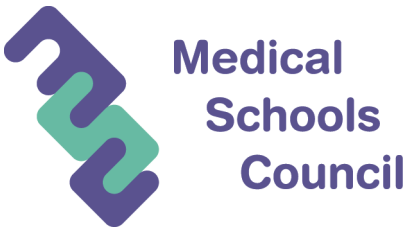


ORGANISATION AND MANAGEMENT OF MEDICAL SCHOOLS:

A SURVEY OF TEN U.K. UNIVERSITIES

August 2012

Report prepared by

Professor David Wynford-Thomas, Pro-Vice Chancellor and Dean of Medicine, University of Leicester

With the collaboration of

Professor Paul Stewart, University of Birmingham

Professor Peter Mathieson, University of Bristol

Professor Paul Morgan, Cardiff University

Professor David Cottrell, University of Leeds

Professor Ian Greer, University of Liverpool

Professor Chris Day, University of Newcastle

Professor Ian Hall, University of Nottingham

Professor Tony Weetman, University of Sheffield

Professor Iain Cameron, University of Southampton

INTRODUCTION

From being at one time some of the most stable organisations in the country, UK universities (and their medical schools) have over the last few decades been undergoing change at an ever-increasing pace. Many of the drivers have of course been external– notably successive research assessment exercises (RAEs) and the introduction of student fees. Increasingly, though, internal competition within the sector has also become a major factor, as universities fight for league table rankings in the struggle to attract the best students and staff.

Of course adaptive change can be beneficial, and indeed often essential, for survival. There is, however, a down-side if change is reactive as opposed to planned. The last few RAEs provide a good example of how relatively arbitrary decisions by an external body - in this case the way in which research areas were grouped into Units of Assessment (UoAs) - led some biomedical faculties to restructure along the same lines, only to find that the rules had changed again (or even reverted !) by the next assessment exercise. The internal market can also trigger such "knee-jerk" responses as when an unexpected fall in the league table ranking leads a university to believe that "restructuring must be the answer".

Change therefore has a tendency to become self-perpetuating and infectious – which might not matter if it did not also incur massive costs, both in time, money and, not least, staff morale. There is a need therefore to take a more scientific approach to evaluating the need for change and determining the most cost-effective models of organisation, if this potentially endless spiral is to be kept in check.

This report is an initial step towards this goal, focussing specifically on Medical Schools. It is essentially a descriptive cross-sectional study, comparing and contrasting the current organisational structure and *modus operandi* of a sample of provincial medical faculties and their host universities. It is intended to lay the foundations for subsequent work which will analyse the rationale behind the choice of models and their subsequent effectiveness.

METHODS

Ten provincial universities with medical schools from across England and Wales were chosen to represent as homogeneous a group as possible with respect to potential confounding factors such as size and history (hence excluding for example the “new” Medical Schools, as well as Oxford and Cambridge). These institutions are: Birmingham, Bristol, Cardiff, Leeds, Leicester, Liverpool, Newcastle, Nottingham, Sheffield, and Southampton.

Information on organisational structure was initially gathered by searching sources in the public domain - including university and faculty/school web sites, and annual reports. Draft organograms were then sent for comment and correction to Heads of Medical Schools/Faculties and/or their Senior Administrators.

Since structure does not always allow accurate prediction of function (which was ultimately the purpose of this survey), we next sought information on policies and processes (particularly relating to strategic decision making and resource management) by means of a structured questionnaire sent to the above staff (reproduced in Appendix C).

RESULTS AND DISCUSSION

The organograms in Appendices A and B set out the organisational structures pertaining at the time of writing in the ten universities included in this survey. Appendices A describe the structural units while B shows the corresponding senior staff posts and their reporting lines. Based on this data and the responses to questionnaires, we have compared and contrasted the institutions with respect to the following features: 1) internal structure and function of the Medical School; 2) its organisational relationship with the wider university; 3) strategic planning and resource management.

1. Internal structure and function of Medical Schools: relationship between Teaching and Research

The traditional model which operated in most schools until the late 20th century was for departments to be based around the major clinical specialties (the "-ologies"), with each responsible for all aspects of teaching (as well as research) in its own field. Overall co-ordination of teaching was achieved through a Board/Committee structure, with administrative support from a "Medical School Office" (often seen by students as the core of the "Med School"). Major external pressures affecting both teaching and research over the last two decades have now led all schools to move away from this model to a greater or lesser extent.

One of these external drivers has undoubtedly been the UK Research Assessment Exercises. These have forced Medical Schools to focus their research on ever more specific areas in order to achieve the critical mass needed for international excellence (indeed the RAE was originally termed the Research Selectivity Exercise). A key consequence has been that only the very largest institutions could attempt to maintain research excellence across all the traditional clinical specialties. Hence nearly all institutions have instead created units ("Schools" or "Departments") based on research-led groupings. In some cases (eg Nottingham) these resemble the units of assessment of RAE2001 i.e. Laboratory, Clinical and Community-based research. In most cases, however, they represent cross-cutting research themes such as "Cancer Studies" or "Infection & Immunity", resembling more closely the Units of Assessment of RAE2008 (and in some cases, eg Leicester, mapping exactly to these – see Box 1).

In parallel with (and in part probably due to) the above, an equally significant change has occurred in the organisation of undergraduate medical teaching in most schools, with a move towards much greater centralisation. Following the lead of universities such as Newcastle, most have now established dedicated units responsible for some or all aspects of the organisation and management of the MBBCh, including the coordination of delivery of the curriculum, assessments and quality assurance (Table 1). In many cases (such as Leicester, Liverpool and Leeds), these units have the status of full departments, equal to their research-based counterparts described above (see Box 1), although terminology varies (an increasingly common variant being Research "Institutes" and Teaching "Schools"). One obvious advantage of this model is that the existence of a specialist teaching department should strengthen the management and organisation of the MB BCh programme and gives a clear identity and visibility to the unit (and staff) responsible.

One driver for this model has undoubtedly been the increasing "professionalization" of medical education over the last two decades, resulting of course from external changes (led by the GMC) but also from an increasing awareness of the importance of pedagogic principles by medical schools themselves.

An additional, more indirect driver, however, has probably been the parallel change to research theme based departments described above, since one (unwanted) consequence of the increase in research selectivity resulting from this has been that, in any given School, some of the traditional clinical specialties will no longer be included in the research portfolio and hence may not have clinical academics associated with them. This creates an inherent risk of gaps in the coverage of the curriculum which can only be filled by "commissioning" the relevant teaching from NHS partners. The presence of a "professional" Teaching department with responsibility for overall coordination of teaching is clearly valuable in managing such scenarios.

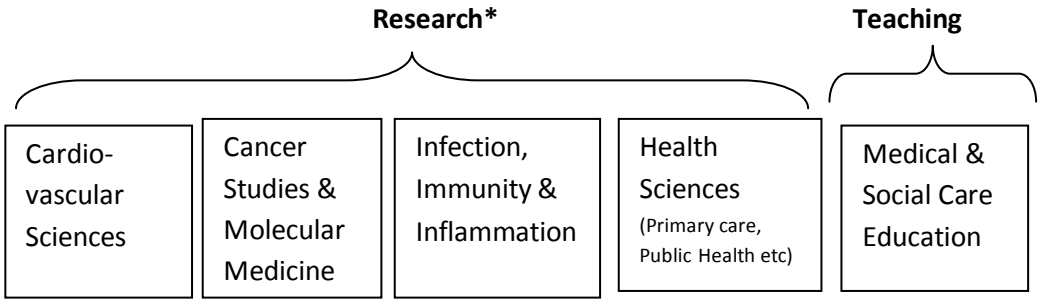
Not surprisingly, therefore, the majority of universities in this survey have now established Departments/Units of Medical Education (exceptions include Bristol and Birmingham and until very recently, Cardiff). Indeed the popularity of the model is underscored by the current demand for leaders of such units -usually designated "Directors of Medical Education"; at the time of writing there were no fewer than four national advertisements for such posts !

The evolution towards R-led departments plus a dedicated T department is well illustrated by Cardiff - which was one of the last in our survey to adopt this model (see Box 2).

While the split "R + T" model is an understandable response to external drivers, it has led to some unwanted effects, resulting from the quasi-disappearance of at least some traditional clinical academic specialties in most schools. This is sometimes *ad hoc*, determined by the historical distribution of research strengths (for example, orthopaedics and dermatology are no longer represented in Leicester). Some "–ologies" however have been more universally disadvantaged, notably pathology and radiology. While the negative effect on undergraduate education can and has been mitigated by Medical Education Departments commissioning provision from the NHS, this does not apply to post-graduate training, where the absence of visible clinical academics undoubtedly deters would-be academic trainees in these specialties. This is particularly relevant to the ACF/ACL programme where opportunities in any given school are potentially more restricted than would have been the case in the traditional specialty-based model. (Interestingly, Newcastle has addressed this issue by establishing a Clinical Academic Office led by a "Dean of Clinical Medicine")

BOX 1 The split "R and T" model of Medical School organisation: Leicester as an example

This increasingly common organisational model consists of predominantly Research-based departments together with a separate dedicated Teaching department. In this example, the R-based departments (created by a major reorganisation in 2004) are based clearly on the Units of Assessment of RAE2008. Prior to this there were no fewer than 32 departments representing all clinical specialties (and sub-specialties) !



RAE2008: UoA1 UoA2 UoA3 UoA6, 7, 8

*note that some MB BCh delivery is still provided by these departments but all the organisation and management of the course (including "commissioning" from NHS partners) is carried out by the Department of Medical Education.

