A Price on their Heads: Measuring Management Costs in NHS Trusts

The cost of NHS management has received greater attention recently...

♦ the internal market has put pressure on trusts to control costs
♦ new tasks, such as contracting, require more managers
♦ there is political pressure to keep management costs down

...and the Audit Commission has developed a reliable benchmark.

♦ it uses a definition of senior management which can be applied consistently in all trusts
♦ it allows comparisons both between trusts and from year to year

Using this measure, senior management costs vary widely...

♦ average expenditure was £2.1m, or 4 per cent of total costs in 1993/94
♦ most spent between £1m and £3.5m

...and although most can be explained by trust size, there remains significant unexplained variation.

♦ costs as a percentage of total expenditure, range from two per cent to six per cent
♦ there are economies of scale since larger trusts spend proportionately less than smaller ones

♦ it appears unrelated to differences such as the type of trust, or expenditure on less senior managers in professional grades

More work is needed to measure management effectiveness...

♦ expectations for the outcomes of management need to be agreed
♦ improved data will be required

...so sound judgements can be made about optimum levels of expenditure on management.

The Commission will work in partnership with the NHS to develop this initiative further.

Introduction

1. The National Health Service (NHS) has an international reputation for providing cost-effective health care. A key element of that success has been its ability to control overheads and concentrate funds on the direct provision of care. The cost of managing the NHS forms a significant part of the overheads, and various measures have been introduced in the past to try to control it. But policy has not been confined solely to keeping costs down. The Griffiths Report in 1983 argued that the health service needed to give overall management responsibility to individuals at different levels, paving the way for the employment of more accountable – and better paid – ‘general’ managers. And from 1990, an extra £70 million a year has been allocated to health services in England and Wales specifically to bolster finance, personnel and information services for implementing the NHS and Community Care Act reforms (1990).

2. With the implementation of that act, however, expenditure on management ceased to be under central control. Commissioners and providers of health care were given the freedom to spend on management whatever they judged necessary and reasonable given local circumstances. In the case of NHS trusts, cost-control pressure generated by the internal market in effect replaced central restriction of management overheads.

3. The pendulum is now beginning to swing back again. In Wales, as a result of the Welsh Office’s ‘Caring for the Future’ initiative, trusts have been required since April 1994 to contribute to a shift of resources from management and administration to direct patient care which will total £12.5 million a year by April 1997. In England, the NHS Executive intends to publish annual management cost figures for trusts from 1995.

4. In these new circumstances it is all the more necessary to monitor management costs in order to ensure that they do not run out of control. This paper addresses that need in the case of senior management in NHS trusts by asking two sets of questions:
   ♦ How much is currently being spent on senior management in trusts, and has the amount changed?
   ♦ How does such expenditure vary between trusts, and to what extent can any variation be explained?

The paper then discusses the relationship between expenditure on senior management and performance of the whole organisation.

5. The points made in this report are not the Audit Commission’s last words on management costs, but rather its first contribution to a moving debate. Areas in which the Commission thinks it could usefully undertake further work are set out in the concluding section.
...although it is more important than ever to monitor management costs, the existing information is clearly not up to the task

Defining senior management costs

6. One way of estimating senior management costs is to use existing grades and posts, in particular the 'general and senior managers' category into which most trusts place their senior non-clinical staff. In 1993 there were more than 20,000 managers in this category in England and Wales. But the use of such categories to estimate management costs has a serious flaw. They are not linked to any common understanding, let alone agreement or specification, of the content of the jobs in the category. Consequently, although it is possible to calculate the cost of designated senior NHS managers, this bears no guaranteed relationship to the cost of 'senior' management. Some trusts may have relatively few designated senior managers but compensate with other staff who, although engaged predominantly on management tasks, are employed in administrative and clerical posts, or even nursing jobs. Conversely, some incumbents of designated senior management posts may have significant clinical or other non-managerial commitments. For example, in one trust examined as part of this study, of the 62 staff classified as senior managers, three were responsible respectively for repairing wheelchairs, making artificial limbs, and making prosthetics, four were medical audit assistants, three were clinical nurse specialists, and three were night sisters with a predominantly clinical role. The information routinely available at the moment cannot disentangle such problems. These inadequacies are well known and are currently being addressed in England as part of the NHS Executive's initiative to revise NHS occupational codes.

