

Are there too many managerial layers in providers?

Summary by Nigel Edwards

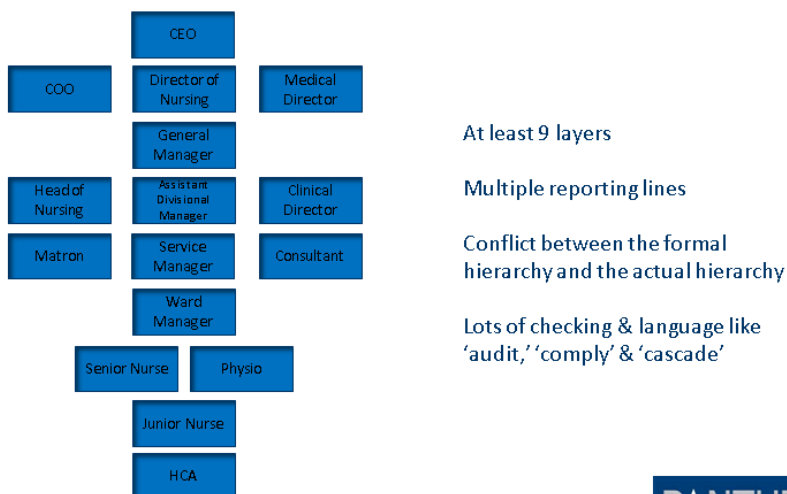
Introduction

There is a good case that better managed health care produces better results. We have always claimed, I think with some justification, that the NHS is under managed, but there seems to be anecdotal evidence of growth in the middle layers of management in some organisations. We have staunchly defended management from what are often some very unpleasant and unjustified attacks. But just because some attacks are unfair does not mean we should not take a hard look at what is happening.

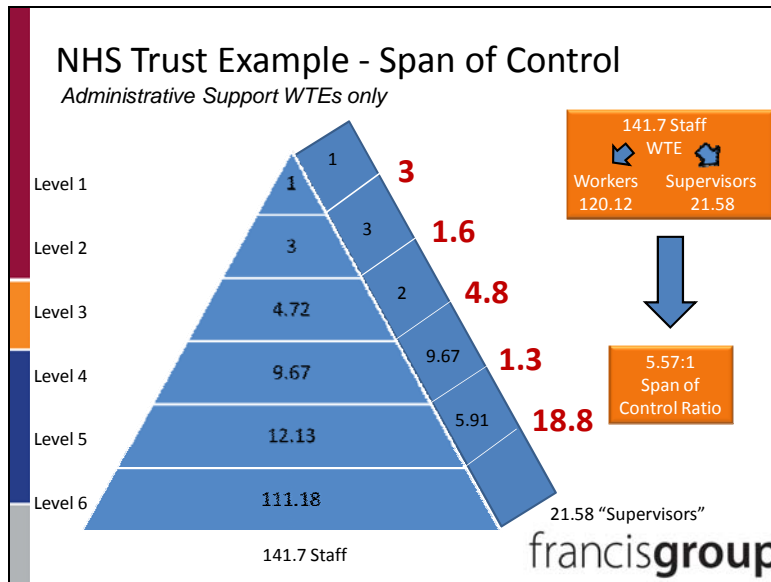
We asked two consultancy firms that generally work on organisational design outside the NHS and a group of NHS leaders to look at this issue: the results are not particularly comfortable. An important message is that a simplistic approach to delayering would be wrong. First it's important to understand what has caused the problem and what other changes are required before changes are made.

Is there a problem?

