Management capacity

. . . . framework and assessment guidelines

(capacity: ‘the ability or power to do something’ - *Oxford English Dictionary*)

*Cranfield Healthcare Management Group*

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How do they manage?
a study of the realities of middle and front line management work in healthcare

David A. Buchanan and Ciara Moore; October 2011
In an acute trust, management capacity can be defined in terms of the ability of the management population to deal effectively with the size of the agenda, or the scale of the challenge, with which they are presented at any given time - such as QIPP.

Deciding if management capacity is adequate or not is a matter of judgement. The aim of this briefing is to offer a framework that can help to inform that judgement.

The numbers game: from 3 to 33

- **pure plays:** roles which are wholly managerial
- **hybrids:** roles which combine clinical and managerial responsibilities

There has been a lot of controversy around the number of managers in the NHS. Some commentators argue that the service is over-managed. Compared to other sectors and healthcare systems, some argue that the NHS is under-managed. This briefing adopts a different approach. The raw number is only one component of management capacity. This does not mean that the numbers are irrelevant. Recent debate, however, has focused on the numbers, and also on the wrong numbers. So let’s put that right before we go any further.

The NHS Information Centre census shows that the service employs around 45,000 managers - 3 per cent of all NHS employees. That proportion has been fairly stable for the past decade. The census does not count as managers any ‘hybrid’ clinical staff whose roles have a managerial component: clinical directors, modern matrons, ward sisters, lab team leaders. The census counts middle managers and supervisory staff as ‘administrative and clerical’.

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We take a different approach. While clinical directors and ward sisters are not ‘managers’, they do have managerial responsibilities, and they perform management work. And we know that middle managers have highly significant roles in developing ideas, shaping and implementing change, driving innovation. On this basis, we asked the workforce information managers in two trusts taking part in this study to estimate the total numbers of their ‘pure plays’ and ‘hybrids’ in order to develop a more accurate profile of the management population. Their estimates were similar: the proportion of staff with managerial responsibilities in an acute trust is around 33 per cent. Is this just more ammunition for those who would argue that the service has more managers than it needs? No, and this is because:

- hybrids are not full time managers
- most hybrids have had little or no management development
- many hybrids do not even regard themselves as managers
- some pure plays have specialist roles and are also not full time managers

Enumerating full time equivalent managers in an acute trust is difficult. But are these the main issues? Our sidebar summarizes the management agenda of a typical acute trust. These are all ‘big ticket’ items’, strategic priorities, always critical. This is called **multiloading**.

The key question has to be - do we have the *capacity* across the management function as a whole - regardless of numbers - to handle this multiloaded agenda effectively?
Management capacity is the product of six sets of factors, three relating to individual dimensions, and three to properties of the organization:

### The Management Capacity Six

<table>
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<tr>
<th>Individual Dimensions</th>
<th>Organizational Properties</th>
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<td>Capabilities</td>
<td>Resources and infrastructure</td>
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<td>Engagement and motivation</td>
<td>Clinical-managerial relationships</td>
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<td>Numbers of pure plays and hybrids</td>
<td>Ability to generate requisite variety</td>
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The individual attributes are self-explanatory. With organizational properties, managers need adequate support - time, money, facilities, systems - to create an 'enabling environment'. The third organizational property is based on 'the law of requisite variety', which says that the management function must be able to field at least the same levels of variety and complexity as the system being managed is able to adopt. Variety and complexity are required in order to deal with variety and complexity (although responses to complexity are often mistakenly aimed at simplification). A lack of multiple perspectives and diverse thinking has been shown to reduce organizational resilience and contribute to system failures. A management function with members from different backgrounds can generate greater diversity than a more homogeneous group; the quality of clinical-managerial collaboration is therefore critical.

These dimensions - including ‘numbers’, cannot be measured directly. We need to look for indicators to assess capacity. Indicators of over-capacity, or ‘slack’ might include:

- Two or more individuals or groups trying to solve the same problem
- Senior management doing work that middle managers can or should do
- Multiple communications due to overlapping roles
- Establishing an internal ‘turnaround team’ to help manage a crisis
- Some tasks/jobs get done twice, or more often
- Lots of new ideas and projects and initiatives being added to the change agenda
- Clinical/medical staff say that they are well supported by management

What if a trust or division has excess management capacity?

- Find ways productively to use that additional capacity to drive further specific innovations, service improvements, and to explore service growth
- Tackle the problems about which people repeatedly say, ‘there must be a better way to do this’, but nobody has come up with one (Winnie the Pooh syndrome)
- Consider upcoming demands, pressures, and initiatives, and the extent to which current overcapacity can be used proactively to address those challenges early
- Reduce the management burden on clinical/medical staff, giving them more time to spend with patients, and to update professional skills and knowledge
- Reduce management numbers

A degree of slack is of course desirable, as this allows for rapid responses to crises and other unexpected events, and provides time and space for creativity and innovation.
When ‘lean’ becomes ‘too lean’

Our evidence indicates that acute trusts either lack management capacity, or that capacity is under-utilized (see sidebar). The indicators of under-capacity that we have observed include:

- problems arranging, cancelling, rescheduling meetings due to full diaries
- regular evening and weekend working
- managers saying they have difficulty coping with the workload
- repeat complaints about ‘our firefighting culture’, and ‘panic of the week’
- change is painfully slow and projects are rarely completed
- problems are not solved, crises are not averted
- hiring external management consultants to help manage a crisis
- clinical/medical staff say that managers block and slow things down

Responses to under-capacity, apart from increasing management numbers, can include:

. . . work longer hours . . . shift the profiles of hybrid roles towards management tasks . . . increase management training and development . . . hire part time and contract staff to drive special projects . . . defer less important initiatives . . . make ‘smarter’ use of IT to streamline time consuming processes . . .

*In the current ‘cuts and changes’ climate, we need to pay more attention to management capacity than to numbers. If you have a view on this issue, please let us know.*

Sources


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This study is based on interviews and focus groups with middle and senior managers, on a management survey, and on case studies exploring how changes are managed in the aftermath of serious incidents.

Participating trusts

- Bedford Hospital NHS Trust
- NHS Bedfordshire Primary Care Trust
- Cambridge University Hospitals NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Northampton General Hospital NHS Trust
- North Bristol NHS Trust
- Whipps Cross University Hospital NHS Trust

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