Table 1 Patterns of internal organisation in ten Medical Schools

[NB does not include units in other faculties/schools eg bioscience]

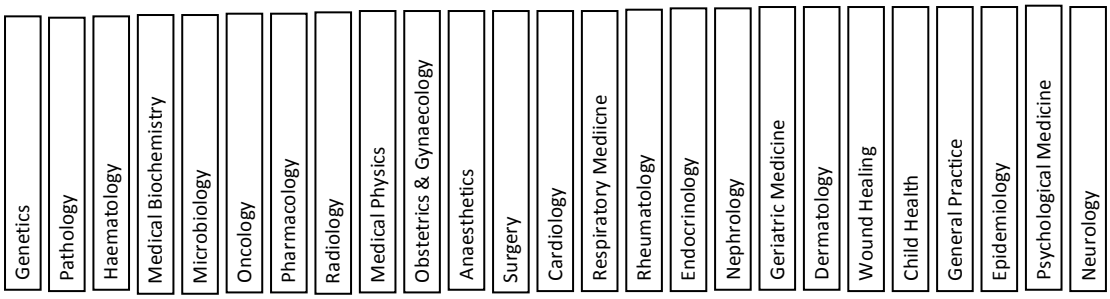
University	Pattern of organisation
	Split R plus T models with dedicated unit for MBBCh curriculum delivery and management (see Box 1):-
Leeds	3 R institutes plus 1 T institute
Leicester	4 R departments plus 1 T department
Liverpool	5 R institutes plus 1 T institute
Sheffield	5 R departments plus 1 T academic unit
Cardiff (since 2011)	6 R institutes plus 1 T institute
Nottingham	4 R Schools plus 1 Medical Education Unit
Southampton	4 R-based Academic Units plus 1 T Unit
	Models with "Board of Studies / Committee" model for MBBCh management:-
Newcastle	7 R-based Institutes *
Birmingham	4 R-based Schools, no dedicated T School
Bristol	2 R/T Schools

*The Medical Education "unit" in this case is not primarily responsible for *running* the MB programme, but contribute *inter alia* to development (of the curriculum, learning environments etc), evaluation and pedagogic research

BOX 2 Evolution of Medical School organisation: the Cardiff example

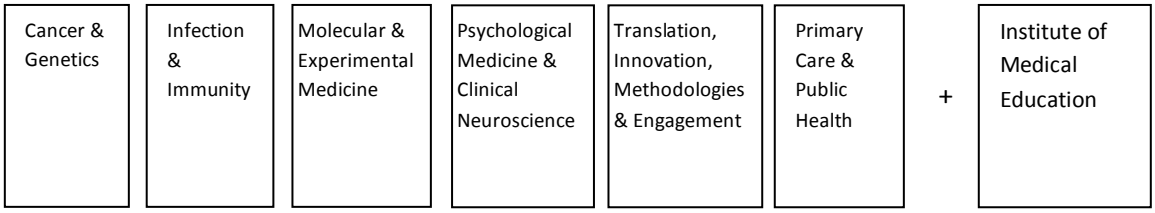
In 2004, Cardiff Medical School contained no fewer than 25 departments of widely varying size, each with its own academic leadership and administrative support. Delivery of the MB teaching was distributed across departments, with coordination and management of the course being carried out largely by Boards and Committees. Through a process of merger of cognate departments, their number was progressively reduced eventually reaching 9 roughly equally-sized departments by 2008. At the same time there was a firming up and centralisation of the management of the MB BCh course, culminating in the establishment of a Medical Education Unit. During this time, research was organised through a series of cross-departmental "Interdisciplinary Research Groups" (many corresponding to the UoAs of RAE2008). In 2011, however, the clinical specialty-based model was finally abandoned in favour of the R + T model, with the creation of 6 Research Institutes plus 1 Teaching Institute responsible for managing all aspects of the MB BCh programme.

2004: 25 departments based on clinical specialties



2008: 9 departments based on groups of cognate specialties

2011: 6 Research Institutes + 1 Teaching Institute



2. Location of the "Medical School" within the wider University structure: organisational relationship with other disciplines

Nearly all universities in the survey have now adopted a "divisionalised" organisational structure, based on a relatively small number of multi-departmental "Faculties" or "Colleges". Particularly in those which have re-organised more recently (where the term "College" is the norm), this is associated with devolution of budgetary control and other management functions (see Section 3 for further discussion). The notable exception to this pattern is Cardiff University, which has retained a "flat" structure of 26 separate Schools with no higher-level unit of organisation (and is hence treated separately in some of the analysis below).

The overall organisational pattern of 9 out of the 10 HEIs in this survey is therefore broadly similar, with Medicine forming a large part of one Faculty/College, typically bearing a title such as "Medicine & Health". There are nevertheless subtle differences in the internal composition of such Faculties/Colleges (Table 2a), which have a potentially significant "functional" impact.

Dentistry and Professions Allied to Medicine (PAMs)

One common feature of Medical Faculties/Colleges is that where the university also has Departments/Schools of Dentistry and/or PAMs eg nursing or physiotherapy (which is true of all except Leicester in this survey), these are nearly always co-located with Medicine. The one exception is Southampton, which is unusual in having Medicine as a "single-discipline" Faculty, with PAMs in a separate "Faculty of Health Sciences".

Biological Sciences

In contrast to the above, another discipline closely linked to Medicine – Biological Sciences – is more often than not separated off into a different Faculty/College, usually with Chemistry and the Physical Sciences. This is the case in five universities in this survey (Table 2a). Only in two institutions (Leicester and Liverpool) is Biological Sciences wholly grouped with Medicine. In the remaining two (Nottingham and Newcastle) there is a split, with the more bio-medical (cell/molecular) areas of Biological Sciences co-located with Medicine, while the ecology/plant sciences component is located in a Faculty of Science.

The latter observation reflects the inherently dual-facing nature of Biological Sciences in most universities (i.e. medical vs non-medical) which is potentially one factor explaining why the choice of "partner" discipline and Faculty "home" for Biological Sciences is not as straightforward as with Dentistry and PAMs. However, as discussed below, there is a more pragmatic explanation, based simply on the size and balance between Faculties/Colleges in a given university.

Table 2b shows that the number of Faculties/Colleges per university in this survey varies from three (Liverpool and Newcastle) to eight (Southampton and Leeds). There is a clear (and statistically significant) trend (Fig 1a) for Biological Sciences to be grouped with Medicine in those university with the fewest (and hence relatively largest) Faculties, with a "tipping point" at n=5, above which all universities have Biological Sciences in a different Faculty from Medicine. Furthermore, of the three institutions having five Faculties, in the two which have Dentistry plus PAMs (Birmingham and Sheffield) Biological Sciences is separated from Medicine, whereas in the university with only PAMs (Nottingham), they are grouped together (Table 2b, Fig 1b).

Although the numbers are small (and too low for any formal "cluster analysis") these observations suggest that the co-location of Biological Sciences in the same Faculty as Medicine is dependent largely on the *capacity* remaining in that Faculty once Dentistry and/or PAMs have been included (the assumption being that these disciplines are given first priority since they have no logical alternative Faculty "home"). Or, in other words, in universities with numerous, "small" Faculties, adding Biological Sciences to Medicine (+/- Dentistry and PAMs) would create a Faculty whose size would be disproportionately large in relation to the other Faculties.

This conclusion is indeed consistent with the historical accounts obtained from several institutions contacted in this survey.

We have not attempted here to explore the reasons *why* the number (and hence relative capacity) of Faculties varies so widely between universities in our survey. It would be interesting however to explore the unintentional consequences this decision may have had on the effectiveness of collaboration between Medicine and Biological Sciences, given the key importance of this synergy in both biomedical research and teaching and the inevitably greater practical difficulty of working *across* as opposed to *within* Faculties/Colleges.

Psychology

In contrast to the above disciplines, the organisational location of Psychology in universities in this survey appeared to follow no logical pattern (Table 2a), being unrelated to either the number of Faculties or the nature of their other component parts. Thus Psychology is grouped with Medicine in four institutions - having numbers of Faculties/Colleges ranging from three (Liverpool) to eight (Leeds). Conversely it is in a separate "Science" Faculty in five universities (and in Southampton in a separate "Faculty of Social & Human Sciences").

Table 2a Composition of Faculties/Colleges containing Medical Schools

HEI	Disciplines co-located in "Medical" Faculty				
	Medicine	Dentistry	PAMs	Biological Sciences	Psychology
Group 1: Biological Sciences co-located with Medicine					
Liverpool	X	X	X	X	X
Leicester	X			X	X
Newcastle	X	X		X*	X
Nottingham	X		X	X*	
Group 2: Biological Sciences in separate Faculty/College from Medicine					
Sheffield	x	x	x		
Birmingham	x	x	x		
Bristol	x	x			
Leeds	x	x	x		X
Southampton	x				
Cardiff	*N/A (26 separate Schools)*				

Table 2b. Relationship between Faculty/College number and composition and the "location" of Biological Sciences

HEI	Number of Faculties/Colleges	Dentistry (D) or PAMs (P) in HEI ?	Biological Sciences co-located with Medicine ?
Liverpool	3	D+P	YES
Newcastle	3	D	YES
Leicester	4	-	YES
Nottingham	5	P	YES
Sheffield	5	D+P	NO
Birmingham	5	D+P	NO
Bristol	6	D	NO
Leeds	8	D+P	NO
Southampton	8	P	NO
(Cardiff	*N/A (26 Schools)*	*D+P*	*NO)*

Fig 1a. Relationship between number of Faculties/Colleges and location of Biological Sciences in nine HEIs

There is a significant trend for Biological Sciences to be co-located with Medicine where Faculties are fewer in number, and hence relatively larger in relation to the whole university

