With regard to other recommended information, it would be particularly helpful if more employers could set interview dates in advance (in this study only 6% of advertisements gave an interview date). This would facilitate the planning of locum cover. It would also be useful if employers could give a contact name for inquiries, preferably someone who could provide useful information about the post. Only 18% of advertisements gave a medical name as a contact in this survey, although this was much more common in psychiatry than other specialties. The content of the advertisements did not otherwise seem to be affected by grade or specialty of the post or by employer. When the unified training grade is introduced as a result of the Calman report² junior doctors will usually seek one long rotation as a specialist trainee, rather than having to change jobs several times as the current system requires. Matching the right doctor to the right training programme will become even more important

for both employer and trainee as the two will usually be linked for five or more years. It would therefore help to include more information in advertisements for specialist training programmes.

Although certain specialties and geographical areas find it difficult to recruit suitable junior doctors, few employers seem to construct advertisements that are designed to attract applicants. Those writing advertisements for doctors in a training grade might wish to review their practice in relation to the BMA guidelines. More informative advertisements may attract more job applicants.

1 NHS Management Executive. *Junior doctors: the new deal*. Department of Health, London: 1991.

2 Department of Health. *Hospital doctors: training for the future. Report of the working group on specialist medical training*. London: HMSO, 1993. (Calman report.)

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Management for Doctors

Analysing your organisation and environment and setting its strategy

John S M Zorab, Ann Lloyd

This is the eighth in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson, chief executive, British Association of Medical Managers

Frenchay Healthcare Trust was a second wave trust and came into being on 1 April 1992. It has an annual budget of £89m and employs 4000 staff. The organisational structure, comprising seven clinical directorates and four executive directorates, was introduced the previous summer.

The underlying philosophy of the organisational structure is that the delivery of the clinical service is the responsibility of those consultants who have been appointed as clinical directors. The clinical directors are central to the management process and are directly accountable to the chief executive. This places the clinical directors firmly within a general management context without any intervening tiers filtering the communication and accountability between them and the chief executive.

This, combined with the responsibility that goes with budgetary control and the management of staff and contracts, has enabled the relevant consultants and managers to work as unitary teams. Responsibility for setting the direction for each directorate within the whole organisation truly rests with the clinical director—together with the management and coordination of directorate activities.

An essential component of this system is that each clinical director is supported by a high quality general manager (grade SMP 13-15) together with, in some instances, a specialist grade senior clinical nurse. Nevertheless, both the general manager and the senior nurse are responsible to the clinical director for the work of the directorate. Thus the clinical director is not a medical manager but a director supported by a professional manager and a professional nurse.

All clinical directors sit on the management team, which advises the chief executive on all strategic, policy, and major operational issues. Clinical directors therefore influence decisions affecting the whole trust within which they must manage their directorates.

It is our firm belief that consultants do not need to learn to be professional managers. They do, however, have to learn the language and skills of their managerial role to function effectively as heads of specialties, clinical directors, or as medical directors. General

managers also have had to learn to understand better the clinical perceptions of their clinical directors.

Strategic direction of the trust

This management structure, however, has to work within, and be able to pursue, the strategic direction of the trust, as set by the trust's board in the light of advice from the management team. The mission statement of the trust incorporates the phrase "excellence in practice" and, at an early stage in the life of the trust, the trust's board agreed that the strategic direction to be followed should be based on the following precepts.

AIMS OF THE SERVICE

The service provided would:

- Respond to the needs of patients
 - By "excellence in practice," provide the highest possible quality of health care
 - Respond to the needs of purchasers
 - Play its part in the implementation and achievement of national strategies for healthcare.
- The above precepts also indicate the agreed priorities: patients come first.

STRATEGIC PRINCIPLES

The principles adopted by the management team to achieve this broad based strategy were:

- To build on the strengths of the organisation and its services
- To analyse and, where appropriate, implement service development opportunities
- To develop opportunities for services not currently provided by the trust

Board of Frenchay Healthcare (NHS) Trust

Chair and five non-executive members plus

Chief executive	Finance director
Medical director	Chief nurse
Business director	

Frenchay Healthcare NHS Trust, Frenchay Hospital, Bristol BS16 1LE

John S M Zorab, *medical director*
Ann Lloyd, *chief executive*

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Management team, Frenchay Healthcare (NHS) Trust

chief executive

Director of surgery	Director of neuroscience	Director of clinical support	Director of clinical facilities	Director of mental health	Director of medicine	Director of community services
Medical director	Business director	Chief nurse (Chair, medical staff committee (co-opted))	Finance director	Personnel director	Operations director	

- To shed the weaker areas of service which were being better provided elsewhere.

