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Skills, training and development within an insular labour market: the changing role of catering managers in the healthcare environment

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Skills, training and development within an insular labour market: the changing role of catering managers in the healthcare environment

Abstract

Purpose of the paper

This paper addresses labour market insularity in the context of a specific sub-sector of healthcare management, that of catering and facilities. The paper is set in the context of growing public interest in the non-clinical environment of hospitals and other healthcare facilities has recently been greatly sharpened by political debate and professional concern.

Design/methodology/approach

The research was based on a survey of members of the Catering Managers Association in order to determine their perceptions of their jobs, their career paths to date and future aspirations and the skills that they require for their work. Useable responses were received from 74 members or 23% of the Association.

Findings

The findings of this paper addresses the roles that managers within in the UK's National Health Service who are responsible for catering and related facilities management perform and considers the responsibilities, in terms of skills, that these roles impose. The background and training of catering professionals in healthcare is also considered together with their long-term career aspirations. The key finding is that the healthcare environment constitutes a relatively insular labour market within which inward and outward mobility is rare. Managers in the sector are probably under trained for their level of responsibility and are limited in their career aspirations outside of the sector.

Research limitations/implications

This study provides a limited insight into a complex work environment and findings are based on a relatively small response rate. Non-members of the Catering Managers Association were not surveyed.

Practical implications

The study poses challenges to the healthcare sector in addressing the need for more effective career management and development for managers with a facilities and catering function. The issue of vocational insularity is one that needs to be addressed.

What is original/value of this paper

This paper represents the first study of its kind to address career development and training issues with respect to catering managers within healthcare in the UK and raises important questions about the insularity of this relatively large national labour market.

Keywords: labour markets; skills; healthcare; hospital catering; catering management

Introduction

There is a general trend within developed economies for a weakening of labour market characteristics and for an increasing interchange of skills and labour between different sectors of the economy. This is reflected in educational programmes in business and management at undergraduate and postgraduate level within which the focus is on the development of generic and transferable management skills. Such programmes, consequently, have less focus on the requirements of a specific sector within which graduates may seek to work. At the same time, closed or insular labour markets do exist within most economies and their dynamics merit investigation. This paper addresses labour market insularity in the context of a specific sub-sector of healthcare management, that of catering and facilities.

Public interest in the non-clinical environment of hospitals and other healthcare facilities has recently been greatly sharpened by political debate and professional concern. In the United Kingdom, for example, perceptions of increased incidence of the superbug, MRSA, as a result of what the press and politicians ascribe to poor hygiene standards was a major issue in the 2005 General Election and featured in the manifestos of the major political parties. Likewise, hospital food was accorded headline treatment by the media in the UK when it was suggested that a celebrity chef could help overcome perceived quality problems in menu planning and food preparation (BBC, 2005).

At the same time, the operational and strategic environment within which managers of non-clinical services such as food service, cleaning and wider facilities undertake their responsibilities is subject to internal and external challenge. Firstly, this reflects changes in patient and wider consumer expectations of services in a general sense and of the healthcare environment in particular. Secondly, this challenge emanates from changes in the clinical environment, both as a result of medical advances as well as alterations in organisational practice (Stubbings and Scott, 2004) both of which impact significantly on non-medical managers in healthcare. The final driver reflects the manner in which the organisational environment within healthcare has imposed major role change for managers on the environment in which they operate. This relates to, among other things, the imposition of increased budgetary restraint, technological innovation and expectations of enhanced responsiveness to customer requirements. In the UK, the context within which this latter operates is a process entitled "Agenda for Change", primarily designed to modernise remuneration structures within the National Health Service but, in fact, acting more widely as a vehicle whereby roles and responsibilities of all staff (both medical and non-medical) and, in particular, managers have been subject to detailed review and reorientation (National Health Service Modernisation Agency, 2005).

In this context, therefore, the challenges faced by those charged with managing this change environment are complex and demanding. Ensuring that those charged with such responsibilities have the range of skills and capabilities required to meet such challenges is critical if change is to be achieved. The discussion in this paper focuses on the roles

that managers within in the UK's National Health Service, responsible for catering and related facilities management, perform and considers the challenges, in terms of skills, that these roles impose. This environment constitutes a relatively insular labour market within which inward and outward mobility is rare. The background and training of catering professionals in healthcare is also considered together with their long-term career aspirations.