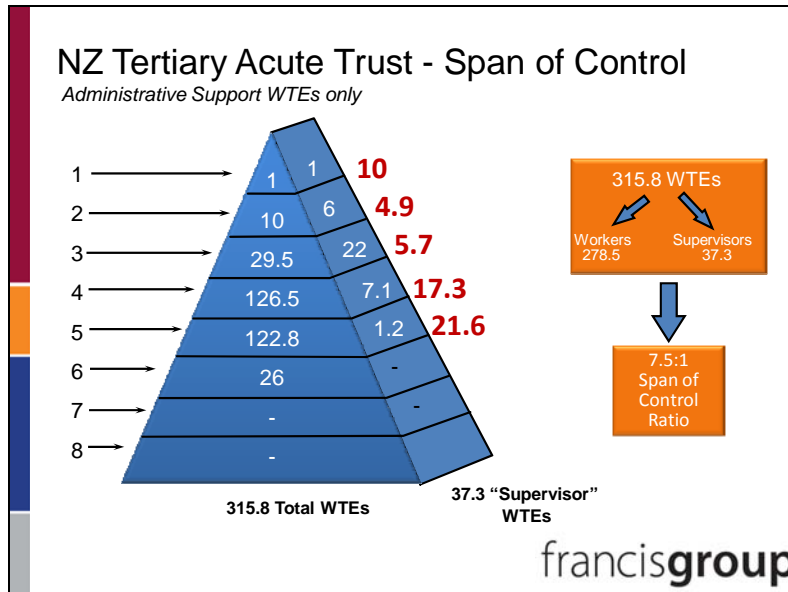
Over the last few years some organisations do appear to have acquired a surprising number of additional layers. Tesco orchestrates half a million people and thousands of suppliers to deliver groceries, telecoms, financial services and more to support £50bn of revenues from 100m+ customers with 7 layers of management. Our seminar heard about hospital trusts with between seven and eleven layers between CEO and the front line – particularly in clinical management. A number of people in these hierarchies had surprisingly few people reporting to them, particularly at the top. So while front line supervisors and managers often had over 20 direct reports - too many to be effective - the average for some of the third and fourth in line people was less than two. A second worrying feature was that there appeared to be a significant overlap in responsibility between the different levels, particularly in the middle of the organisation: so subordinates thought their managers were responsible for areas that their managers thought the subordinates were dealing with.



Unsurprisingly, one of the results of this is a degree of confusion about reporting lines. This is compounded by the fact that in some organisations the clinical director may be formally in a reporting line to the chief operating officer or medical director but in reality this is not actually how the relationship operates.



This is not just a UK phenomenon: which suggests there may be something about the nature of modern healthcare that is driving this.



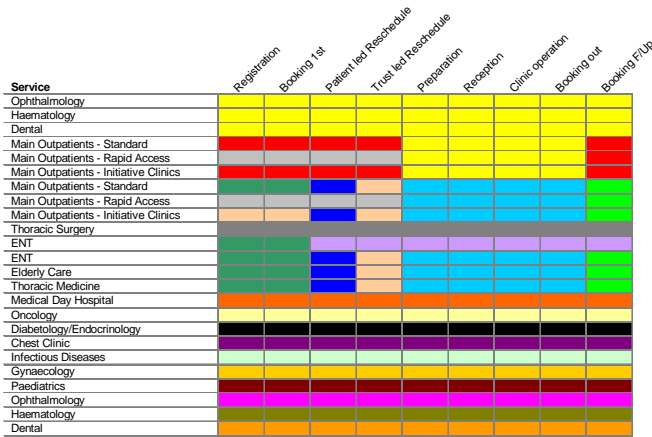
Causes of growth

There are a number of possible reasons for this growth. Organisations have tended to get bigger and more complex. The growth of management structures based on clinical silos rather than patient value streams may have often added further complexity. The response to this has often been to add additional coordination, problem solvers and people with managerial skills who can intervene to solve problems. This may be compounded by a

tendency to fix immediate crises, fire fighting or develop work-arounds rather than understand and deal with the root causes of problems. To some extent the growth of management can be seen as a response to a perception that front line staff are not willing or able to step up to solving their own everyday operational problems or, more benignly, a view that it would be helpful for them if someone else took this on. This may have had the unintended effect of disempowering and deskilling front line staff and thereby increasing the perceived need for more management intervention.

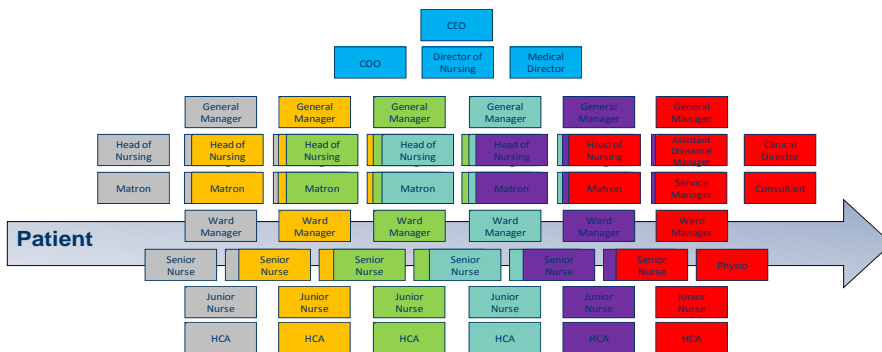
Outpatients: Tasks and processes split between multiple teams, each time done for a good reason, each part doing its best but with no line of sight to the patient

Where is the patient focus when processes are run by 19 OPD functions/teams?