The strategy for the trust had to be developed in the light of a mixture of cooperation and competition from neighbouring trusts in Bristol, and within the context of a developing purchaser's strategy meeting the health care needs of the local population.

STRATEGIC THEMES

The general strategic direction for the services of the trust has three main themes:

- To provide high quality, locally based, community services for the Frenchay district of about 250 000 population, complemented by excellent secondary care general medical, general surgical, and mental health services
- To provide high quality subregional services in neurological, plastic, burns, head and neck, and thoracic surgery
- To provide high quality major trauma services based on the first and second themes.

All the activities of the trust must be directed towards achieving these goals.

Some of the existing services provided by the trust do not fit tidily into these three strategic themes. Most, if not all, of the services enhance the general services provided and in themselves represent opportunities for development, such as health promotion, forensic, and drug abuse services. A view has had to be taken about their continuation as part of the trust's services.

REVIEW OF SERVICE

To complement this general strategy the trust's board and the management team needed to review:

- The strategic direction for services for the next five years
- The strengths and weaknesses of services currently provided
- Service development opportunities for the trust
- Development opportunities for services not currently provided by the trust
- Prospective strategies of the purchasing authorities and fundholders.

In pursuing the strategy for service provision, a degree of uncertainty exists in defining:

- The strategic direction of the main purchaser
- The extending role and responsibility of general practice fundholders
- The requirements of the Patient's Charter and other national directives
- The extent to which fundholders will "buy" community staff and services
- The rate at which priorities will be pursued in Health of the Nation targets
- The extent to which more distant purchasers will wish to invest in "local" contracts
- The impact of community care legislation
- The financial resources available to purchasers
- Advances in the practice of medicine
- Statutory training requirements for staff
- Changes in demography in the population
- The balance between cooperation and competition with neighbouring trusts.

The trust has to be flexible in determining its marketing policy so that it can adapt to changing circumstances. Thus all directorates have had to identify strengths, weaknesses, threats, and opportunities for their services as part of their business plans.

Case study

In March 1993 the trust learned for certain that its 1993-4 contract income would be £1.3m less than expected and that it would have to find a further £1m to meet other unavoidable costs (cost pressures). Thus income would be £2.3m less than expenditure.

The management team had been aware that there could be a small shortfall. The final "bill" for savings, however, was much higher than originally anticipated due to the late agreement of contracts. The management team agreed a set of principles to guide the process of making the necessary savings.

- Managerial costs and non-clinical overheads would bear the brunt of the savings
- Savings would be made in an objective and rational way. The principle that emergency admissions would always be accepted would be protected
- The savings should have a minimal impact on patient care. First priority would be given to maintaining and developing high quality patient care services
- Facilities required to provide patient services would be rationalised to match the lower contracts. This meant that the clinical directors would look at the facilities they needed to meet their contracts and that existing facilities would be slimmed down or extended, on the basis of those needs

- The need for savings and the ways of making them must be understood, accepted, and owned by the clinical directors, the consultant body, and by all managers in the organisation
- The need for the reduction in expenditure must be explained to the entire workforce.

Only by maintaining excellent communications with the workforce would it be possible to keep their support through what was clearly going to be a difficult and taxing exercise. This task fell largely to the chief executive.

Clinical directors were expected, with their managers, to devise the cost savings and match the facilities required to meet contracts and then to implement the proposals, doing their utmost to keep all staff fully informed of the reasons behind this process.

All clinical directors were asked to check the accuracy of their budgets; advise the management team on mismatch of facilities against contract; test their services against a potential 1%, 2%, and 5% cost saving target while maintaining necessary and agreed developments.

These were hard tasks and in this relatively young organisation it was the first time that the clinical directors had had to shoulder the responsibility of deciding where major reductions in expenditure could or should be made. The clinical directors themselves had learnt enough to understand the necessity for the reductions, and one of the early and major tasks was to convince the consultants and other professional staff within their directorates.