Managing healthcare catering and facilities

The field of healthcare catering and its management is sparsely treated in the literature, considering the importance of the area, both in terms of health policy and practice and as a significant field of services operations management, operating as a crossover between both the public and private sectors in many countries. Management skills debates, particularly insofar as they address the balance between what are styled technical and generic skills requirements, have pertinence in the context of this research and this study draws on the work of, for example, Knights et al, 1985; Noon and Blyton (1995); Dench (1997); Keep and Mayhew (1999); and Blanthome et al (2005) in this context.

In some respects, the area draws from the wider area of hospitality management and, in this sense, consideration of management skills and competencies in hospital catering management can be said to draw on related work undertaken in this domain (Christou and Eaton, 2000; Baum, 2002; Nickson et al, 2002). At the same time, the specialist nature of the healthcare context means that any consideration of skills employed or required for

work in healthcare catering must also draw on an understanding of skills in the wider health environment (for example, Cowling et al, 1999; Calhoun et al, 2002; Fine, 2002; Shewchuk et al, 2005).

Discussion of healthcare management with regard to catering and facilities is approached from a number of angles that are of relevance to this paper. There is a body of work which considers the specialist nature of this workplace environment, perhaps in doing so emphasising the insularity of the area. Thus, both Hwang et al (1999) and Williams and DeMicco (2003) address the specific catering requirements of acute hospitals. In a similar vein, Hwang et al (2003) consider patient perceptions of meal quality in hospitals. From a different perspective, Edwards et al (2000) look at food service systems that are suited to the specific eating requirements of hospitalised consumers, while Rodgers (2005) takes a similar approach in considering the selection of appropriate food service systems. Strategic issues in this branch of the healthcare sector are considered in relation to tendering processes (Kelliher, 1996) as well as from the perspective of the emergent field of facilities management, a theme that has importance in the context of roles performed by respondents to this survey. Shohet and Lavy (2004) provide a comprehensive review of this theme which is one that has generated considerable role discussion among professionals in this area. This is an issue also considered by Akhlaghi (1997), Okoroh et al (2000) and Lennerts et al (2005). Consideration of human resource management themes in the context of catering and facilities in hospitals focuses primarily on operational and technical staff. Thus, Lee-Ross (1999 and 2002) addresses issues relating to hospital chefs in the UK and Australia but there is absence of analysis that considers

skills or wider human resource issues with respect to either unskilled operative staff within the sector or their managers. This paper seeks to, in part, address the latter gap.

Research methodology

This paper is based on responses to a survey conducted under the auspices of the Catering Managers Association (CMA) which is the UK's professional body for those employed in the management of food service and facilities within both the National Health Service and private sector healthcare. A survey questionnaire was distributed to all currently employed members of the Association (excluding those retired), a population of 324. Membership of the CMA is not a professional requirement and the total eligible population within the NHS and private healthcare sector in the UK is unknown. Useable responses were received from 74 members or 23% of the Association. All but one of the respondents works within the public (NHS) service and, for consistency purposes, the responses from the non-NHS respondent have been excluded from analysis here. In consultation with the CMA, a decision was made not to seek detailed personal information (age, gender, ethnicity) from respondents as this was seen as intrusive and likely to reduce response rates.

Respondents were asked to complete both open-ended and 6 point Likert-type questions and the latter responses were analysed using a statistical package. Findings were presented to the Annual Conference of the HCA, held in Eastbourne in April 2005 and conclusions verified through discussion at this forum.

Research findings

Job titles and functions

The research sample was striking in the diversity of job titles that respondents hold. A total of twenty-one different position titles were reported, ranging from the highly functional (Kitchen Manager) to more strategic and corporate positions (Director of Hotel Services, Director of Facilities). To some extent, this divergence is a reflection of seniority and experience but this is not a complete explanation as the length of service of some of those in functional positions exceeds that of many in more generalist posts. The diversity of job titles and functions that operate within the health service in the UK reflects changing roles and responsibilities noted worldwide in the literature (de Bruijn et al, 2001; Okoroh et al, 2002; Shohet and Lavy, 2004; Lennerts et al, 2005) but also points to a lack of professional cohesion and identity within the professional area, something which the *Agenda for Change* process in the UK, once completed, may address.