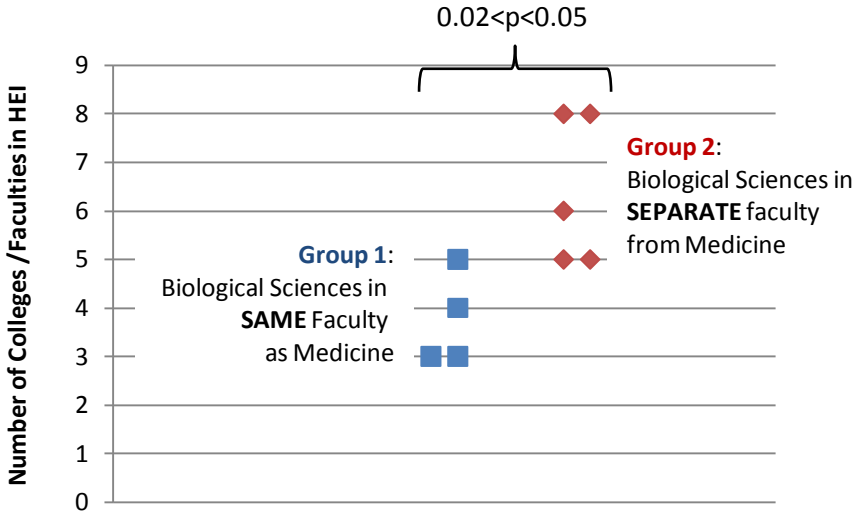
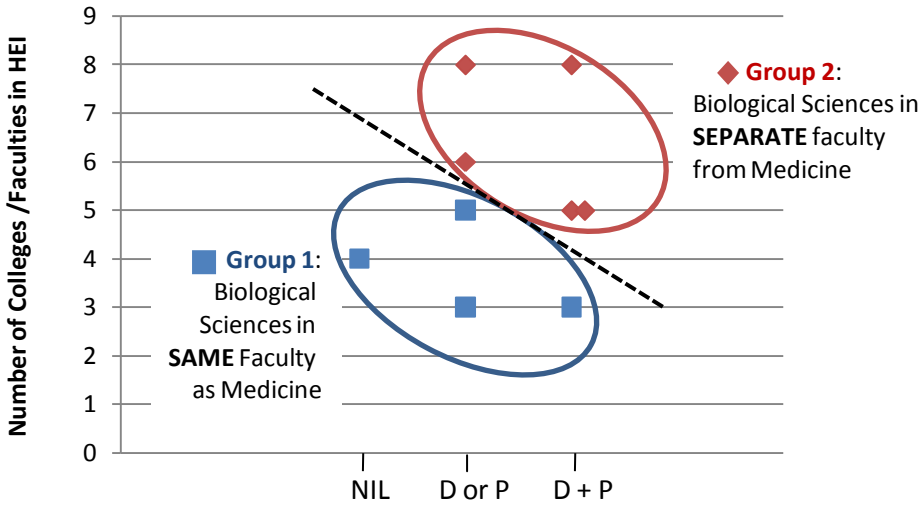


Fig 1b. Relationship between number of Faculties/Colleges, and presence of Dentistry +/- PAMs on location of Biological Sciences

The overlap between Groups 1 and 2 in Fig 1a is "split out" according to the presence or absence of both Dentistry (D) plus PAMs (P), improving discrimination between the groups (data from Table 2)



3. Role of the "Faculty of Medicine" in University leadership and management

In this section, we turn from "structure" to "function" and look at the role of the "Faculty/College/School of Medicine" (and indeed the Dean or equivalent) in the development and implementation of strategy in the ten universities surveyed, focussing in particular on the extent to which strategic decision making and management of resources are devolved within the organisation.

3.1. Strategy (Table 3a)

In all ten medical faculties/colleges surveyed, there appears to be an acceptable degree of autonomy in strategic decision-making in teaching and research, provided that local strategies broadly align with central University strategy and policy. Such decisions might include for example the introduction of a new MSc course or the prioritisation of a research area for investment. In no case was there a feeling that such decisions were dictated by the "centre".

However, there were variations in the exact level at which such local strategy is set. In five universities, this was reported as being at the level of the "Medical" Faculty/College and in just two at School/Department level. In the remaining three cases, there was a hybrid model with oversight by the Faculty/College but extensive devolution to School/Department level.

Moreover, there were also significant differences between universities regarding the "upward" influence of the Medical School/Faculty on central university strategy and policy. In five cases, there is direct representation of the Medical School through the Dean (or equivalent) being a Pro-Vice Chancellor and a full member of the University's Senior Management Team. In the other five however, the link is much more indirect, usually through a "functional" PVC (eg PVC Research or PVC Teaching) who is given responsibility for the Medical / Bioscience faculties/colleges without necessarily having any professional background in these fields. Historically, this used to be the predominant model in most of the universities surveyed, and perhaps not surprisingly, where respondents had experienced the switch to the newer "direct representation" model, this was perceived as a major advance from a Medical School perspective.

Table 3a. Factors affecting development of Strategy in Faculties/Colleges/Schools of Medicine

HEI	To what level is strategic decision-making affecting the Medical School devolved ?		What is the upward link between the Medical School and central University decision-making bodies?	
	College/Faculty	School/Dept	Direct, via presence of Dean (or equivalent) on University Senior Management Team	Indirect, e.g. via a "non-medical" PVC
Birmingham	+ →	+		+*
Bristol	+			+
Cardiff	*n/a*	*+*		*+*
Leeds		+		+
Leicester	+		+	
Liverpool	+		+	
Newcastle	+		+	
Nottingham	+ →	+		+
Sheffield	+ →	+	+	
Southampton	+		+	
TOTAL	5	5	5	5

*via non-medical Head of College
Arrows indicate further devolution within Faculty/College.
TOTALS relate to lowest level of devolution

3.2. Resources (Table 3b)

Budget setting

In the majority of Faculties/Schools in this survey, annual budgets are now determined on a formulaic basis, linked to Teaching and/or Research activity, i.e. a Resource Allocation Model (RAM). Only one institution (Liverpool) reported retaining fully the traditional model in which budgets had a "historical" basis, adjusted by an annual "bidding" process managed by the University centrally. One university (Bristol) was in the process of moving from this older model to a RAM and another (Birmingham) operated a "hybrid" model.

Devolution of budgetary control

There was considerable variation between institutions in the level at which budgets (once set) are *managed* (Table 3b). Non-staff budgets were, in all but three cases, devolved down to School/Department level. In contrast, staff budgets were more often controlled at Faculty/College level. In four cases, control was entirely at this level; in another three, there was some further devolution to School/Department level. In only three was there full devolution to this level (and in one of these – Cardiff – this was inevitable due to the absence of Faculties/Colleges). Notably, in many cases, irrespective of the above, Professorial posts are considered an exception, requiring authorisation at University level.

Table 3b. Resource management in Faculties/Colleges/Schools of Medicine

HEI	To what level are budgets devolved ?				How are budgets set ?	
	Staff		Non-staff		Historical basis	Formula (RAM)
	College/ Faculty	School/ Dept	College/ Faculty	School/ Dept		
Bham	+ →	+	+ →	+	+/-	+/-
Bristol	+/-*		+		+***	
Cdiff	*n/a*	*+***	*n/a*	*+*		*+*
Leics	+		+ →	+		+
Leeds	+ →	+	+ →	+		+
Lpool		+		+	+	
Ncastle	+		+			+
Nttham		+**		+		+
Sheff	+ →	+	+ →	+		+
Stton	+		+			+
TOTAL	**3**(4)	**6**	**3**	**7**	**2**(3)	**7**(8)

*University authorisation required for all posts
**University authorisation required for Chairs
***Moving to Formula basis
Arrows indicate further devolution within Faculty/College.
TOTALS relate to lowest level of devolution (figures in brackets take account of "partial" status)

CONCLUSIONS

UK medical schools have been undergoing a period of "convergent evolution" over the past two decades, as a result of which they now share many common features (or at least variations on a common theme).

For example, most schools have adopted a model of internal organisation based on discrete "research" and "teaching" units (although the exact remit of the T unit varies from full responsibility for programme delivery to a more supportive role in development and educational research).

Likewise, most institutions now operate a devolved system of management and budget allocation (though the exact "level" of control varies from Faculty/College to School/Department).

Nevertheless, there remain some major differences, in both form and function.

Apart from the single exception of Cardiff (which is itself now under review), in all institutions Medicine forms part of a larger faculty or college. However, there is a major difference in the choice of related disciplines, with roughly half of our sample grouping Biological Sciences in the same faculty/college as Medicine and half not.

There is also a similar 50:50 split in relation to an important functional issue – the direct representation (or not) of the medical school/faculty on the university senior management team. Anecdotally, there is a strong preference for this newer model amongst Medical Schools, but with potentially opposing views from an institutional perspective.

Clearly, the present cross-sectional survey does not allow an objective assessment of the relative *merits* of any of the different models described here. It does, however, highlight major, persisting differences between institutions whose potential functional impact, we believe, is of sufficient magnitude to justify further work designed to enable such evaluation.