7. So, although it is more important than ever to monitor management costs, the existing information is clearly not up to the task. The solution is to collect better information. The ideal method would be to define the activities that constitute 'management' and then ascertain how much time all staff spend on them, apportioning their time accordingly to management or non-management tasks. But such an approach would be very time-consuming; and moreover if questions are too detailed, answers tend to be unreliable. Some sort of compromise is needed between this ideal method and the current (and quite inadequate) reliance upon local definition of what constitutes a 'management post'.

A workable methodology

8. A compromise solution might start by including only those posts that were quite clearly filled by people consistently involved in management tasks (e.g. the finance director). Beyond these posts, it would be necessary to look in greater detail at the actual tasks involved; to ask questions such as: 'Are senior nurses doing jobs that involve managing other nurses, planning their time, arranging rotas etc., or are they involved in clinically related tasks such as training other nurses or controlling spread of infectious diseases?' Because most trusts employ several thousand staff, it would be necessary to confine the exercise to staff above a certain level of seniority, which would best be
accomplished by taking an arbitrary cut-off point on the salary scale.

9. The Audit Commission adopted an approach similar to this compromise solution for measuring senior management costs as part of its audits of trust management conducted during 1994. The methodology was developed with help from trust chief executives and finance directors. It has been used widely throughout the NHS over the last twelve months, and has been made freely available to anyone interested. A description of its chief components is included in Appendix 1.

10. It is true that the resulting management costs are arbitrary and ultimately depend upon the details of the methodology. Nevertheless, it represents a major improvement over anything hitherto available. Application of the methodology is robust in the face of variation in interpretation of 'who does what' and in different definitions of senior management tasks – different researchers applied it twice to each of five trusts and produced almost identical results in each case. This has two important consequences. First, it will in future be possible to monitor changes in management costs over time. And second, there is an immediate possibility of making reliable comparisons of management costs between similar types of trusts.

11. Because 1994 was the first year in which this methodology was used, it is not possible yet to assess whether senior management costs have changed. There is no doubt that the number of managers classified in the category 'general and senior managers' (see paragraph 6) has increased dramatically in recent years – from 1,500 in 1988 to over 20,000 in 1993. But equally, much of this increase has resulted from the re-classification of other staff such as senior nurse managers. The real question is how much of the increase stems from re-classification rather than from genuine growth. A small pilot study carried out by the Audit Commission in early 1994 illustrates some of the problems of trying to answer such questions in the absence of reliable and consistent measures (Box A).

12. It is not possible to assess growth in senior management using existing data, and although the new methodology will eventually make it possible to assess changes in management costs with confidence, it cannot be reliably applied retrospectively. It can however be used straightaway to assess present-day variation in costs between similar trusts. The extent of such variation, and the reasons for it, are considered in the next chapter.
## Box A

### Numbers of 'general and senior managers'

#### Introduction

The Audit Commission carried out pilot work to assess whether the number of 'general and senior managers' provided a valid measure of senior management costs. The aim was also to gather information on the true extent of growth in senior management numbers.

#### Methodology

Four trusts were chosen for analysis. The main criteria for selection related purely to the practical needs of the study - they had to have good personnel systems and long-serving directors of personnel (preferably with good memories!). Two trusts, covering acute hospital and community services respectively, were situated in the same district health authority. The other two were 'whole district' trusts, each providing a complete range of hospital and community services. The three district health authorities in which the trusts were based were in different regions.

Each trust was asked to provide a list of staff categorised as 'general and senior managers' (including their post titles), the year in which each post was added to the management category, and to which – if any – previous posts the funds could be traced. The nature of each post was discussed with the personnel director. Staff who had remained 'in-post' during transfer to the management grade were interviewed to assess how much the content of their jobs had changed.

#### Conclusions

Changes in the number of staff categorised by trusts as 'general and senior managers' were not thought to be a valid or fair measure of changes in senior management resource levels. The main reasons were:

- Many trusts transferred appropriate posts to the 'general and senior manager' category only when they became vacant. So the growth of management posts for those trusts was largely determined by the local rate of staff turnover.