The range of job titles can be placed on a continuum from

Catering Operations and Management……>…… Hotel Services ……>……Facilities Management

With roles diverging from specific and operationally focused through to wider/ generalist and less functionally focused. This continuum allowed respondents to be broadly and impressionistically classified into two groups, who have been labelled The Caterers

(Group A, n = 41) and the Facilities/ Hotel Service Managers (Group B, n = 33). This classification is used for further analysis later in this paper.

Respondents and their responsibilities

Notwithstanding differing job titles and apparent roles, the respondents to the survey hold positions that give them considerable financial, human resource and organisational responsibility. Table 1 summarises these responsibilities and demonstrates levels of accountability that are comparable with that of middle managers in many private sector organisations. Indirect budget responsibility refers to areas that are not directly associated with catering such as the wider facilities area.

Table 1: Responsibility profile of respondents
Manage, on average, direct catering budgets of £2.07 million with a range from £0.6 million to £7.81 million
Manage, on average, indirect budgets of £3.25 million with a range from £0 to £11.45 million
Manage, on average, 78 staff of whom 10 are in supervisory roles with a range from 13 to 185
Manage the delivery of service to an average of 681 beds, with a range from 175 to 2160

In taking these levels of responsibility, the survey pointed to professionals whose core training does not necessarily equip them for the tasks that they are expected to perform. Table 2 summarises key features of the training and experience of respondents. These findings point to professionals who have grown within the organisational culture of the NHS to positions of considerable responsibility. A high proportion commenced their

career with vocational training as chefs and some have subsequently taken professional qualifications through HCIMA. A further group used the Hotel and Catering International Management Association (HCIMA) as their initial entry route while a small but significant minority have no formal qualifications in hospitality or related fields. Given the responsibility profile of healthcare catering and facilities managers, the low proportion of managers with university degrees is particularly striking.

Table 2: Career development of respondents

- **Significant proportion entered the profession as chefs via the professional cookery route (with City and Guilds of London Institute706/1/2 qualifications) (35%)**
- **In addition or as an alternative, 61% had pursued the HCIMA (Hotel and Catering International Management Association) professional qualifications route prior**
- **A small number have no formal pre-entry qualifications (8%)**
- **The sample includes very few graduates in cognate or non-cognate fields (5%)**
- **Overall, respondents report very long service in the NHS, averaging 15.2 years**
- **Respondents have held their current post, on average, for 8.2 years**
- **Respondents have very limited non-NHS career exposure except some with early career work as commercial chefs and others who have pursued an armed forces/ school meals route into healthcare catering**
- **Respondents report a very extensive training profile within the NHS and on NHS-specific short courses**
- **However, respondents report very limited training external to NHS (professional or academic)**

In terms of training undertaken within career, the survey points to very high levels of participation in a wide range of courses, almost all offered internally within the NHS system. Respondents appended lists of, generally, short and non-accredited training courses that they had attended over extended careers in the NHS and these ranged from technical and specialist (legislation, hygiene, cookery, informational technology systems) to generic management themes (accounting, people management, customer feedback systems, project management). What is striking in virtually is that all the courses reported appear to reinforce the dominant culture of the national healthcare management system. There is limited external participation and reference to wider learning and business developments. This assessment is reinforced by the low levels of participation reported in

external professional or management training, particularly in terms of accredited programmes such as MBAs.

Routine working responsibilities of respondents

The survey asked respondents to identify their main areas of routine activity and responsibility. Table 3 classifies responses against key headings and points to the diversity of activity undertaken by those involved in the management of catering and facilities within the healthcare sector.