APPENDICES A1 to A10:

Organograms showing the structural organisation of each of the ten universities surveyed and the position occupied by the units responsible for teaching and research in medicine and related subjects (including in particular Biological Sciences)

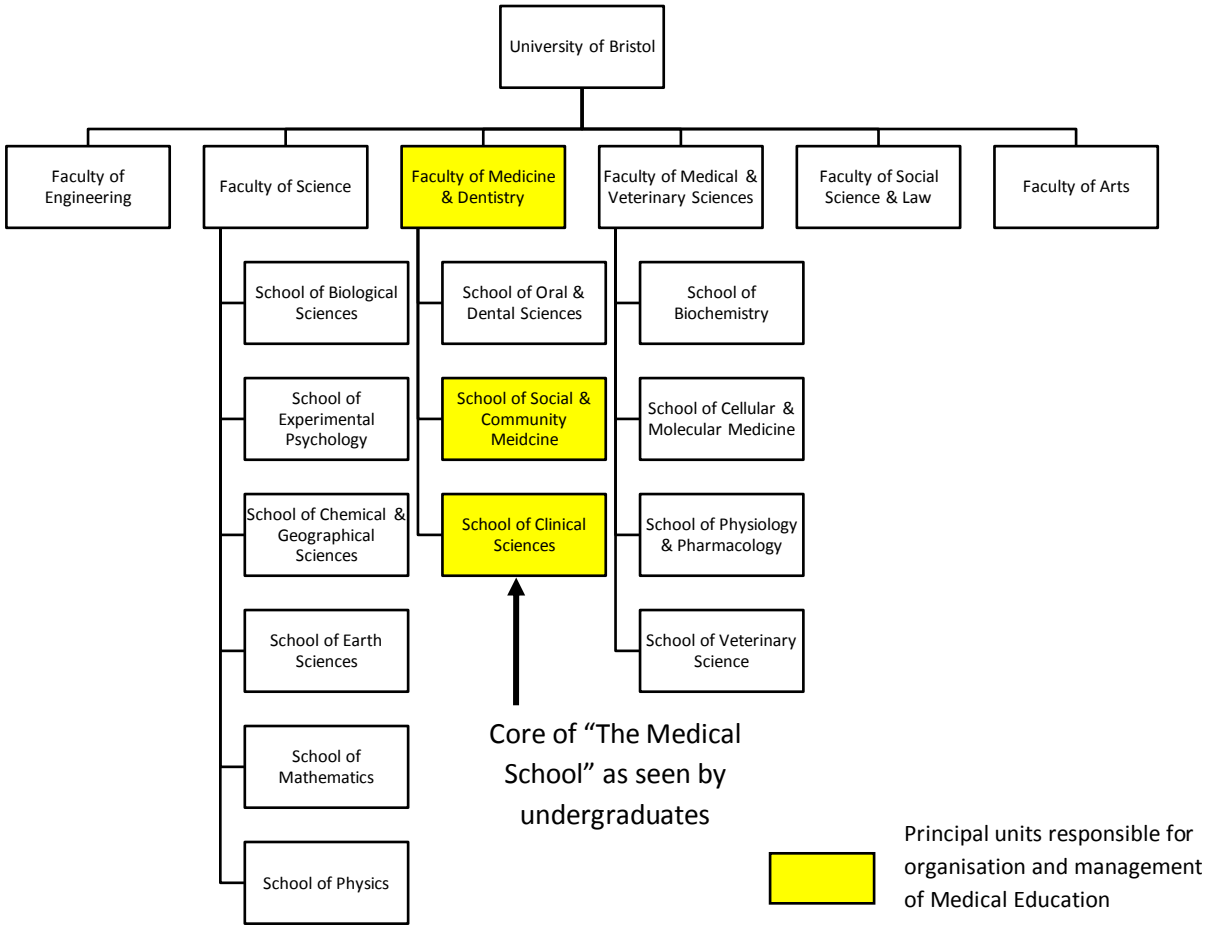
(Note that only top-level information is shown for faculties/colleges not containing biomedical schools or departments.)

KEY:

Principal units responsible for organisation and management of Medical Education

APPENDIX A1:

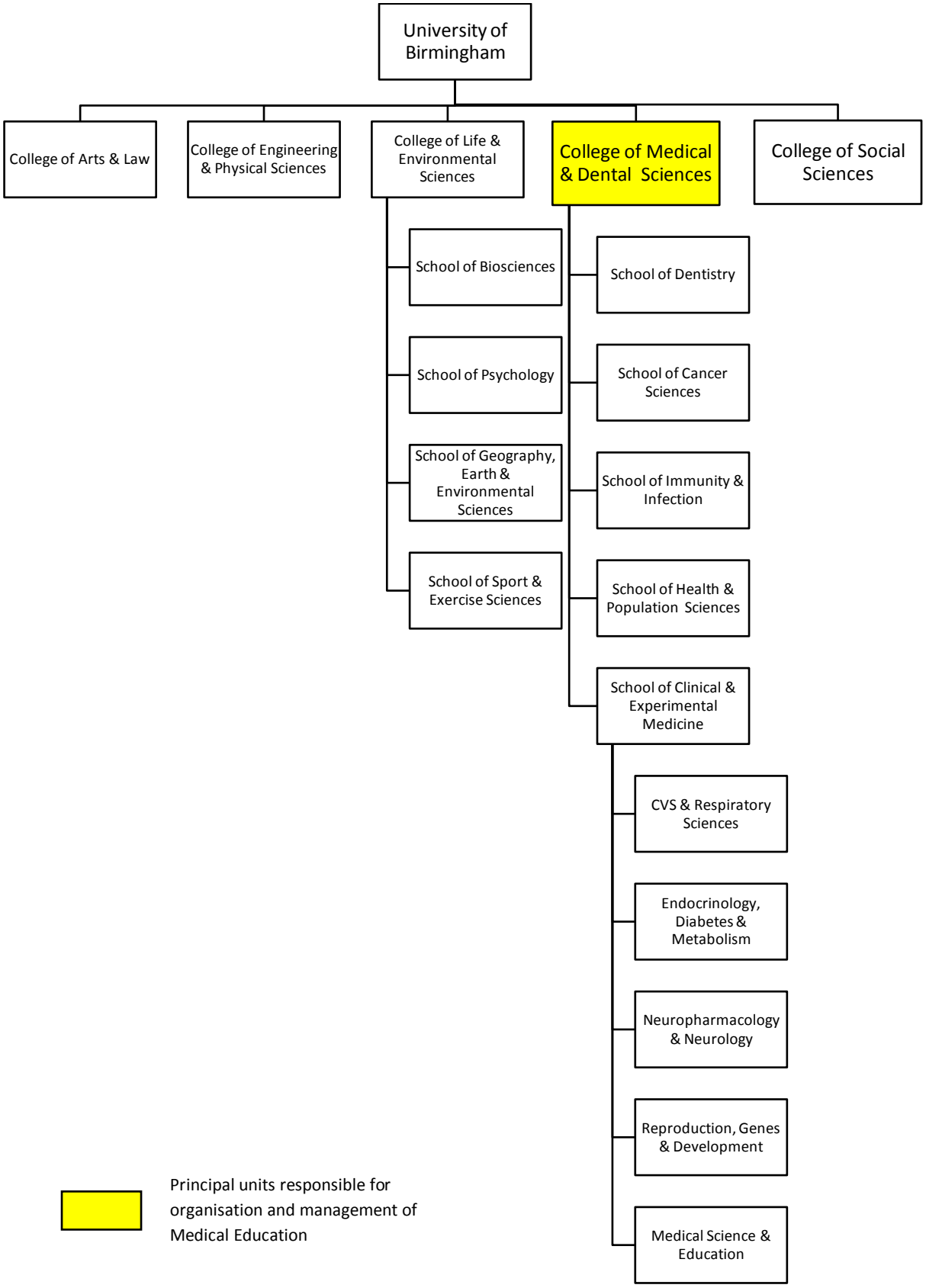
Organogram showing structural organisation and relevant sub-units: University of Bristol



Note: Split of "biomedical" schools across THREE faculties

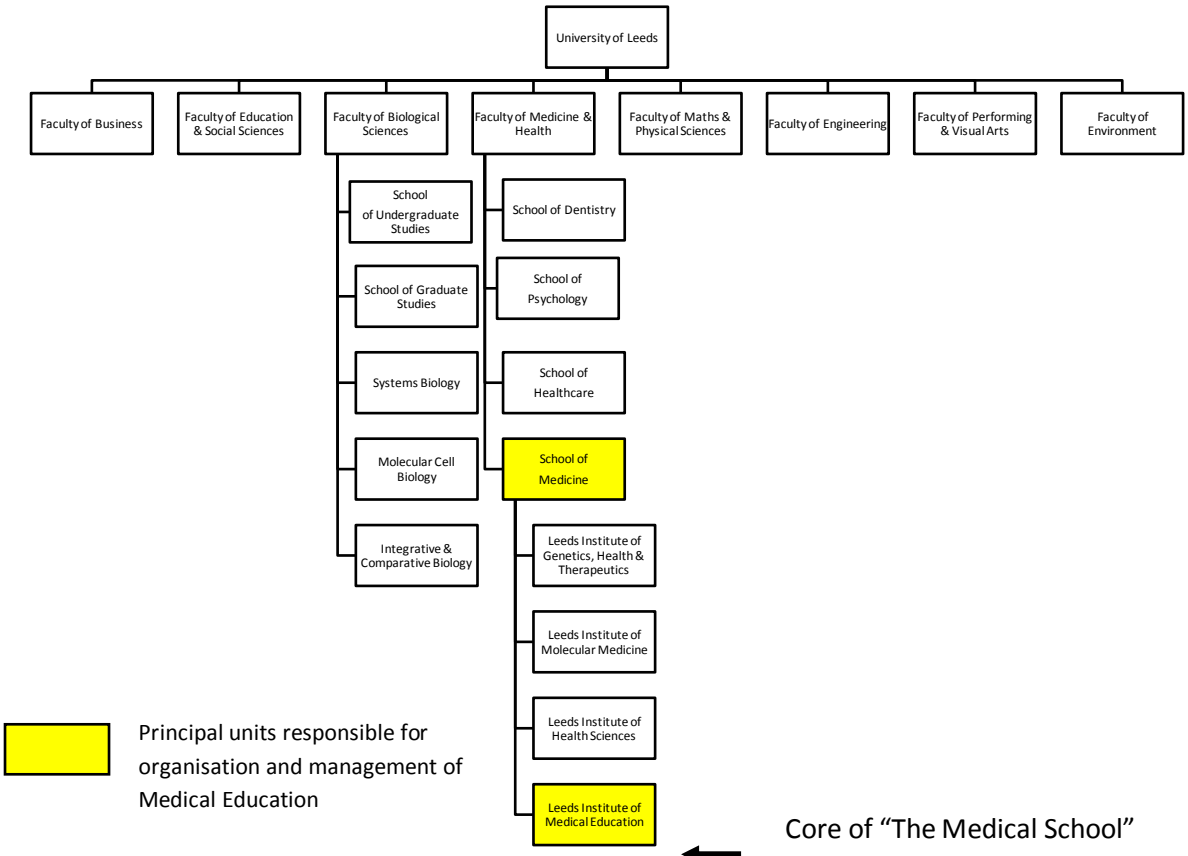
APPENDIX A2:

Organogram showing structural organisation and relevant sub-units: University of Birmingham



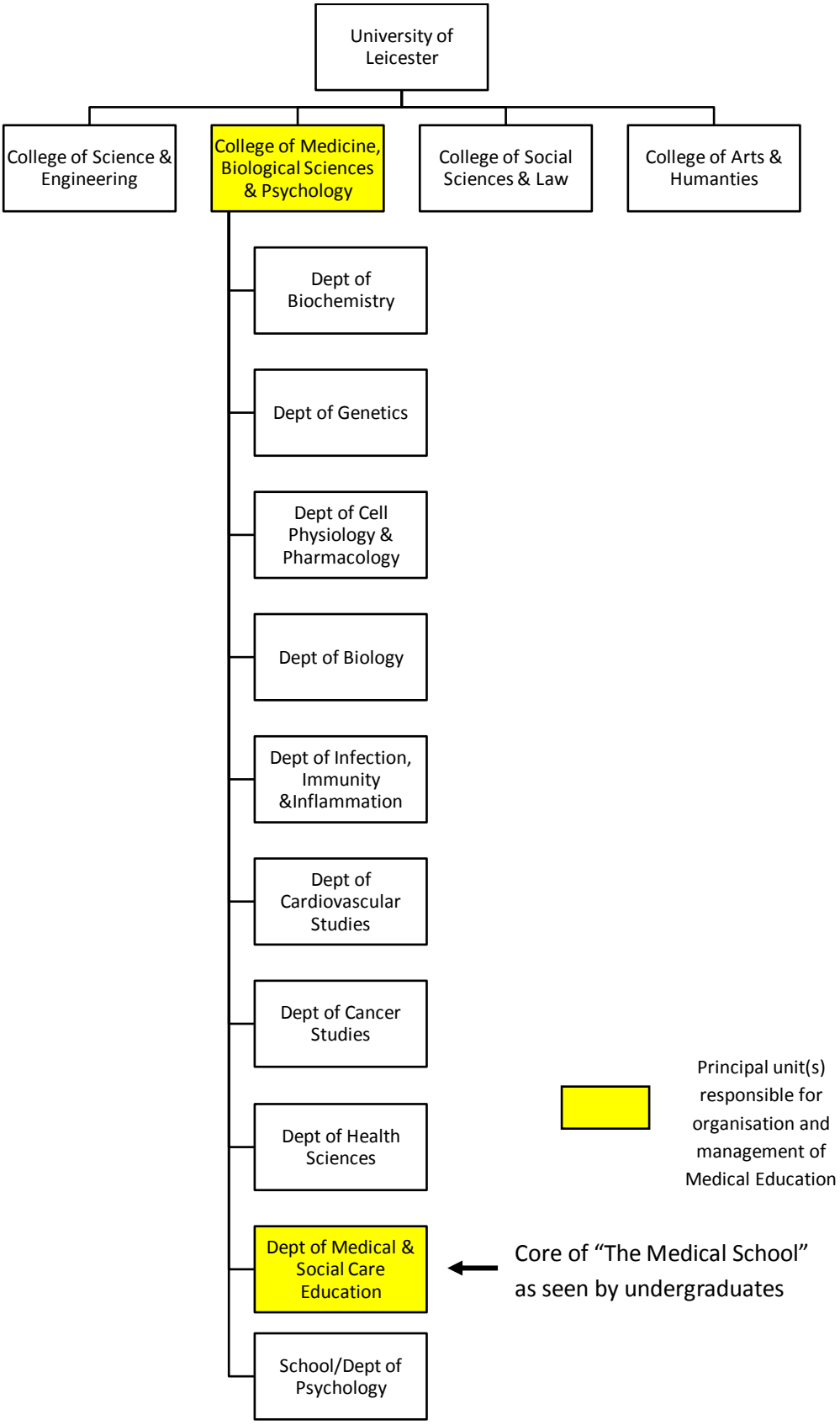
APPENDIX A3:

Organogram showing structural organisation and relevant sub-units: University of Leeds



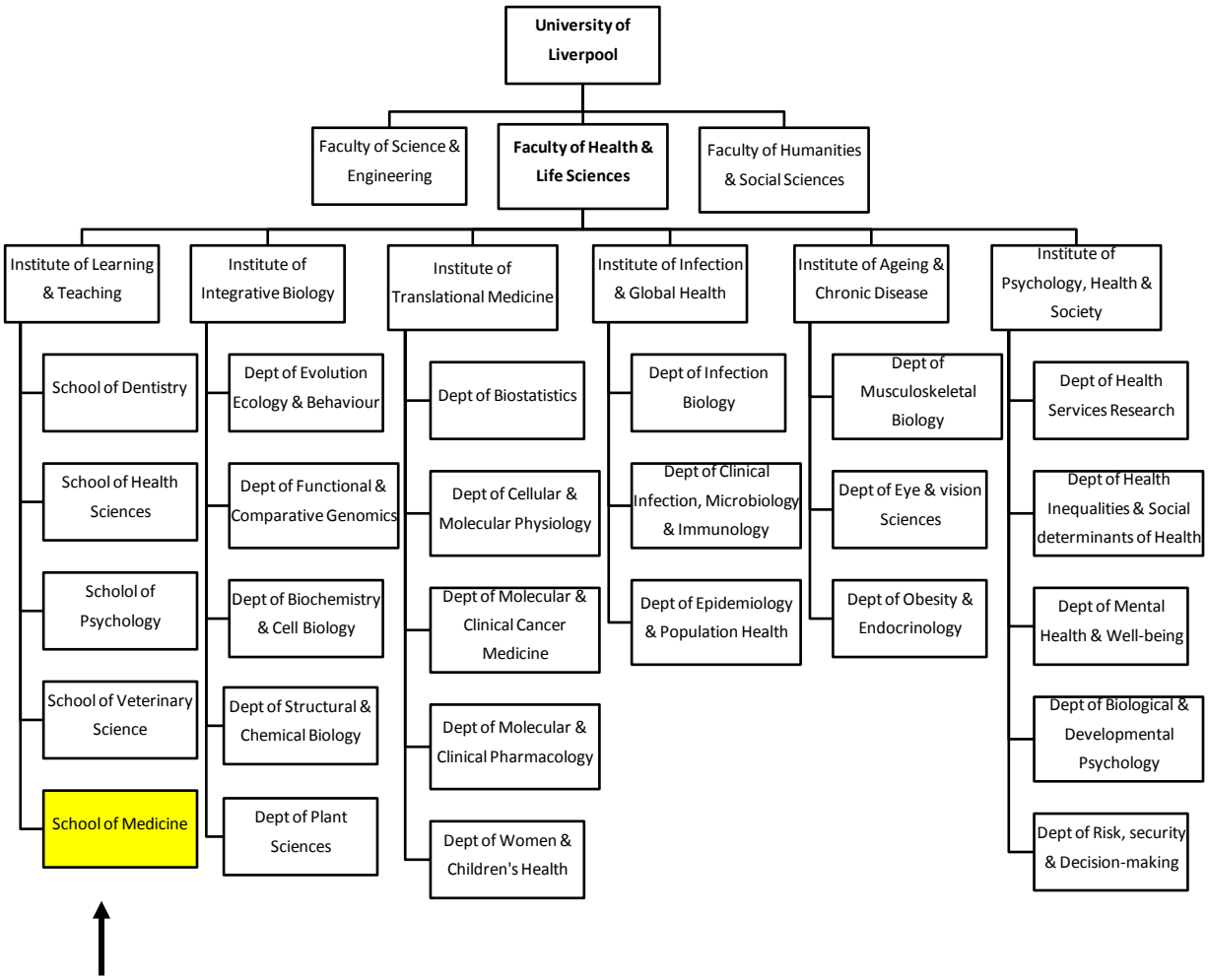
APPENDIX A4:

Organogram showing structural organisation and relevant sub-units: University of Leicester



APPENDIX A5:

Organogram showing structural organisation and relevant sub-units: University of Liverpool