- Transferring an 'occupied' post involves terminating the existing contract between the trust and its employee and agreeing a new one. Unlike most existing contracts, the new management contracts are short-term and include an element of pay based on performance. One trust was enthusiastic about the management grades, and encouraged staff to transfer. Within a short period, all the posts they wished to see on the management grades had been transferred there. Two other trusts took a more relaxed approach, suggesting that staff transfer, but giving them a free hand to decide for themselves. Staff who opted to accept the new contract were classified as managers, while colleagues undertaking identical jobs remained in their old 'non-management' posts. At one of these two trusts, for example, only four of the eight locality managers were classified as senior managers. The fourth trust preferred to keep as many staff on clinical grades as possible.

While it is clear that some of the growth in the 'general and senior manager' category has come about because staff have transferred from what were already predominantly management jobs in other categories, the unreliability of the base data makes it impossible to draw firm conclusions about the extent or pace of any real growth.
Variation between trusts

13. As discussed earlier, any conclusions about the level of management costs are necessarily arbitrary; management costs could be increased or reduced simply by altering the definitions. Using the measure, data collected by the Audit Commission during its audit of senior management costs indicate that in 1993/94, NHS trusts in England and Wales spent approximately £900 million on senior management. This sum represents 4.0 per cent of those trusts’ revenue expenditure. Broadening the definition to include administrative and clerical posts – such as secretaries, ward clerks, and junior finance staff – increases costs by a further £1.4 billion to £2.3 billion, or 10.5 per cent of total revenue expenditure. But although the overall figures derived from the methodology are arbitrary and should be interpreted cautiously, the variation between trusts, based as it now is on a reliable and consistent instrument, is a valid measure.

14. In 1993/94, individual trusts spent between £0.5 million and £6 million on senior management, with an average spend of £2.1 million. There is some variation in average spend according to the broad category of trust (see Exhibit 4 - page 10); for acute trusts it was £2.1 million, for non-acute £1.7 million, and for combined trusts £2.6 million. Differences between the broad categories are more marked in the distribution and range of expenditure (Exhibit 1). Acute trusts have a greater range than combined trusts, which in turn have a greater range than non-acute trusts, in most of which senior management costs fall between £0.5 million and £2 million.

Size, and economy of scale

15. As might be expected, the main reason why some trusts spend so much more than others on senior management is that they are bigger, often with a wider range of services. They simply have more to manage. So if senior management costs are expressed as a percentage of total expenditure (Exhibit 2), rather than in absolute terms, the extent of variation is reduced. This is confirmed statistically by calculating the ratio between the entry point to the upper decile (top ten per cent) and the lower decile (bottom ten per cent). The ratio is less for percentage costs than absolute costs in every case (Box B). Senior management costs vary approximately twofold after allowing for the size of trusts.

16. It is a common finding that average costs decrease as organisations get larger, and then at some point, start to rise again. These economies and diseconomies of scale have a theoretical basis, and although much of it is relevant to manufacturing output and the scale economies of mechanisation, some has relevance to management costs.

17. First, there is the concept of indivisibility – a minimum quantity of inputs is required whether or not an output is actually produced. Hospitals need a board and a general manager however few patients they treat – they cannot have half a manager simply because they are working at a lower level than expected. These costs – often known as fixed costs – can be spread over more units of output in bigger organisations, thereby reducing average cost per unit. The second
Variation between trusts

Exhibit 1
Expenditure on senior management by different categories of trust

There is a greater range of expenditure by acute trusts than for combined trusts. The range for non-acute trusts is narrower still, with most having senior management costs between £0.5 million and £2 million.

Source: Audit Commission analysis of 196 NHS trusts.

Exhibit 2
Senior management costs as a percentage of total expenditure in different types of trust

Variation in senior management costs is reduced when they are expressed as a percentage of total expenditure.

Source: Audit Commission analysis of 196 NHS trusts.

Box B
Extent of variation in senior management costs

The extent of variation is calculated as the ratio between the entry points to the upper and lower deciles.