Table 3: Routine Activities and Responsibilities – key areas
Operations – food production, service delivery, maintenance **Quality – patient care, customer care, food** **Standards - hygiene, cleanliness, service, care** **"Soft skills" delivery – motivation, guidance, problem solving, change management, liaison** **Business skills - HRM, finance and budgeting, marketing, contract management, policy development** **Environmental – legislative, government policy, Agenda for Change, Private Finance Initiative (PFI)**

Table 4 provides more detailed elaboration of the routine responsibilities reported by presenting a sample of the specific tasks undertaken by managers, using their own words from the survey. These responses reinforce the divergent duties performed by respondents and underpin a continuum between highly operational and strategic/ corporate roles undertaken.

Table 4: Routine Responsibilities – a sample of responses
"*Day to day management of contracts through negotiation and monitoring*" (Deputy Facilities Manager)
"*Good food and nutrition; clean hospital; in budget*" (Hotel Services Manager)
"*Lead the planning, development, implementation and review of hotel services strategy …….*" (Hotel Services Manager)
"*Delivering a customer focused service*" (Facilities Manager)
"*Manage the Food Production Unit which produces some 60,000 meals per week together with the Support Services Department*" (Support Services Contracts Manager)
"*To be responsible for management of the catering facilities sector-wide, ensuring the smooth, efficient running of these areas within agreed budgets, and service level agreements*" (Facilities Manager)
"*Improve the quality of patient care, food and service in the trust*" (Trust Catering Manager)
"*Guidance to partnership on all catering matters*" (Catering Operations Manager)
"*Provide high quality catering service – consistently*" (Catering and Administration Manager)
"*Achievement of quality standards and performance goals*" (Catering Manager)

Contribution to a change environment

Respondents were asked to identify the role they play in supporting change within their working environment. Table 5 summarises the areas which respondents identify as their main contributions to change. Again, the findings point to diversity in supporting the change process but also to a recognition of the importance of change within the healthcare management environment in the UK.

Table 5: Managers' Contribution to Change
Building and making full use of experience **Personal qualities – tenacity, leadership, communication, innovation** **Ability to perform daily management tasks** **Ability to develop the team** **Applying technical competencies – ICT, risk management, legal, standards setting** **Developing the profile of the service** **Local management of the *Agenda for Change***

Table 6 provides further illustration of how change roles are implemented and also gives a good flavour of the demands of the work environment as perceived by key managers. For example, the need to respond flexibility to changes in operational and strategic direction is highlighted as a key requirement, pointing to the level of uncertainty that operates within any public health service.

Table 6: Contribution to change – a sample of responses
"*Implementing Government initiatives, eg. Agenda for Change*" (Associate Director of Facilities) "*Try to improve and develop services within the existing budgets*" (Acting Facilities Manager) "*Be able to change direction in an instant when the Trust does*" (Assistant Facilities Manager) "*Ensuring that catering and other facilities services are highlighted at board level, to drive funding and quality from the top*" (Facilities Manager) "*Ensuring that catering and other facilities services are highlighted at board level, to drive funding and quality from the top*" (Facilities Manager) "*Building the profile of the Department within the Trust and region*"(Trust Catering Manager) "*Expertise in the field, experience*" (Hotel Services Manager)

"*Being able to work through the Agenda for Change programme relating to terms and conditions for all staff*" (Catering Manager)

"*Identifying and prioritising service needs*" (Trust Catering Manager)

"*Keeping up-to-date with food hygiene/ HACCP issues*" (Kitchen Manager)

"*Being responsive to patient needs*" (Catering Manager)

"*Motivation and staff support to maintain standards*" (Trust Catering Services Manager)

"*Motivating staff during periods of change*" (Catering Manager)

"*In-depth catering knowledge*" (Catering Manager)

Challenges in the job

The survey asked respondents to identify the areas that provided most challenge to them within their current jobs. Table 7 indicates these areas by means of a generalised classification and points to come interesting issues. In particular, the constraining environment imposed by tensions between clinical and support services can be identified within the responses. Working with staffing teams who are perceived to be of low skills with limited commitment and poor motivation is also highlighted and points to issues raised elsewhere in the literature in relation to both general healthcare and the specific catering environment (Hurst, 1997; Lee-Ross, 1999; Lee-Ross, 2002). The impact of change is evident in terms of the demands imposed as a result of external, competitive tendering for some areas of service within healthcare. The challenge of managing relationships in this context needs to be highlighted.