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Silo management: The creation of service lines *may* improve vertical management but causes significant problems for patients and other who have to navigate horizontally.



Patients often moves horizontally through the vertical mesh of hospital organisations, across processes & silos, multiple reporting lines & multiple hand-offs

Lots of checking & language like 'audit,' 'comply' & 'cascade'

PANTHEA

Some of the pressure for growth has been internally generated by a desire to get internal systems working better, but a significant amount appears to have been driven by the external environment. The last 20 years have seen an explosion in external regulation, supervision, targets and standards, often backed up with punitive sanctions. This and an epidemic of risk averse governance has required additional management to try to reduce the risks to the organisation. Once managers are appointed to these roles they have a tendency to generate work for other managerial colleagues. This is associated with very large numbers of meetings which have to have every silo represented. These meetings burn up time, are poor at arriving at actionable decisions and can focus attention way from the areas where management can add real value. They can also spread further ambiguity about who is leading a particular area. Too often this can mean that the focus of some of these roles is not on areas that add value to patients.

All of this tends to be exacerbated by a tendency for clinical staff to be promoted to supervisory and managerial positions without receiving very much training or preparation. There is still an assumption in some places that people who are excellent clinicians will automatically translate into managerial roles.

The consequences

The results of this appear to be a number of quite serious issues in the sites looked at by our speakers:

- A lack of supervision, appraisal and support for front-line staff as managerial effort tends to be sucked into activities related to compliance, performance management, immediate problem-solving and dealing with work generated by other managerial silos
- Systems are created which make innovation, such as the introduction of new techniques, processes or technology more difficult as there is a need for multiple levels of approval both vertically and horizontally with each actor having the power and often the incentive to veto proposals
- A lack of clarity about what is required, the objectives of individual's own part of the organisation. This seems to support the NHS Confederation's own research and the results of the NHS staff survey
- Overlapping teams and functions which create delays, hand-offs and waste, not least the rework, expediting and other types of demand created by the failure of the system to get things right first time.
- Problems in transmitting values and objectives through the organisation
- Very high and unfair expectations of staff management by the least senior managers and little managerial leadership of staff by more senior managers
- There are opportunities for improving team well-being, customer-focus and staff satisfaction, which would improve with better structured teams.

Solutions

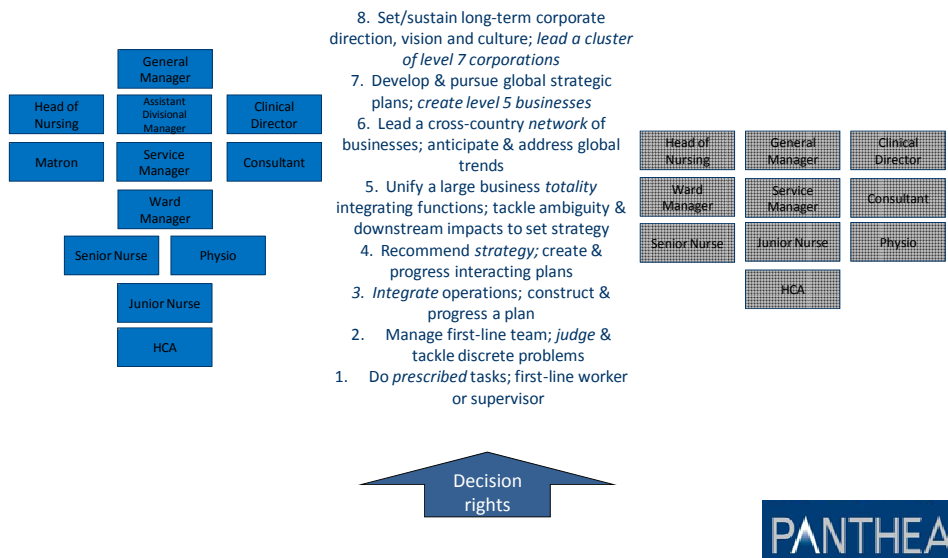
The solution to this problem is not simply to de-layer although this may be one of the end points. The consultants and our management informants thought that the place to start was with a more fundamental look at the organisation.