<table>
<thead>
<tr>
<th>Category of trust</th>
<th>Absolute costs</th>
<th>Percentage costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>4.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Combined</td>
<td>2.7</td>
<td>1.8</td>
</tr>
<tr>
<td>Non-Acute</td>
<td>3.2</td>
<td>2.1</td>
</tr>
</tbody>
</table>
relevant concept is that of specialisation. Bigger organisations can increase the degree of each worker’s specialisation, enabling them to handle their tasks more efficiently, so reducing average costs. This could apply to trust management. For example, small trusts usually combine the task of handling complaints with other responsibilities for one person. This might typically take up a half of their time. But a larger trust of say four times the size, would not necessarily require two complaints officers. One person working full time on the task will usually suffice (and may even do the job better) because they become a specialist. Lastly, diseconomies of scale are thought to occur because very large organisations need many layers of management which themselves have to be managed. Coordination problems arise, the organisation can become over-bureaucratic in response, and average costs may begin to rise if the situation is not carefully handled.

There is no reason why these concepts should not apply in the case of health service management costs. A plot of senior management costs against total trust size suggests that there are economies of scale (Exhibit 3). The curve that best fits the data intercepts the y-axis above the origin – suggesting some fixed costs – while the fact that the curve is downwards as overall size increases suggests that some specialisation is taking place. The limited amount of data on very large trusts makes

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**Exhibit 3**

**Senior management costs and total revenue costs**

Comparing senior management costs and total costs suggests that there is some economy of scale.

*Source: Audit Commission analysis of 196 NHS trusts.*
Variation between trusts

18. 'The inevitability of high proportionate management costs in small trusts will create a pressure for some form of action in order to reduce overheads.'

19. However, the fact that there are some economies of scale does not mean that these could not, or should not, be greater. It is entirely possible, for example, that the curve should be more pronounced, and that large trusts are failing to achieve all the efficiency they might through management specialisation.

20. The theory predicts that small trusts will have high average senior management costs, and there is some evidence that this is indeed the case. For example, the nine trusts which spent seven per cent or more on senior management have an average total spend of £21 million, compared to an average for all trusts of £52 million. The inevitability of high proportionate management costs in small trusts will create a pressure for some form of action in order to reduce overheads, such as mergers, or the sharing of management and other staff resources.

21. Although a trust's overall size accounts for most of the differences in senior management costs, there is still considerable unexplained variation – most trusts lie above or below the line in Exhibit 3, not directly on it. Looking at the cluster of trusts at around the £50 million total revenue mark makes the point again that there is at least a twofold variation in senior management costs that is not due to trust size. This is a significant variation and it is important to ask what other factors could explain it? A number are examined here.
Exhibit 4
Categories and types of trust in the sample

Trusts have been sub-divided into seven categories to see whether their costs are affected by differences in services provided.

Types of trust

22. Average expenditure on senior management is similar in the three categories of trust: acute, non-acute and combined. However, each of these categories is a broad church (acute hospitals must at the very least be sub-divided into 'teaching' and 'non-teaching', for example). Some of the variation not explained by size may result from differences in the nature of clients and services between the sub-categories. To test this hypothesis, the broad categories of trusts have been further sub-divided creating seven types in all, as shown in Exhibit 4.

23. In order to compare management costs between types of trusts, it is necessary to control for the effect of size. Teaching hospitals, for example, are usually bigger than non-teaching hospitals, and would be expected to spend relatively less on management because they can benefit from economies of scale. This bias can be eliminated by comparing the actual management costs of each trust with the average costs expected for a trust of that size (the 'curve of best of fit' in Exhibit 3). Trusts with a management level of '0.5' would spend half as much on management as might be expected given their size; trusts with a management level of '2' would spend twice as much; and those
with a level of '1' would spend the expected amount exactly. Once the effect of size is allowed for in this way, it is apparent that there is no significant difference in average senior management costs between different types of trusts (Exhibit 5).

24. Similar analyses were also undertaken to look for any relationship between senior management costs and numbers of staff or beds, or the number of sites a trust occupies. After taking the size of the trust into account, none of these factors was associated with the variation in management costs.