Table 7: Challenges
Personal issues – communications, time, keeping an open mind **Operational issues - improving patient care, using ICT, health and safety** **People management - staff shortages, staff sickness, teamwork** **Managing the tendering process of external contracts and management of relationships when such contracts are in place** **Working within the envelope – budgetary, organisational, hierarchical, cultural** **The change environment - *Agenda for Change*, funding**

Table 8 elaborates on the identified challenges and provides a better flavour of how they are perceived by individual respondents. The responses also point to the difficulties of taking on ever expanding roles and responsibilities, often beyond core competence and training.

Table 8: Challenges – sample of responses
"*Delivering nutritionally adequate patient meals for all patient groups, complying with national and local standards with poor resources*" (Head of Nutrition and Dietetic Services) "*Delivering a quality service (both catering and domestic) with limited and diminishing budgets*" (Hotel Services Manager) "*The management and development of a quality service which meets organisational and patient needs in an ever changing environment*" (Hotel Services Manager) "*Managing new services with no prior training or experience*" (Facilities Manager) "*Managing relationships with a variety of external service suppliers"* (Hotel Services Manager) "*Dealing with the high, ever increasing expectations of patients, staff and the general public*" (Support Services Manager)

"*Keeping a full complement of trained/ good staff*" (Catering Manager)

"*Managing the staff – on a daily basis you have no idea how many staff will turn up*" (Catering Services Manager)

"*Coping with unrealistic targets/ expectations from senior management*" (Trust Catering Manager)

"*Exposure to irate and stressed patients, customers and staff*" (Catering Manager)

"*Taking risks to work within the envelope*" (Catering Manager)

"*Managing in a highly unionised environment and trying to comprehend Agenda for Change information*" (Assistant Catering Manager)

"*Losing control after the food leaves the kitchen*" (Trust Catering Services Manager)

Skills and Knowledge for the job

Respondents were asked to rate 37 attributes/ skills areas on a scale from 1 – 6 where 6 is the highest. Each item was rated in terms of its *importance* to their work and, secondly, their own perceived *capability* in that skills area. Table 9 summarises the outcomes of this rating exercise and points to overall consistency between perceptions of importance and capability. The analysis also uses the broad classification of respondents as "Caterers" and "Facilities Managers" in order to identify perceived differences. Here and in further discussion (Tables 15 – 18), these groups are identified as A and B respectively.

Table 9: Skills and knowledge: perceived importance and competence

- **Average rating for IMPORTANCE = 5**
- **Average rating for CAPABILITY = 4.9**
- **Average rating for IMPORTANCE (A – the Caterers) = 5.1**
- **Average rating for CAPABILITY (A – the Caterers) = 4.9**
- **Average rating for IMPORTANCE (B – the Facilities Managers)= 4.9**
- **Average rating for CAPABILITY (B – the Facilities Managers) = 4.9**

Table 10 identifies the areas of skills and knowledge deemed most important by respondents to the survey. Those rated highest relate to relatively sophisticated skills in areas of quality, standards, staffing, budgeting and change management, none of which are specific to the healthcare environment in which respondents work.

Table 10: Skills and knowledge: perceived importance and capability: highest rated IMPORTANCE (average respondent rating)
• **Assuring catering quality (5.9)** • **Setting standards (5.6)** • **Staff motivation (5.6)** • **Formulating/ controlling budgets (5.6)** • **Controlling expenditure (5.6)** • **Managing change (5.5)** • **HACCP (5.5)** • **Opportunities to improve service (5.4)** • **Justifying budgets (5.4)** • **Problem solving (5.4)** • **Interpersonal skills (5.4)** • **Staff performance quality (5.4)**

Areas identified as of least importance by respondents (Table 11) are, by and large, technical and operational skills in catering, technology and management information systems. It is interesting that, in an increasingly sophisticated and demanding management environment, the use of ICT and management information are not deemed important by respondents.