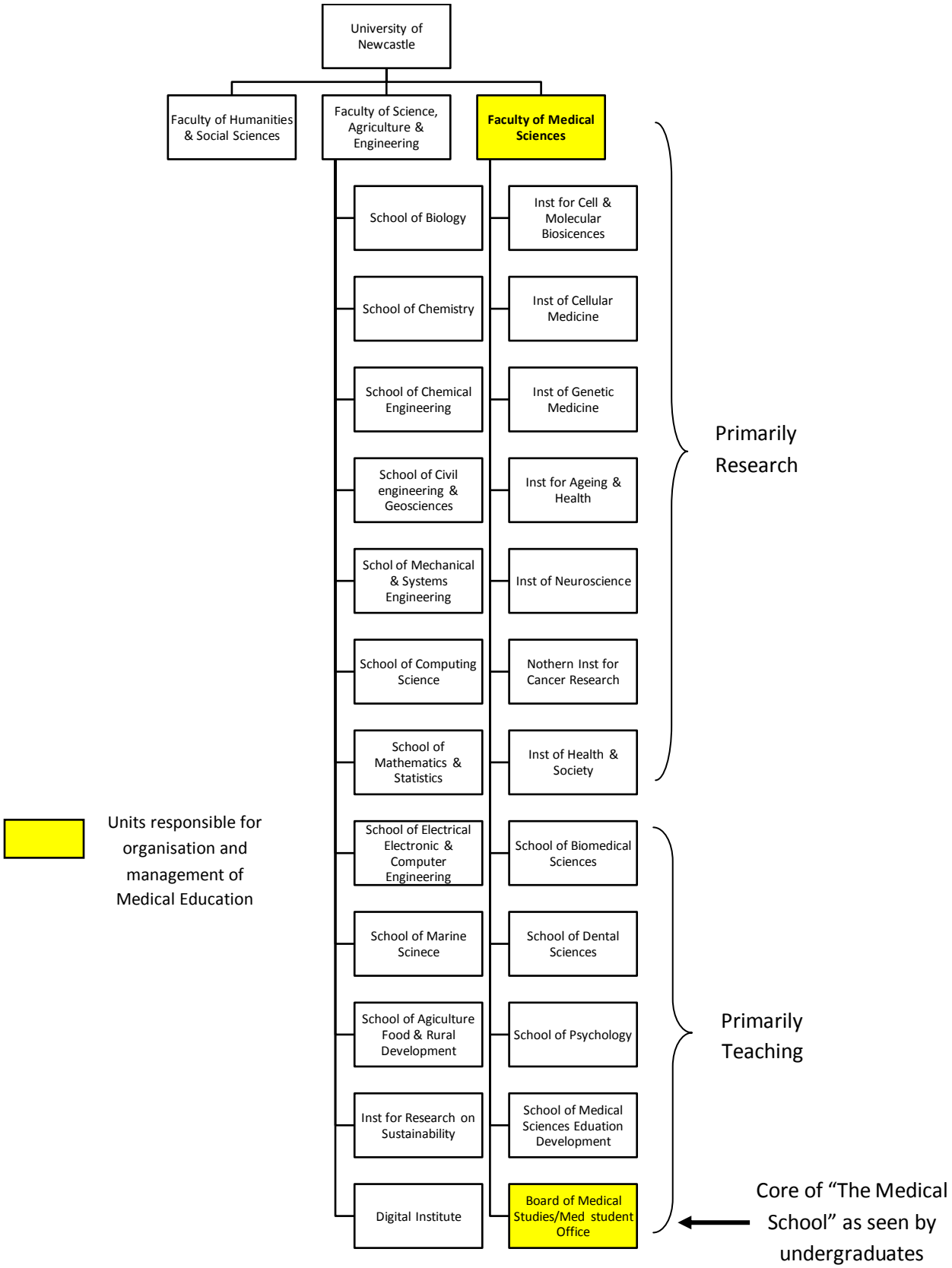


Core of "The Medical School" as seen by undergraduates

Principal unit(s) responsible for organisation and management of Medical Education

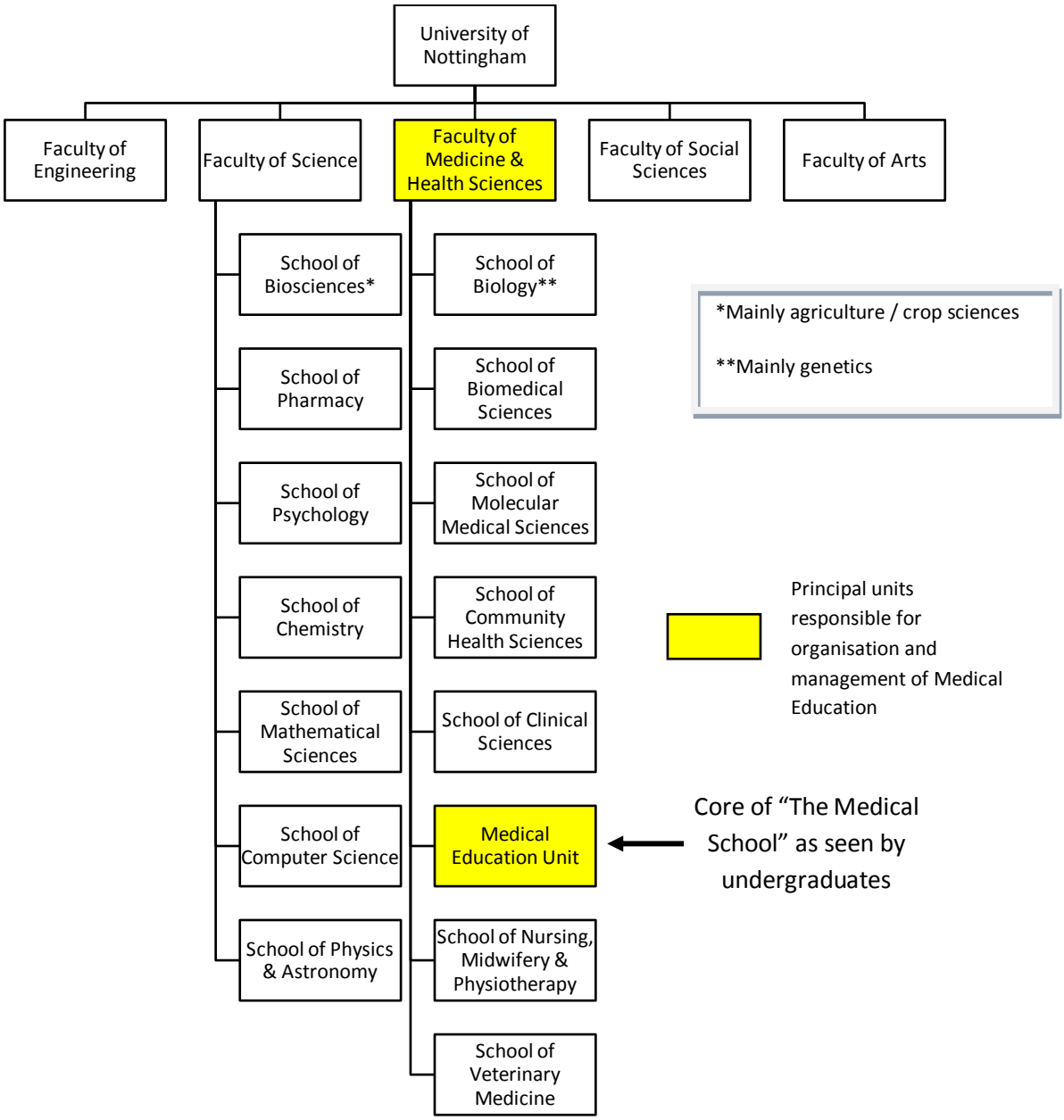
APPENDIX A6:

Organogram showing structural organisation and relevant sub-units: University of Newcastle



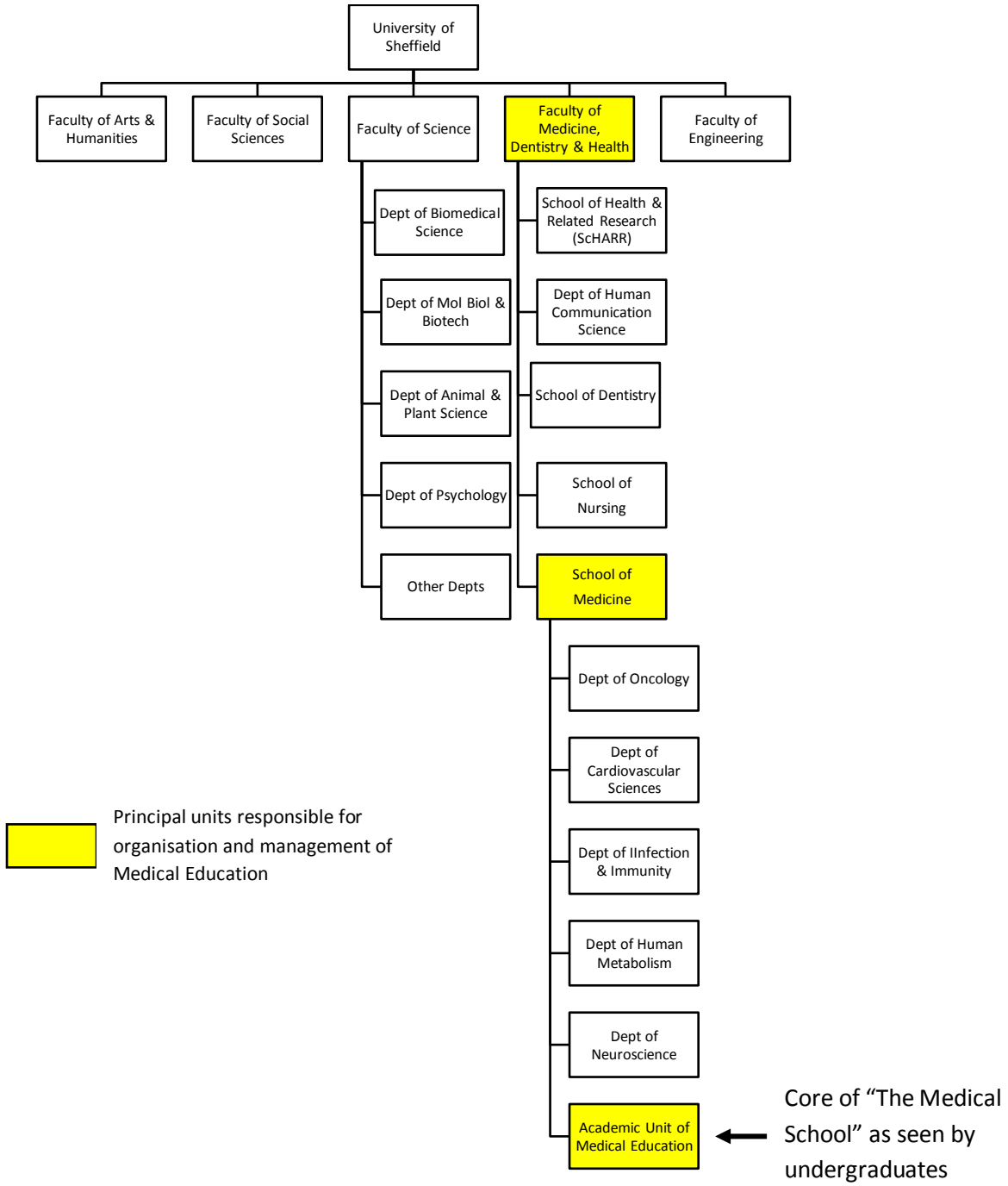
APPENDIX A7:

Organogram showing structural organisation and relevant sub-units: University of Nottingham