Substitution

25. Rather than costing every person with management responsibilities, the methodology only includes managers over a defined level. Differences in the costs included, therefore, may be explained by the costs of management that have been excluded because they fall below the threshold. For example, a trust could have low senior management costs, but at the expense of high costs in middle management. In order to test for this, costs were also collected for the two staff groups where such 'substitution' is most likely to occur: administrative and clerical staff, and

Exhibit 5

Average expenditure on senior management by different types of trust

There is no significant difference in average senior management costs between different types of trusts.

Source: Audit Commission of analysis of 196 NHS trusts.
No association was found between senior management costs, taking size into account and expenditure on administrative and clerical staff.

Source: Audit Commission analysis of 187 trusts.

Salaries

26. The bulk of senior management expenditure consists of ‘in-house’ salary costs – the ‘paybill’. Variation in expenditure could result from either of the two main factors within the paybill – the number of managers employed and the average costs of employing them. In 1994 the average annual cost of an acute trust manager falling within the Audit Commission’s definition of management, was £28,500, with a range from £21,000 to £34,000. (It should be noted that the average cost to a trust is not the same as the average pay, which is less).

27. There are several reasons for the variation, some of which, like inner London weighting (£2,000 per manager in 199394), are unavoidable. But much of the variation results simply because some trusts employ more of their managers at a higher grade. To what extent do such differences in average salary costs explain the variation in senior management costs? The answer is that they have little effect – there is no clear relationship between average salary levels and whether trusts spend more or less than expected on senior management given their size (Exhibit 7). Variation in total senior management costs must therefore result chiefly from differences in numbers of managers trusts employ, and this is borne out by the available data. There is a clear correlation between the relative number of managers a trust employs and its expenditure on senior management (Exhibit 8).
Variation between trusts

Exhibit 7
Average salary costs of senior managers and expenditure on senior management

There is no relationship between average salary levels and whether trusts spend more or less than expected on senior management given their size.

Source: Audit Commission analysis of 93 acute hospital trusts

Exhibit 8
Average number of senior managers employed and expenditure on senior management

Variation in senior management costs results chiefly from differences in numbers of managers trusts employ.

Source: Audit Commission analysis of 91 acute hospital trusts – see footnote relating to Exhibit 7.

I A better comparison is possible between trusts’ average pay levels for managers employed (Exhibit 7) by restricting the analysis to one type of trust. This is because the posts and nature of workload in trusts of one type have a greater similarity than would be the case between trusts of all types. Acute trusts were chosen because that category had the largest number in the sample (they are probably also the most homogenous type in terms of the services managed).

II The numbers of ‘managers per £10m total revenue expenditure’ relates to additional managers above a ‘fixed’ number of managers – estimated at 14 – that every trust employs regardless of size.

28. In conclusion:

♦ there is considerable variation in senior management costs between trusts;

♦ these differences are mostly related to the size of the trusts, and there appears to be some economy of scale, but:

♦ there is still considerable variation in senior management costs after taking size into account – this residual variation has yet to be explained;

♦ whatever the causes of above or below average expenditure on senior management costs, they appear to be manifested through the numbers of senior managers rather than their salary levels.
What does management achieve?

'To constrain or even reduce management expenditure in the absence of any evidence on what benefits it does or does not achieve, is a dangerous game'

29. The variation in senior management costs raises the issues of what the expenditure is for, and what managers actually achieve. Is higher than average expenditure on management a waste of money, or a worthwhile investment? Initiatives to reduce management costs have usually been based on an assumption that money spent on management would be better spent directly on patient care. But it is undeniable that managers share the same objectives as their clinical colleagues – to deliver better health care more efficiently – and it is therefore at least possible that spending more on management may in some circumstances bring the greater benefit. To constrain or even reduce management expenditure in the absence of any evidence on what benefits it does or does not achieve, is a dangerous game, however popular it might make the player.

30. So what evidence does exist on the effectiveness of management? There is very little, chiefly because to date there has not been a reliable definition of management and therefore no reliable measurement of management costs or numbers. But now that we have a reliable measure of senior management, as described in this paper, it may be possible to relate senior management input to measures of a trust’s output or performance. Unfortunately consideration of this possibility does not reveal any simple answers; instead it unearths a pressing agenda for further work.