Table 11: Skills and knowledge: perceived importance and capability: lowest rated IMPORTANCE (average respondent rating)
• **Kitchen skills (4.1)** • **Designing and organising opinion surveys (4.2)** • **Use of new catering technology (4.3)** • **Evaluating catering equipment (4.3)** • **Statistical methods and presentation (4.4)** • **Food service staff/ visitors (4.5)** • **ICT (4.5)** • **Report writing (4.5)** • **Nutrition and therapeutic diets (4.6)** • **Delivering training (4.6)** • **Food service – wards (4.7)**

Table 12 addresses respondents' perceived capabilities with respect to the skills and knowledge areas identified. These capabilities, while not rated as highly as their perceived importance, focus on a range of predominantly operational functions that have to do with service delivery, standards and staff management.

Table 12: Skills and knowledge: perceived importance and capability: highest rated CAPABILITY(average respondent rating)
• **Food service – staff/ visitors (5.4)** • **Setting standards (5.4)** • **Assuring quality – catering (5.4)** • **HACCP (5.4)** • **Interpersonal skills (5.2)** • **Liaison (5.2)** • **Talking with patients and visitors (5.2)** • **Problem solving (5.2)** • **Menu planning (5.2)** • **Shift rostering (5.1)** • **Control and security of goods and cash (5.1)**

Perceived weaknesses with respect to respondent capability are presented in Table 13, with a focus emerging on information management techniques and tools in this category.

Table 13: Skills and knowledge: perceived importance and capability: lowest rated CAPABILITY(average respondent rating)
• **ICT (3.9)** • **Statistical methods (4.0)** • **Nutrition and therapeutic diets (4.2)** • **Report writing (4.3)** • **Use of new catering technology (4.5)** • **Forecasting demand and controlling waste (4.5)** • **Designing and organising opinion surveys (4.5)** • **Evaluating catering equipment (4.5)** • **Industrial relations (4.7)** • **COSHH (4.7)**

Taking the findings from this analysis of perceived skills and knowledge in terms of their importance and of respondent competence, it is possible to locate specific skills and knowledge areas in quadrants of a matrix, on the basis of deemed importance and

claimed capability (Table 14). This, in turn, helps to identify areas where respondents identify a skills gap (Quadrant 1) as a point for developmental action. It also helps identify those important areas where respondents feel that they have sufficient capability to meet demands (Quadrant 2). At the same time, the analysis also highlights areas where capability is high but importance is low, in other words skills that managers have but may not require in their present jobs (Quadrant 4). Quadrant 3 should attract least attention as it addressed skills of low importance where respondents, appropriately, have relatively low skills levels. Tables 15 to 18 identify the skills that fall into each of the Quadrants. In each case, average scores are noted for the full respondent sample as well as for the two segments of caterers (A) and facilities managers (B).

Table 14: Skills and knowledge: a matrix of perceived importance and capability

1 **HIGHER IMPORTANCE** **LOWER CAPABILITY**	**2** **HIGHER IMPORTANCE** **HIGHER CAPABILITY**
3 **LOWER IMPORTANCE** **LOWER CAPABILITY**	**4** **LOWER IMPORTANCE** **HIGHER CAPABILITY**

Table 15 reports the key training and development areas as identified in this skills and knowledge analysis. These are the areas of importance where respondents do not report high levels of capability and, on this basis, provide training and development agenda for

those involved in the management of catering and facilities in the healthcare sector. The focus is on a fairly disparate range of skills in human resource management, financial control and change. There is some identifiable variation between the two groups (A and B), particularly with respect to financial skills where the two groups identify differing strengths, at an operational level (Group A) and at a strategic planning level (Group B).

