cleaning duties
Computer use by WHK
Duites
Estates dept liaison
Infection control
Matron considers WHK to do same as nurses
No line management on domestics
Nurses asking WHK to undertake duties

Useful if WHK could help patients eat
Using computers
Volunteers can help patients feed but WHKs cant
WHK asked to do things that are not in job description
WHK ensures standards are met
WHK gives out food
WHK role not to spend time with patients

Flexibility

WHK duties tailored to individual ward requirements
Role tailored to individual ward needs
Recruitment of WHK tailored to ward needs
Prior experience to becoming a WHK
Flexibility tailored to ward needs
Flexibility of WHK to meet needs of Matron
Flexibility of the role
Flexibility of role tailored to ward needs

FM tension

Asked to put drugs away not part of duties
Communication from FM dept to WHK
Defence of FM duties
FM department blocking development of WHK role
FM department has less control over WHK
FM dept plan to rein back in WHK role
FM now not involved in WHK role
FM trying to control recruitment of WHK but failing
Importance of FM dept still involved in recruitment
Lack of contact with FM dept
Matron considers WHK to do same as nurses
Must not do clinical work
No much contact with FM dept
Nurses asking WHK to undertake duties
Resistance to change from the FM team
Role has developed over time with ward guidance
Tension between FM and nurses over WHK management
Tension between FM and WHK
Tension between ward and FM over WHK role
Tension between what WHK asked to do
Tension over what ward manager asked WHK to do
Tension with FM team over line management
Volunteers can help patients feed but WHKs cant
Ward managers wanting to change WHK roles
Ward sisters and Modern Matrons taking ownership of WHK role
WHK asked to do things that are not in job description
WHK has unclear lines of reporting
WHK role now evolved away from FM dept
WHK role would change if FM department not involved
WHKs feel part of ward team rather than FM team

Management

Arranging cover for domestic staff absence
Arranging holiday cover for domestics
Career structure for WHKs
Charge nurse is line manager for WHK
Cover for WHK absence
Cover for WHK when absent
Cover for WHK when she is on holiday
Cover for WHKs
Domestics name changed
FM department has less control over WHK
Funding for WHK role
Funding of WHK role
Initial problem over calling name clash with domestics
Lack of career progression in housekeeping
Lack of WHK cover for sickness
Line management conflict with domestics
Line management of WHK
Line management res for domestics
Line manager for WHK
Line manager for WHK (2)
Line managers for WHK are nurses
Management of WHK
Rebadged domestics as WHK not successful
Relationship with domestics
Team meetings for WHKs
Team working with domestics
Tension between FM and nurses over WHK management
Tension with FM team over line management
Ward manager decides the WHK duties
Ward sisters and Modern Matrons taking ownership of WHK role
WHK can ask domestics to do jobs
WHK cover
WHK cover on holiday
WHK does not have line management responsibilities for domestics
WHK has unclear lines of reporting
WHK holiday cover
WHK line managed by the ward team
WHK role should be at supervisory level but is not

National Support

Trusts unsure of national position with WHK
Lack of national progress on role
Lack of national input into WHK due to gov cutbacks
Lack of national consistency over WHK name

Patient Care

WHK role not to spend time with patients
WHK role in communicating with patients
WHK patient care
WHK enjoys patient contact
WHK can get to know patients better than nurses
Ward manager encourages WHK to have patient contact
Value to patients
Patients confuse WHK with nurses
Patients confuse WHK for a nurse
Patient care from WHK
Patient care
FM contributing to patient care through WHK

Perception of WHK role

WHK uniform
People confused WHK with domestics at first

Recruitment

Ward manager decides the WHK duties
Skills needed for WHK
Recruitment of WHK tailored to ward needs
Recruitment of WHK
Recruitment of role
Recruitment
Personalities important for recruitment
No difficulty appointing domestic staff
Importance of FM dept still involved in recruitment
FM trying to control recruitment of WHK but failing
Domestic staff apply to WHK role

Resources

Arranging cover for domestic staff absence
Caterer shift patterns
Cover for WHK when absent
Funding for WHK
Lack of WHK cover for sickness
Lack of WHK cover nurses have to cover
Number of cleaner and caterers per ward
Number of domestics
Number of domestics and caterers per ward
Number of domestics per wards
Number of WHK per ward
Number of WHKs per ward

One WHK per ward
Shift pattern
WHK cover on holiday
WHK don't work weekends
WHK holiday cover
WHK implemented all but two wards
WHK needs to cover 247 but doesn't
Working hours

Skills needed

WHKs passionate about their role
WHK personalities important to success
WHK motivation good
Skills needed for WHK
Right WHK needed for right ward
Prior experience to becoming a WHK
Personalities important for recruitment
Passion of being a WHK
Hard work being a WHK
Good rapport with estates dept helps
Customer service skills needed

Team Integration

WHKs feel part of ward team rather than FM team
WHK used to have team meetings
WHK team meetings too large
WHK team meetings
WHK should work closely with ward sister
WHK part of ward team
WHK part of the ward team
WHK line managed by the ward team
WHK feels part of ward team and FM team
WHK feels part of team
WHK doesn't need to speak to FM team
WHK doesn't attend team meetings
Ward team meetings
Ward sister support
Teamworking amongst WHKs
Team integration
Support from ward manager
No much contact with FM dept
Initial conflict with auxiliaries
Conflict with auxiliaries

Training

Training of WHK
Training
Shadowing needs to be done earlier

NVQ training for WHKs
Leadership training provided for WHK
Lack of leadership training
IT training
Induction