Clinical directorates

Surgery:	Anaesthetics (including ICU and pain clinic)
General surgery	Day case unit
Gynaecology	Outpatient department
Thoracic surgery	Medical physics
Trauma and orthopaedics	Medical illustration
Plastic surgery	Mental health:
Oral and maxillofacial	Acute psychiatry and rehabilitation
Neuroscience:	Forensic psychiatry
Neurosurgery	Challenging behaviour
Neurology	Drug misuse service
Neuropathology	Community psychiatry
Neurophysiology	Psychiatry of old age
Neuropsychiatry	Clinical psychology
Speech therapy	Medicine:
Physiotherapy	Acute medicine
Clinical support:	Care of the elderly
Radiology (including neuroradiology)	Occupational therapy
Pathology (excluding neuropathology)	Dietetics
Pharmacy	Community:
Clinical facilities:	Community paediatric services
Accident and emergency	Child and adolescent psychiatry
Operating theatres and endoscopy unit	District nursing and health visiting
CSSD and TSSU	Chiropody

The organisational structure in Frenchay has proved particularly appropriate for pursuing this strategy. The clinical directors have been able to develop both the services provided by their own directorates as well as developing the strategy of the whole organisation. Even so, such a cohesive structure does not confer immunity from the problems of functioning in a market oriented environment, illustrated by the case study.

The merits of the organisational structure began to shine through. For instance, several consultants did not take kindly to being told that their operating time or beds, or both, would have to be curtailed because of fewer contracts, but it became clear that this message was more acceptable coming from a consultant colleague than from a "manager" because the clinical director was perceived as appreciating the clinical consequences of the measures being advocated.

WHERE TO REDUCE COSTS

Each clinical director, in conjunction with his general manager, examined the performance of the various functions within the directorate, matched this performance with the newly agreed contract volumes, and explored ideas for reductions in expenditure. In the acute bed directorates (surgery, medicine, and neurosciences) numbers of beds were compared with contract levels, projected duration of patient stay, needs for investigations, drugs, and theatre time. Emergency workloads provided one of the biggest problems as in medicine and surgery this was not subject to control. The reduced contract volumes could therefore only be matched against elective work, which then became a smaller proportion of the total workload and therefore made the service's ability to cope with a variable and unknown workload that much more difficult. A similar exercise was undertaken within the mental health and community directorates.

In the more service orientated directorates (clinical facilities and clinical support) services were matched against the projected reduced demand.

HOW TO REDUCE COSTS

Tough decisions then had to be taken by the management team about the ways in which the savings would be made and the possible effects on the quality of the clinical services and the support services. There was much agonising over the continuing need for investment in the various services. In the main the trust's list of "necessary developments" contained

items identifying changes in clinical practice which our main purchaser did not recognise as being a priority for investment but which had already been implemented as being improvements in patient care. These included increased use of isotopes, higher costs of drugs due to an increased number of emergency admissions, implants for spinal surgery, and disposables for laparoscopic surgery. Continued use of these techniques was debated at length before being authorised.

The outcome of the reviews by the clinical directors identified that 152 staff would be at risk of redundancy and 35 staff would be downgraded. The problem was lessened by a "freeze" on the filling of all vacancies as soon as the problem was recognised. A trust steering group had been set up, to which requests for the filling of vacancies were submitted. Whenever feasible, short term contracts were offered.

Owing to the foresight of the management team and the hard work of the clinical directors and their managers most of the "at risk" staff had been found other jobs in the organisation within three months. Most of the remainder had accepted early retirement or voluntary redundancy.

ROLE OF THE CLINICAL DIRECTOR

The critical factor in producing a successful and workable plan was the involvement of the clinical directors in developing proposals for their own services and promoting the need for change among their clinical colleagues, and the need to be involved in the process. This was coupled with the trust which existed between the clinical directors, the chief executive, the other members of the management team, and the cadre of specialty directors.

The execution of the implementation plan for 1993-4 really tested the trust's version of the involvement of the clinicians in management. The clinical directors, without having any managerial authority over their clinical colleagues, had to manage a cost savings exercise which would affect them all. The chief executive had to resist the temptation to intervene when problems loomed—the clinical directors had to be given the opportunity to consolidate their managerial credibility. She acted as a sounding board and adviser and intervened only when it was necessary to reinforce the decisions of the clinical directors.

As a result of the exercise, the trust's expenditure was reduced in line with its income and the trust was one of the few which met all its financial targets.

The lessons

When the problem first arose it was tempting, and would have been all too easy, to adopt the conventional

Effectiveness of a clinical directorate

- Clinical directors have to be given real responsibility for the delivery of the clinical service of their directorate
- Such responsibility must include budgetary control, staff management, and contract management
- Clinical directors must have good quality management, nursing, financial, and information support
- There must be no intervening layer of management between the chief executive and the clinical directors
- The chief executive must be able to adopt a "hands off" approach to operational management while ensuring the strategic aims of the organisation are fulfilled and that the clinical directors are fully supported in making their decisions
- This is not a cheap system of management, but the full integration of the clinicians brings benefits which far outweigh the additional costs

solution and insist that the problem be solved by the general managers rather than through the agreed structure. This, however, would have undermined the principles on which the structure had been based.