Table 15: QUADRANT 1 - HIGHER IMPORTANCE AND LOWER CAPABILITY(with average respondent rating)
• **Understanding and delivering staff motivation (5.6;4.9 – A 5.6;4.9 – B 5.6; 4.8)** • **Formulating and controlling budgets (5.6;5.1 – A 5.5;5.0 – B 5.8; 5.3)** • **Controlling expenditure within budgets (5.6;5.0 – A 5.7;5.1 – B 5.7;4.8)** • **Managing change (5.5;5.0 – A 5.6;5.0 – B 5.4;4.9)** • **Assessing quality of staff performance (5.4;5.0 – A 5.4;4.9 – B 5.4; 5.2)** • **Opportunities to improve services (5.4;4.9 – A 5.2;5.1 – B 5.6;4.8)** • **Forecasting demand and controlling waste (5.0;4.5 – A 5.3;4.5 – B 4.4;4.5)**

Table 16 notes those areas where respondents are comfortable in the delivery of important skills in areas of standards, service quality and HACCP (the Hazard Analysis Critical Control Point system of food safety management). Perhaps not surprisingly, perceived capability, with respect to HACCP, is significantly lower among Group B respondents.

Table 16: QUADRANT 2 - HIGHER IMPORTANCE AND HIGHER CAPABILITY (with average respondent rating)

- **Setting standards for staff (5.6; 5.4 – A 5.6;5.4 – B 5.6;5.5)**
- **Assuring quality of service (5.9;5.5 – A 6.0;5.5 – B 5.8;5.4)**
- **HACCP (5.5;5.4 – A 5.7;5.4 – B 5.2;5.4)**

As already indicated, Table 17 reports an area of academic but little practical interest, skills areas where respondents capabilities are in tune with the perceived importance of the area to their work environment.

Table 17: QUADRANT 3 - LOWER IMPORTANCE AND LOWER CAPABILITY (with average respondent rating)

- **ICT (4.5;3.9 – A 4.5;4.0 – B 4.5;3.6)**
- **Statistical methods and presentation (4.4;4.1 – A 4.6;4.0 – B 4.3;4.0)**
- **Nutritional and therapeutic diets (4.6;4.2 – A 4.8;4.2 – B 4.5;4.2)**
- **Report writing (4.5;4.4 – A 4.4;4.1 – B 4.6; 4.5)**
- **Using new catering technology (4.2;4.5 – A 4.3;4.5 – B 4.1;4.4)**
- **Designing and organising opinion surveys (4.2;4.5 – A 4.3;4.5 – B 4.2;4.6)**
- **Evaluating catering equipment (4.3;4.3 – A 4.5;4.6 – 4.0;4.2)**

Table 18 reports findings with respect to Quadrant 4, areas where respondents have skills which might be deemed of lower value or, indeed, redundant in the context of their current responsibilities. These areas all lie firmly within operational functions. Interestingly, Group A respondents generally rate these skills as more important that their

Group B colleagues but claim lower levels of actual skills in the areas, possibly reflecting closer proximity to their execution within their work.

Table 18: QUADRANT 4 - LOWER IMPORTANCE AND HIGHER CAPABILITY (with average respondent rating)
• **Kitchen skills (4.1;5.2 – A 4.3;5.3 – B 3.7; 5.0)** • **Food service – staff/ visitors (4.5;5.4 – A 4.8;5.4 – B 4.1;5.5)** • **Food service – wards (4.7;5.3 – A 4.9; 5.1 – B 4.7;5.6)** • **Shift rostering and maintaining cover (4.5;5.1 – A 5.0;5.4 – B 4.0;4.6)** • **Delivering training (4.6;5.0 – A 4.6;5.0 – B 4.6;5.1)**

The future

The survey finally asked respondents how they saw their careers developing and what skills and qualifications they would require in order to make their next career move. Table 19 identifies the expected career paths of respondents, with less than half expecting upward mobility of any kind within the near future. Given the average length of service in current post of 8.2 years noted in Table 2, this is, perhaps, not surprising. Respondents who are aspirant in their careers are more likely to fall into the Group B category although within this group a number of respondents are already at the top of their career ladders. The number seeking to develop careers within general management is small but notable although it is questionable whether they all have the formal qualifications necessary to undertake such responsibilities.