Value of WHK role

Benefits of WHK role
Contribution of WHK
Evaluation of WHK role
FM contributing to patient care through WHK
Good team morale with WHK
Job satisfaction
Lack of recognition from nurses
Value of WHK
Value of WHK (2)
Value of WHK role
Value of WHK to ward sister
Value to patients
Ward managers key to success of WHK role
Ward sisters used to undertake WHK duties
WHK can get to know patients better than nurses
WHK enjoys her job
WHK free up nurses time
WHK free up nursing time
WHK freeing up nurse time
WHK frees up nursing time
WHK invaluable
WHK motivated
WHK role in communicating with patients
WHK role invaluable
WHK success down to personalities

Ward Hygienist

Ward hygienists
New ward hygienist role

Appendix 8 Senior Ward Housekeeper responsibilities from case study 11

Main Responsibilities

To undertake all Housekeeping roles, Catering, and be the focus for all Facilities Services provided to patients in the ward areas.

To be responsible for food and nutrition in the wards, to include ordering of special foods and supplements, monitoring of beverages, materials and snacks and safe storage of patients foods.

To be responsible for general tidiness, cleanliness, refuse, clinical waste, reporting of maintenance and minor repairs.

To be responsible in liaison with the Shift Leader and Senior Sister on duty in both areas in respect of cleanliness of toilet facilities, waiting areas, entrance areas, corridors.

To work independently and take initiative to work closely with the Dietician and ward staff in respect of improvements in Patient Facilities Services

To maintain a clean safe environment through the provision of Housekeeping duties, supplementing those provided by the main contractor. This would include cleaning of all areas as required, vacuuming, damp mopping and polishing of floors.

Removal and replacement of curtains where required and to ensure compliance with the 6 monthly curtain changing programme and as when necessary.

Undertake cleaning of areas occupied by isolated patients.

Dealing with dirty linen and clean linen.

Undertaking food hygiene training and ensure the safe keeping and availability of food in line with the Food and Nutrition policy.

Maintaining access to equipment, stock levels of cleaning and food stuffs materials for use.

Ensure the delivery of meals, snacks, hot food and drinks to patients and their relatives as required, including collection of meals from the Patient Food Court

Liaise with each patient to ensure they make an adequate choice for both lunch and supper meals from all the Catering Services available, taking into account their eating/drinking status and any special dietary requirements. To be involved in satisfactory surveys in respect of the ward environment and services and to feedback to the Ward Manager and staff.

To ensure patients' bed tables are clean prior to delivery of the food.

To ensure each order is with the appropriate Catering Supplier at the correct time, i.e. Hotel Services, Patient Food Court, WRVS trolley service or the Cook Chill System.

To ensure meals are issued to each patient and that the patient can reach the meal to eat, in addition to ensure nursing staff are alerted to feed patients who require assistance and to assist patients are required.

To assist in monitoring the patients overall intake in conjunction with the Link and other nursing staff and liaise with the named nurse where there is a concern regarding patients intake, including documenting of intake of food.

To provide alternative nutrition where identified, i.e. supplement or a soup.

To ensure the ward is prepared for meal service and is generally tidy, clean and clear of debris.

To receive guests in the ward and generally be responsible for the floor in respect of tidiness, cleanliness and to keep corridors clear of trolleys, wheelchair, etc.

To ensure sufficient quantities of all food and beverages are available in liaison with the Ward Hostess at all times at ward level in line with requirements of the National Plan.

To liaise with nursing staff to ensure orders are placed for items required for the out of hours meal service, i.e. bread, butter, baked beans, fruit juice, soup, etc.

To ensure locum, bank and agency staff are briefed concerning all aspects of the Housekeeping Service, in particular relation to food service to ensure a continuity of approach in respect of food and nutrition.

To feedback to Facilities Management, Ward Management, Nursing, Dieticians concerning catering or other Hotel Services issues. To meet with department Manger, Dietician and Nutritional Link Nurses monthly to review progress.

To liaise with the ward teams and the Nutritional Link Nurse in respect of training, handover, information exchange concerning all aspects of food and nutrition services.

To participate in ensure patients complete all the appropriate patient satisfaction surveys, both verbal and written. To understand the work of the Patient Advocate and Patient Liaison officers in relation to the ward activities.

To update the menus and content of Hotel Services handbook at the bedside to ensure all patient information forms are up to date with the appropriate week's menu and information sheets.

To replace the Hotel Services booklets and comment cards are required, engaging volunteers in some roles.

To account for the issue of vouchers for meal services and record all voucher numbers and other information required by the Finance, Hotel Services and Dieticians.

To ensure adequate explanation of the services provided for patients and staff is made available to all staff.

To ensure all complaints are dealt with immediately and appropriate response are given to patients.

To ascertain view of patients with regard to all aspects of the Hotel Services on each shift, in order to resolve any difficulties at that time.

To participate in training requirements as part of a ward team.

To undertake a "ward tour" at the end of each shift to check for patient satisfaction with Facilities Services.

To be responsible for the ward voucher system in relation to meal service.

To be involved in the recruitment selection of Hotel Services staff to work on the ward.

Team Responsibilities

To work as a collaborative member of the A & E Teams.

To contribute to the effective communications within the A & E area.

To comply with statutory legislation in respect of the working environment and to maintain a secure environment in line with Trust policies.

Feedback to departmental management, nursing, dieticians, Hotel Services staff concerning catering and associated Hotel Services issues.

To liaise with the ward teams of a Nutritional Link Nurse in respect of training, handover, information exchange concerning all aspects of food and nutrition services within the A & E area.

To participate in ensuring all patients complete the appropriate patient satisfaction surveys in respect of Facilities Services.