31. The first matter to decide is which outcomes to measure. Ideally, one would like to ascertain whether expenditure on management is related to clinical outcomes. Unfortunately there are too many other variables involved in determining these and the question is quite unrealistic at present. There are however plenty of other more measurable outcomes that might be expected to result from good management. These include good financial control, high productivity from the labour force, performance against consumer measures such as the patient’s charter standards, and a host of specific measures that good management might be expected to improve such as sickness absence rates and staff satisfaction ratings. It is not difficult to assemble data on many of these, and an example is shown in Box C.

32. The Audit Commission has started to look for association of senior management costs with a number of possible performance measures. No associations have so far been found. However, this negative result could have several explanations, and is far from demonstrating that expenditure on management has no effect. First, data quality is still suspect for many of the outcomes that one would most want to examine. Second, relating management costs to only one outcome measure is clearly narrow. Managers have many responsibilities and should be judged on their overall performance. Yet to put several disparate outcome measures together is no easy task.
What does management achieve?

**Box C**

**Senior management costs and productivity**

Faced with demand outstripping resources, and pressures to contain or reduce costs, managers have to find ways of increasing productivity. Perhaps having more managers might help. One measure of productivity is a trust’s unit labour cost. The ‘unit of labour’ is a notional output measure standardised for all trusts by weighting each trust both for differences in the types of activity it produces (e.g. outpatient and inpatient) and differences in its mix of specialties. Its cost depends on how many clinical staff are required to produce it and, to a lesser extent, what those staff cost.

Unit labour costs were calculated for thirty six of the acute hospital trusts with management costs data. There was no apparent association between unit labour costs and management costs.

Source: Audit Commission analysis of 36 acute hospital NHS trusts.
33. Nevertheless, at some time in the future it may be possible to agree upon the relevant measures and to construct a composite outcome indicator based on valid and accurate data. Having got such an outcome measure it would then be a relatively simple task to relate it to management costs and to how high or low they were for the particular size and type of trust being studied. Caution would still be required however. A lack of association between management costs and the outcome measure could have other explanations.

34. First, management costs might not be the appropriate measure of management input. Other factors, albeit related, may be equally important:

- the balance between numbers and the seniority or grade of managers;
- the way in which management is structured - the number of layers for example;
- how well performance management techniques are applied; and
- other variables that might affect the impact of management, such as the quality of available management information and the use of information technology.

35. Second, many other factors could be involved in affecting the components of the outcome measure. This would depend upon the precise nature of those measures. For example budgetary control could be affected not just by the number or quality of managers but also by factors beyond their control such as short term and unpredictable changes in external cost inflation, or disease epidemics in areas of work covered by fixed-income contracts.

36. Third, the effect that managers have on performance may take some time to manifest, so if outcomes are measured too early, no effect of expenditure on management will be found.

37. The only way of dealing with the first two problems is some form of multi-variate analysis which would assess the contribution of managerial and other factors to performance on the outcome measure. Measures would also need to be taken over a number of years to assess the extent of any time lags between management action and performance improvement. Ability to carry out such analysis will depend to a large extent upon the availability of high quality data.
Conclusions

38. The Commission’s method of collecting management cost data has proven to be reliable and useful. By providing chief executives, chairmen and boards with basic knowledge of how their management costs compare with those of other trusts, it should enable them to make better informed decisions on recruitment and staffing policy for this sector of their workforce.

39. The analysis set out in this paper will be of further assistance to trusts taking the following action:

- using figures produced for the audit of local management arrangements in 1993/94 and the relevant charts in this report, each trust should compare its costs with those of others to see if the larger sample now available has changed its relative position;
- in particular, each trust should see how its costs compare with those expected for a trust of the same size (represented by the ‘curve of best fit’) using Exhibit 3;
- acute hospital trusts can make comparisons of their average salary costs for senior managers and the numbers of senior managers employed per £10 million of total expenditure.

In subsequent years:

- trusts should continue to monitor cost levels and keep them in line with local policy; the Audit Commission’s costing proforma will be circulated annually for that purpose.