Table 19: Perceptions of future career path
• **UPWARD WITHIN (for example, to Director of Facilities) – 32%** • **UPWARD AND OUT (into General Management in healthcare or elsewhere) – 9%** • **STAY WHERE I AM - 27%** • **GET OUT (Consultant; Retirement) – 11%** • **UNCLEAR WHERE I AM GOING – 21%**

In order to progress careers or, indeed, to undertake present responsibilities more effectively, respondents were asked to identify their training needs priorities (Table 20). A minority focused on the acquisition of further formal qualifications in the form of a bachelor's or masters degree. Given the low level of graduate presence within the profession, this was, perhaps, surprising. The majority seek additional training in specific training in technical, interpersonal or business-related skills areas, probably within the established NHS development environment. The vast majority of respondents identified their current employers as very supportive in terms of meeting this form of training requirement although there was greater uncertainty with respect to external training and qualifications.

Table 20: Career progression – training aspirations
Enhance Qualifications **(11%)** • **Gain a degree** • **Study for an MSc Facilities Management/ MBA** ***Focus on Specific Topics*** **(66%)** • **Estates management** • **ICT** • **Financial management** • **Project management** • **People management** • **Change management** • **Political awareness** • **Training and presentation skills** • **Communications and negotiation** ***No further training identified*** **(23%)**

Conclusions

This paper reports the findings of a survey of healthcare catering and facilities management professionals in the United Kingdom and reports findings with respect to their work responsibilities, the focus of their challenges in the workplace, their career aspirations and their perceptions of skills and knowledge within this work environment. Although based on a relatively small response rate from members of the HCA, the study does report important findings in a neglected area of healthcare and hospitality management. Given the extent and nature of change within the sector, findings of this study are of value to both professional and academic audiences.

The findings of the study paint a picture of a relatively insular labour market within the UK's healthcare system, with managers developing long-term careers in the service with relatively little career mobility to associated areas of the management of hospitality or

facilities. Career progression in this sector of healthcare management is slow and there appears to be a certain level of acceptance of a static labour market in that over a quarter of respondents have little aspiration to move further in their careers. Respondents to this survey are relatively comfortable within their skills envelope and there is relatively little significant divergence between the perceived importance of key skills areas and respondents' perceived capability in performing them.

The survey points to a labour market within which most respondents have progressed on the basis of experience rather than formal qualifications. The level of their entry qualifications is primarily vocational and professional and, perhaps, does not reflect the demands of the work that they are expected to undertake. The virtual absence of graduate entrants to this branch of healthcare management in the UK reflects the decline in university programmes geared towards this sector and points to a possible need for dialogue between the profession and the educational sector. Given the financial and organisational level of respondent responsibilities, the nature of their entry profile places a considerable onus on the effectiveness of in-service training within the NHS and such development support is clearly in place and widely used. The NHS is reported as a very supportive employer in terms of training and development that is available within the system. Consequently, participation in external training, especially leading towards awards and qualifications is very limited. Therefore, it is difficult not to conclude that the NHS operates a strongly paternalistic training and development culture. This culture does not have significant interchange or exchange within the wider educational environment and, therefore, meets of the needs of those within the system without fostering

development that would allow them career moves outwith the system. One consequence of this inward looking environment is the failure to expose managers to opportunity for the exchange of ideas and learning with their peers from other work environments, historically one of the main benefits argued for participation in generic MBA programmes, for example.

The study points to an increasing focus on wider, non-catering responsibilities within this management group, with some evidence that respondents do not feel fully prepared for these new responsibilities. Thus, career progression involves both vertical development within their work (from operational to strategic) and horizontal expansion into wider facilities management to include areas beyond their core skills area. In terms of training and development within this professional area, this finding begs questions as to whether this constitutes a trend towards job expansion from an existing skills base or whether we are seeing the emergence of two distinct management disciplines within this sector of healthcare management. If the latter is, indeed, the case, this has implications for the long-term career opportunities available to those entering with a catering background.

This study, small in scale as it is, does not claim to offer definitive answers to the issue of skills and career progression within the catering/ facilities sub-sector of healthcare management in the UK. What it does, however, is to illustrate the impact of a relatively inward looking, self-sustaining and paternalistic career and development environment within which inward and outward movement is rare and raises a series of questions about competence and capability which require further consideration at both a professional and

academic level. It also begs questions with respect to comparable closed labour markets such as other branches of the public service including government departments and the military, both in the UK and elsewhere and poses questions for future research in this regard.

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