Four major difficulties still remain:

- The demands on the time of the chief executive
- The demands on the time of the clinical directors and their specialty colleagues
- The perceived interruption of the career paths of the general managers
- The potential tensions arising from functional directors, such as finance, delegating responsibility to clinicians and not traditional managers.

The organisation is now far better placed to undertake major projects and initiatives than it was before: decisions are multidimensional and largely consensual, and managers and clinicians work in harmony together. The clinical directors are not disenfranchised but are an essential part of the decision making process in the trust. They are readily accepted by their consultant colleagues as acting in the clinical interests of patients.

We believe that the strengths of our clinical directorate model of management, with its direct access to the chief executive, lead to realistic and robust decisions which minimise disruption to the services, make for faster decision making, and maximise benefits to patient care.

There are several lessons to be learnt from the experiences outlined above as they affected Frenchay Healthcare Trust.

We believe that this system of management has allowed decisions concerning the future of the services

Key point summary

- Strategic direction needs to be established early, determining what is to be provided and how this is to be achieved
- Flexibility is important: the identification of strengths and weaknesses, and threats and opportunities for the directorate needs to be part of the business plan
- A clinical directorate model of management, with direct access to the chief executive, minimises disruption to service provision, while maximising patient care
- The effectiveness of a clinical directorate depends on being given real responsibility and on good support systems

provided and their current performance and potential to be taken by the clinical staff and managers working together to achieve a common goal. It has allowed a synergy to prosper between the aims and objectives of these two groups of staff that is changing the culture of the organisation. It has focused on the importance of decisions being taken by staff with a shared perspective, particularly in times of change.

A book of the series, entitled *Management for Doctors*, is available, price UK £12.95; Overseas £14.00 (BMA members £11.95; £13.00). Order from the BMJ Publishing Group, PO Box 295, London WC1H 9TE (tel 0171 383 6185/6245; fax 0171 383 6662).

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Meningeal granulomas: sarcoidosis or tuberculosis?

Differentiation can be difficult

Nervous system disease is an uncommon complication of sarcoidosis. We present the case of a man found to have extensive meningeal granulomatous inflammation, an intra-cranial mass, and concurrent pulmonary disease all attributable to sarcoidosis. This case highlights the difficulty in firmly diagnosing neuro-sarcoidosis and in distinguishing it from tuberculosis in some instances.

Case history

A 32 year old white man was referred to our hospital for further investigation. He had been well until three months previously, when he had collapsed to the ground with no warning or apparent loss of consciousness. He recovered immediately but suffered two similar episodes, which were witnessed, over the subsequent three months. Two months before presentation he had experienced a "rushing sensation" spreading from the neck to the head and was seen to be staring blankly into the distance with posturing of the outstretched arms for about 20 seconds. He was unresponsive to questioning. Again he made a full, immediate recovery. On another occasion he saw shortlived, strobe-like flashes of light in his left visual field. He was physically fit with no respiratory symptoms. He had no significant medical history and took no drugs. Physical examination showed no abnormality.

He had peripheral blood lymphopenia with an absolute lymphocyte count of 0.8×10^9 , a normal total

white cell count, and normal biochemical profile including serum calcium concentration. His CD4:CD8 ratio was normal. The erythrocyte sedimentation rate was 11 mm in the first hour and the C reactive protein concentration 24 U/l. Syphilis serology gave negative results. Cerebrospinal fluid obtained by lumbar puncture had a lymphocyte count of 4×10^6 /l, red blood count 2×10^6 /l, and a greatly raised protein concentration of 2.1 g/l. Cerebrospinal fluid glucose concentration was low at 2.7 mmol/l, with a plasma glucose concentration of 5.2 mmol/l. No acid-fast bacilli were seen, and no organisms were grown with standard culture techniques. Angiotensin converting enzyme concentration was normal in both serum and cerebrospinal fluid. An electroencephalogram also appeared normal.

A chest radiograph showed abnormal shadowing in both upper lobes, with nodular and linear components, and a more confluent area of soft tissue opacity was present at the left apex. Some associated loss of volume had occurred in both upper lobes. The hila and mediastinum appeared normal (fig 1).

An unenhanced axial computed tomogram of the head suggested the presence of a low attenuation mass about 25 mm in diameter that was compressing the trigone of the right lateral ventricle from above. A second 20 mm diameter mass of similar attenuation to normal brain parenchyma was also noted in the right side of the chiasmatic cistern. Magnetic resonance scans taken before and after enhancement with gadolinium showed brightly enhancing, extensive,