The starting point is that the top management is there to facilitate front line staff. Structure is not the issue: the question is how to focus on creating value for patients. A number of frameworks for looking at this have already been developed and are summarised in the Chris Ham's *Learning from the Best*.¹

Our expert group had a remarkable level of consensus and the two consultancy companies had independently come to the same conclusions about what need:

- Having a clear vision that is clearly and consistently articulated – this requires stable top leadership.
- A key role for all leaders, in the words of our consultants help ‘front line staff do a good job every day’
- Move from top down vertical hierarchy to patient facing models with high levels of delegation and autonomy. More matrix type arrangements would help with this.
- Telescope long lines of command by clearly allocating decision rights at each level and insuring that these do not overlap
- This is predicated on a new set of behaviours amongst all staff which fill the gap that the additional layers of management were designed to address. Staff will also require a new set of skills for diagnosing and dealing with process problems and protected time to let them do this.
- It will also require a concentrated effort to fix the broken and fragmented processes that exist everywhere and which generate huge amounts of ‘failure demand’ – rework and other wasted effort. Rather than solving co-ordination problems through structural approaches – for example centralising booking, attention first needs to be given to design of processes, the underpinning rules, the behaviours and skills of the staff involved.
- A further requirement is clear feedback and information about performance

2 tools: (I) work levels build layers by decision rights



We used 2 tools: (II) a common leadership model for all staff based on improving patient care

<p>1. Take responsibility</p> <ul style="list-style-type: none"> •Makes timely rational judgements from the information available •Initiates action to get things done and monitors progress against objectives •Has a “can do” attitude and won’t shy away from challenges and obstacles •Models appropriate behaviour and standards 	<p>3. Value & support the team</p> <ul style="list-style-type: none"> •Enjoys working with others to deliver results and values their diverse contributions and perspectives •Supportive of members of own and wider team •Thinks about what others need to do their job •Demonstrates respect and empathy for others •Helps to create an environment of openness and trust •Creates an environment where feedback and trust are used constructively
<p>2a. Bring people with you: communicate</p> <ul style="list-style-type: none"> •Structures information (verbal or written) clearly and logically to suit the audience •Shares information with relevant people in a timely manner •Communicates with confidence and impact •Listens well and shows that understands by responding to information •Sensitive to mood and reactions of audience and able to adapt style accordingly 	<p>4. Make the patient & the process better</p> <ul style="list-style-type: none"> •Demonstrates a concern for patient care ensuring patients receive the best care possible •Sensitive to differing patient needs and acts accordingly to meet these appropriately •Behaves with integrity and in a professional manner upholding the values and ethics of the hospital •Has the drive to deliver results and meet or exceed relevant objectives •Tries to make things better and improve performance •Is disciplined and follows the right processes
<p>2b. Bring people with you: influence & persuade</p> <ul style="list-style-type: none"> •Plans the best way of winning support to achieve relevant objectives •Has a range of influencing styles to leverage •Manages conflict goodly and appropriately •Relates well to people at all levels quickly building good relationships •Aware of politics and navigates this sensitively and in hospital’s best interest 	<p>5. Show flexibility & resilience</p> <ul style="list-style-type: none"> •Adapts and copes well with change •Is resilient, coping well with pressure and setbacks

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Conclusions

The uncomfortable conclusion is that there is scope for significant change in management in some organisations. More needs to be done to strengthen both top and front line managers and supervisors. The front line managers need the time and skills to take on significantly more autonomy and there needs to be much more focus on patient facing activities, improving processes for patients and staff and on fixing broken processes rather than fire fighting. In a recent blog Paul Corrigan made the important point that the absence of supervision was a key factor in the poor care highlighted in the Ombudsman’s report. He meant more than just management supervision but also the care for staff undertaking emotionally challenging work. This highlights just how important this layer of leadership is within health organisations and why a simple slash and burn of middle layers without thoughtful organisational redesign would be dangerous.

¹ http://www.hsmc.bham.ac.uk/news/pdfs/Learning_from_the_Best_Final_PDF.pdf