40. Applying the costing methodology in this study has answered a number of questions, particularly on the extent of variation in senior management cost. But it has raised some more. These provide a pointer to future areas of work.

41. First, more detailed analysis needs to be undertaken to develop understanding of why management costs vary - for example by exploring the effects of different pay structures or by extending the definition to include the costs of clinical management or junior administrative staff. And several years’ data need to be collected to observe trends. This will also be important once performance measures are developed, to see whether there is a delayed reaction between investment in management and performance improvement.

42. Second, a wider debate is needed to define what good management should produce, and how that should be measured. A clearer idea of management objectives, and better ways of measuring them, are essential to helping improve management performance.

43. Finally, once management performance is reliably measured, then trusts with consistently high levels of performance can be identified and examined for common characteristics. Some of these characteristics, such as the breadth and depth of the management hierarchy, may be identified through the costing methodology. Others will be differences in management style and method. Of particular importance will be those trusts that can demonstrate high performance levels with low management costs.

44. The Audit Commission will be pursuing the agenda set out above in order to identify and spread good practice in trust management.
Appendix - the Audit Commission costing methodology

Senior management cost

45. Based on a definition of management posts, rather than management activity, the methodology overcomes the problems of broad national pay categories by listing in detail those jobs to be regarded as 'management'. The full salary costs of postholders – including employer's 'on-costs' – are included, whether they are paid on Whitley council or local trust scales. Professional and clinical staff carrying out management roles are therefore counted as managers. The costs of clinical directors' sessions funded for management duties are also included in the total.

46. To differentiate managers in larger departments, a salary threshold of £20,000 per annum is applied (excluding additional payments, such as geographical allowances, enhanced payments, overtime, and 'on-costs').

47. Although the majority of a trust's management posts are included, it is quite possible for trusts to have 'less usual' posts that could be missed. These are picked up by two 'safety net' categories that identify managers among senior nurses and senior managers earning over the salary threshold who have not already been added to the total. Nurses caught by the safety net who are clinical specialists, rather than managers, are excluded from the total.

48. The costs of all the posts are added to any for management consultancy, to form the main management cost figure (which has come to be known as 'M1'). A further two levels of management cost are also recorded, to check for substitution. These add the costs of two other staff groups – first 'F & G' grade nurses, and then administrative and clerical staff – to the main management level. Both groups occupy the middle ground between clinical or clerical work, and management. Neither could therefore be classified within a pure management cost category. Nonetheless, a check of this sort is important because management activity can be delegated, making it possible to achieve reduced top management costs by increasing middle management costs.
Appendix - the Audit Commission costing methodology

Total costs

49. Because management costs are usually expressed as a ratio, an appropriate denominator was required. In this instance, total net revenue expenditure was used. Two necessary adjustments were made to help to 'level-out' possible distortions.

50. First, trusts vary in how much they contract-out. Most of the direct management of a contracted-out service is performed by the contractor and would not appear in the management cost total. The total value of contracted-out services was therefore also excluded from the denominator. (Ideally, the smaller, client-side management costs would also have been removed from the numerator, but they proved too difficult to identify.)

51. Second, whilst capital charges are part of the total revenue costs, they do not in themselves require management. Furthermore, they vary not only because of differences in the size of the estate (or equipment levels), but also because of differences in land values around the country. Capital charges have therefore also been excluded.

52. Unlike the 'charge', the capital itself – or rather the assets it represents – is subject to a degree of management, and does have an effect on costs. This is already accounted for in the denominator - estate size and equipment levels increase in proportion to total net revenue expenditure.

Improving the methodology

53. By using the methodology and analysing the resulting data, the Audit Commission has been able to improve the methodology. Further advice has come from detailed discussions with the NHS Trust Federation, the NHS Executive, the Welsh Office, trust chief executives, finance directors, and auditors. The following three main changes have been made:

♦ Different thresholds for nursing staff have been introduced to improve comparability between hospital and community units;

♦ The denominator 'total net revenue expenditure' has been replaced by 'total income';

♦ The exact contents of the different staff groups used to check for substitution ('M2' & 'M3') have been adjusted.

54. The changes are more fully explained in the new management cost proforma which will shortly be issued to trusts.
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