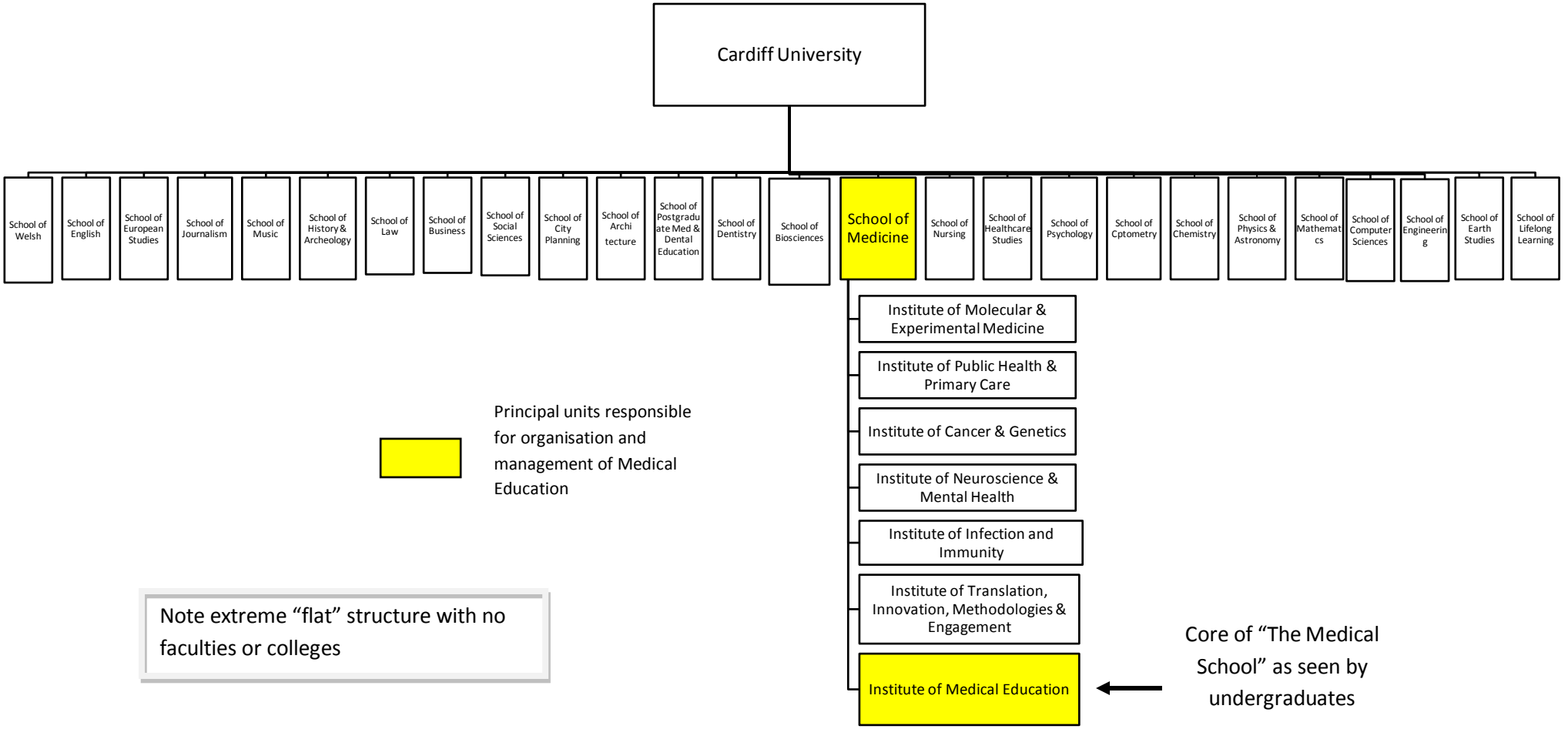
APPENDIX A8:

Organogram showing structural organisation and relevant sub-units: University of Sheffield



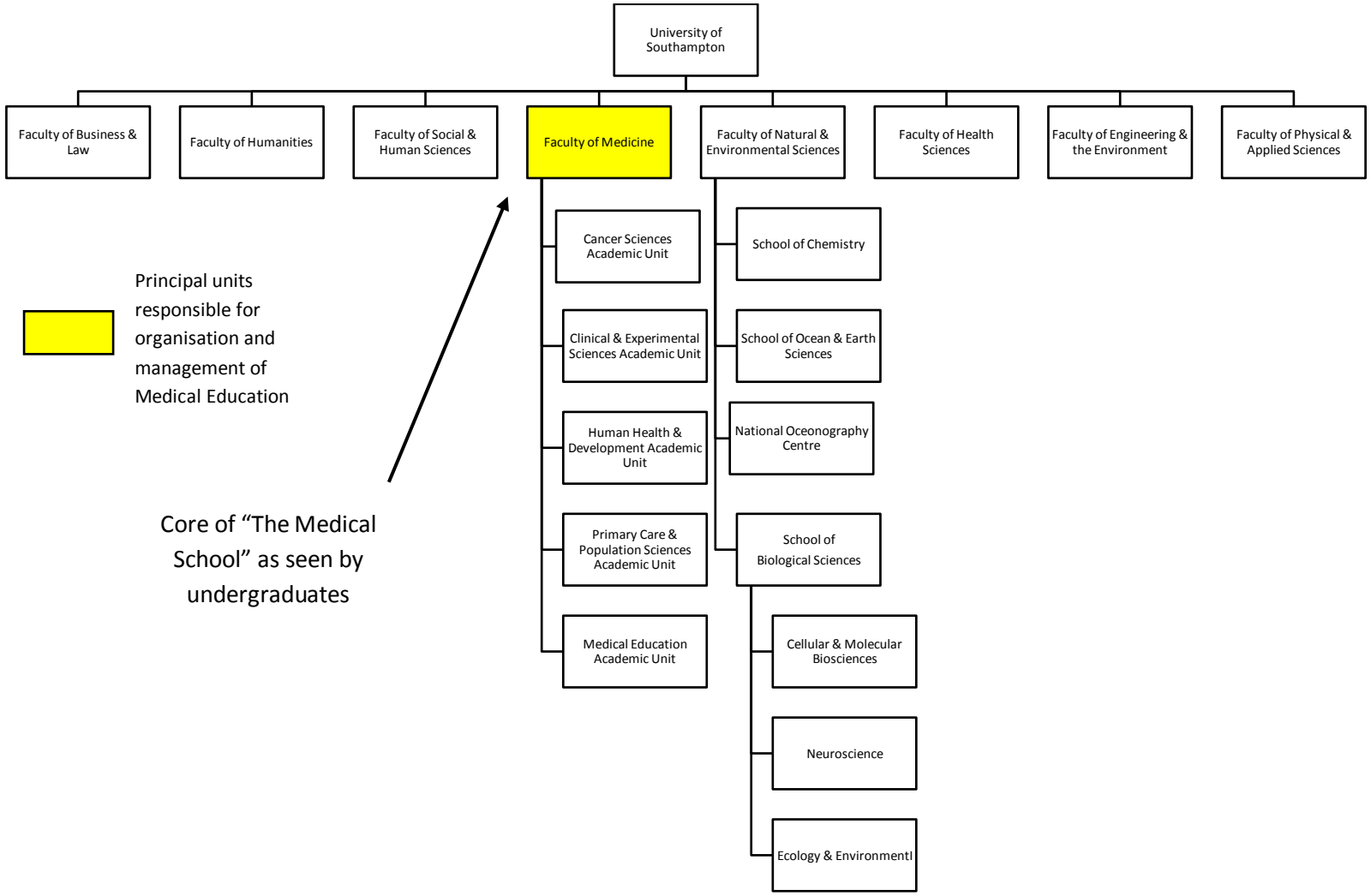
APPENDIX A9:

Organogram showing structural organisation and relevant sub-units: Cardiff University



APPENDIX A10L:

Organogram showing structural organisation and relevant sub-units: University of Southampton



APPENDICES B1 to B10

Organograms based on Appendices A, showing the principal academic posts and reporting lines in the university, drilling down to the level of "Head of Department" or equivalent in the bio-medical faculties/colleges

KEY:

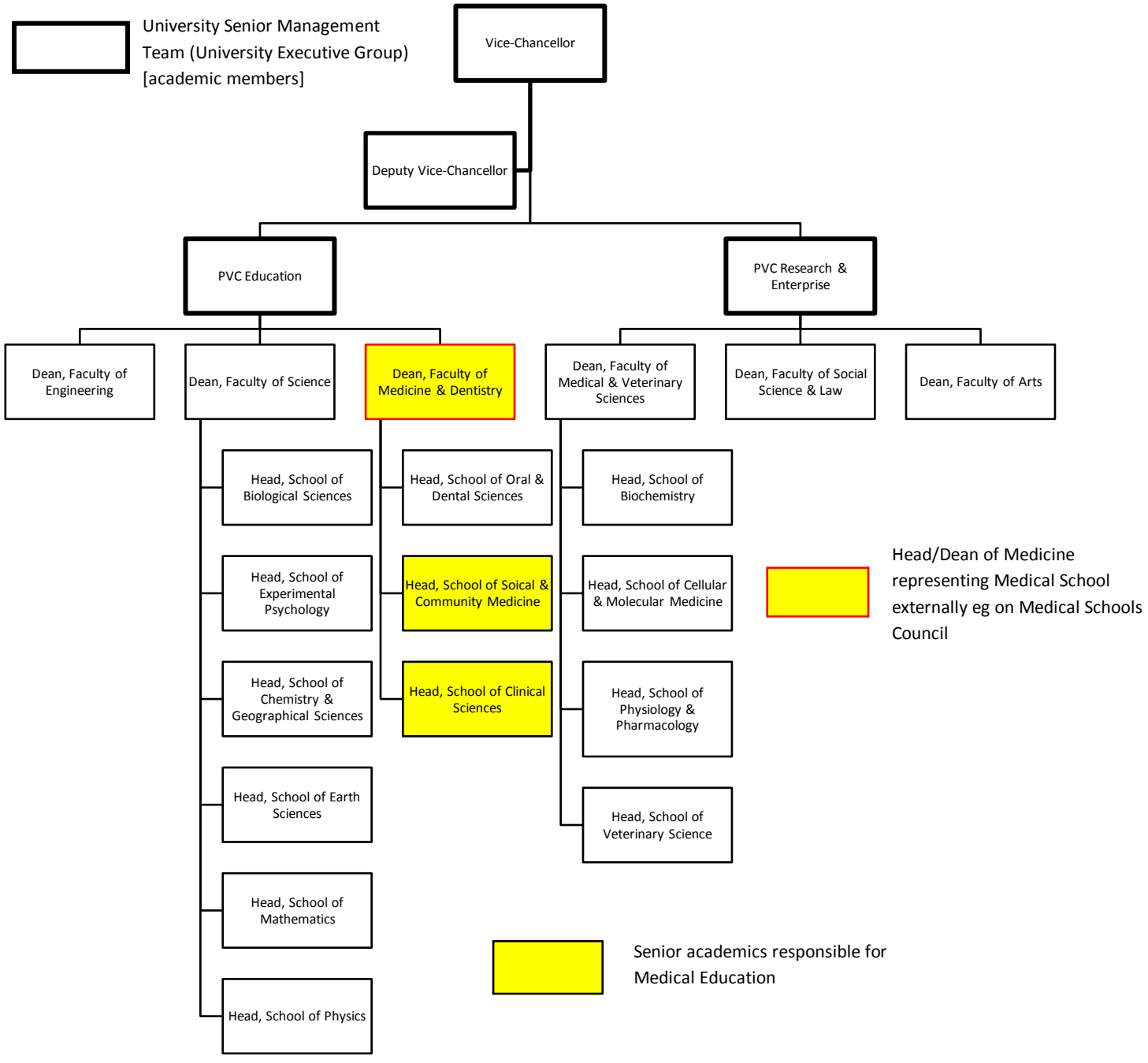
University Senior Management Team (University Executive Group) [academic members only]

Senior academics responsible for Medical Education

Head/Dean of Medicine representing Medical School externally e.g. on Medical Schools Council

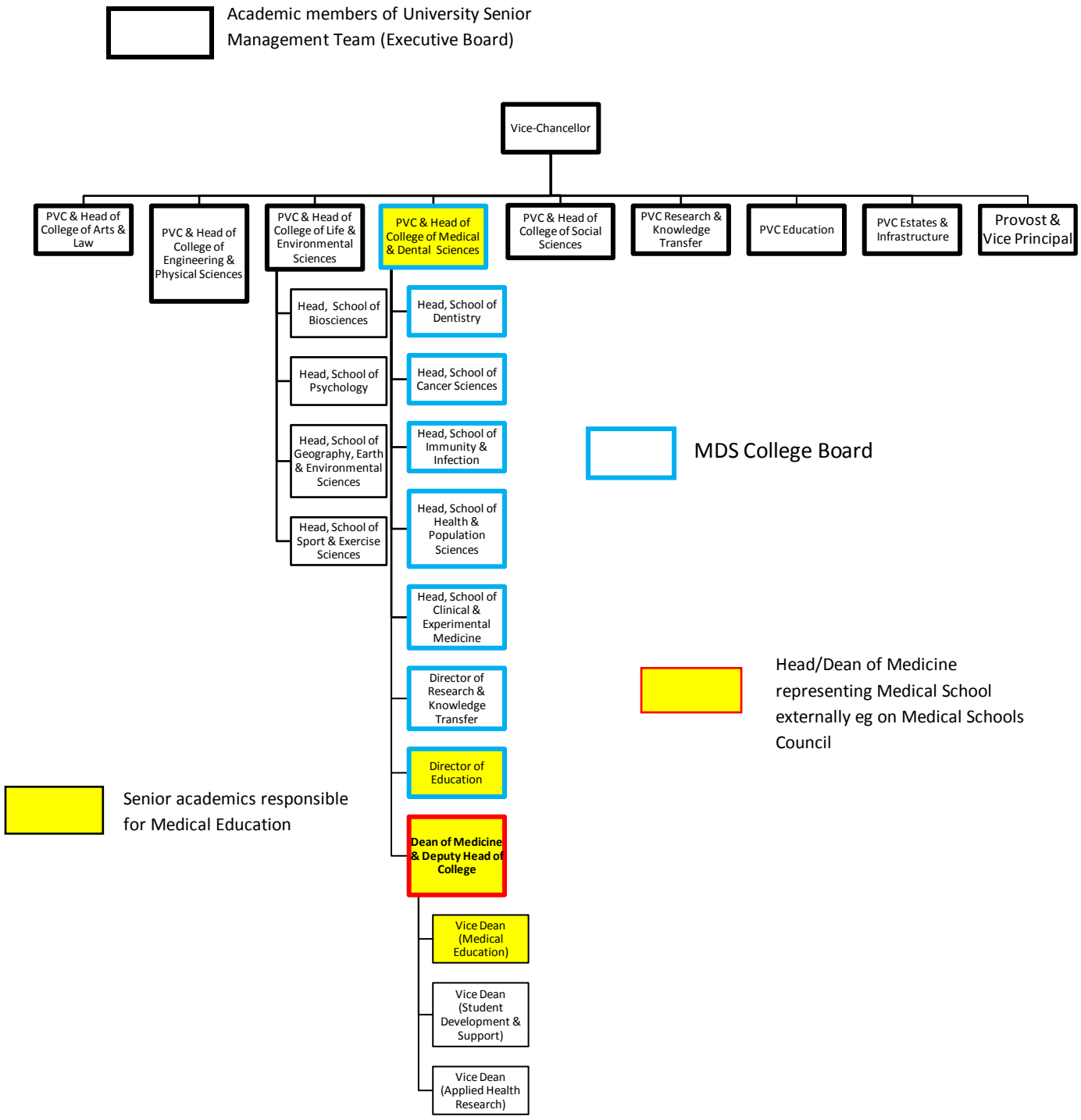
APPENDIX B1

Organogram showing principal reporting lines: University of Bristol



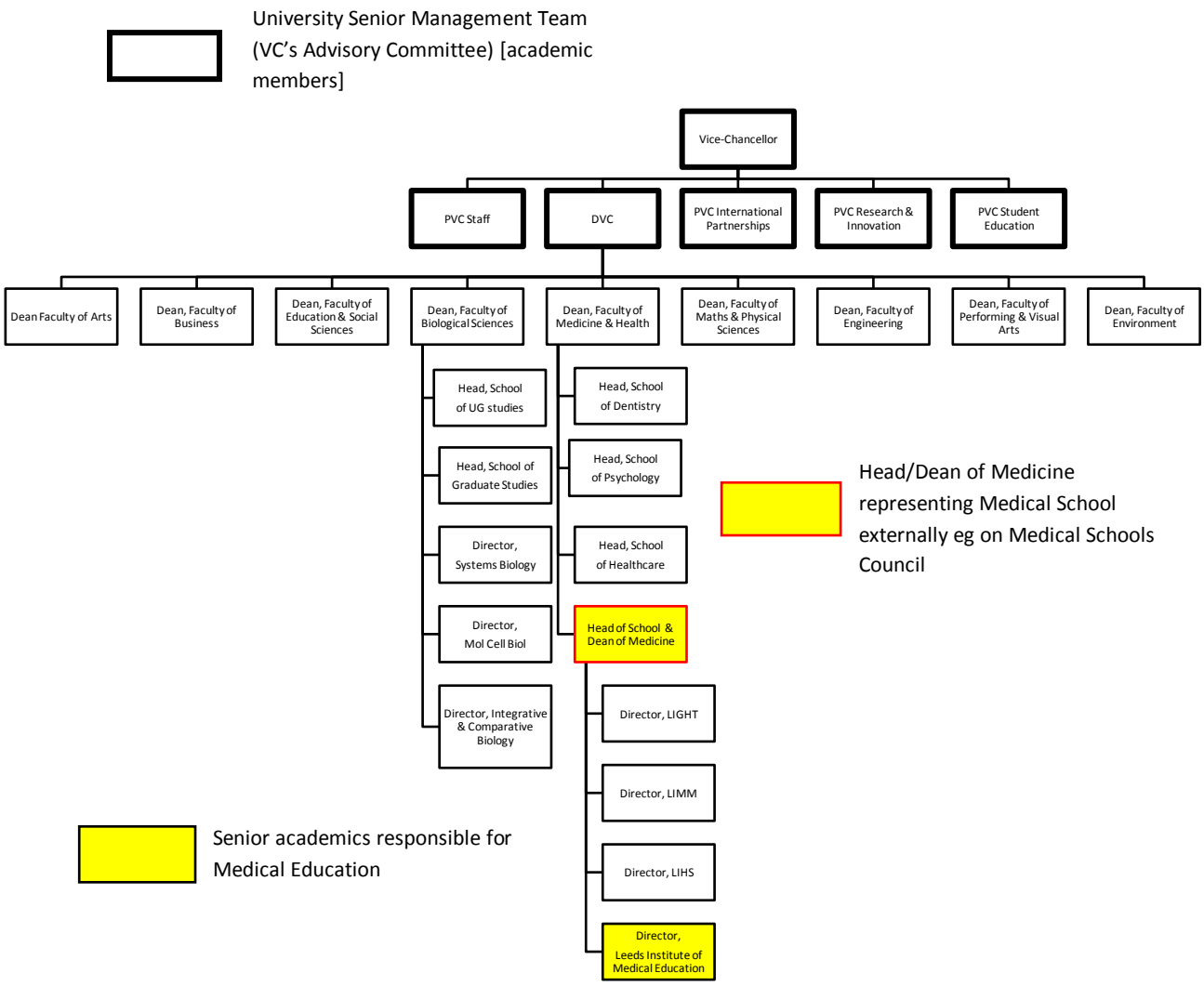
APPENDIX B2

Organogram showing principal reporting lines: University of Birmingham



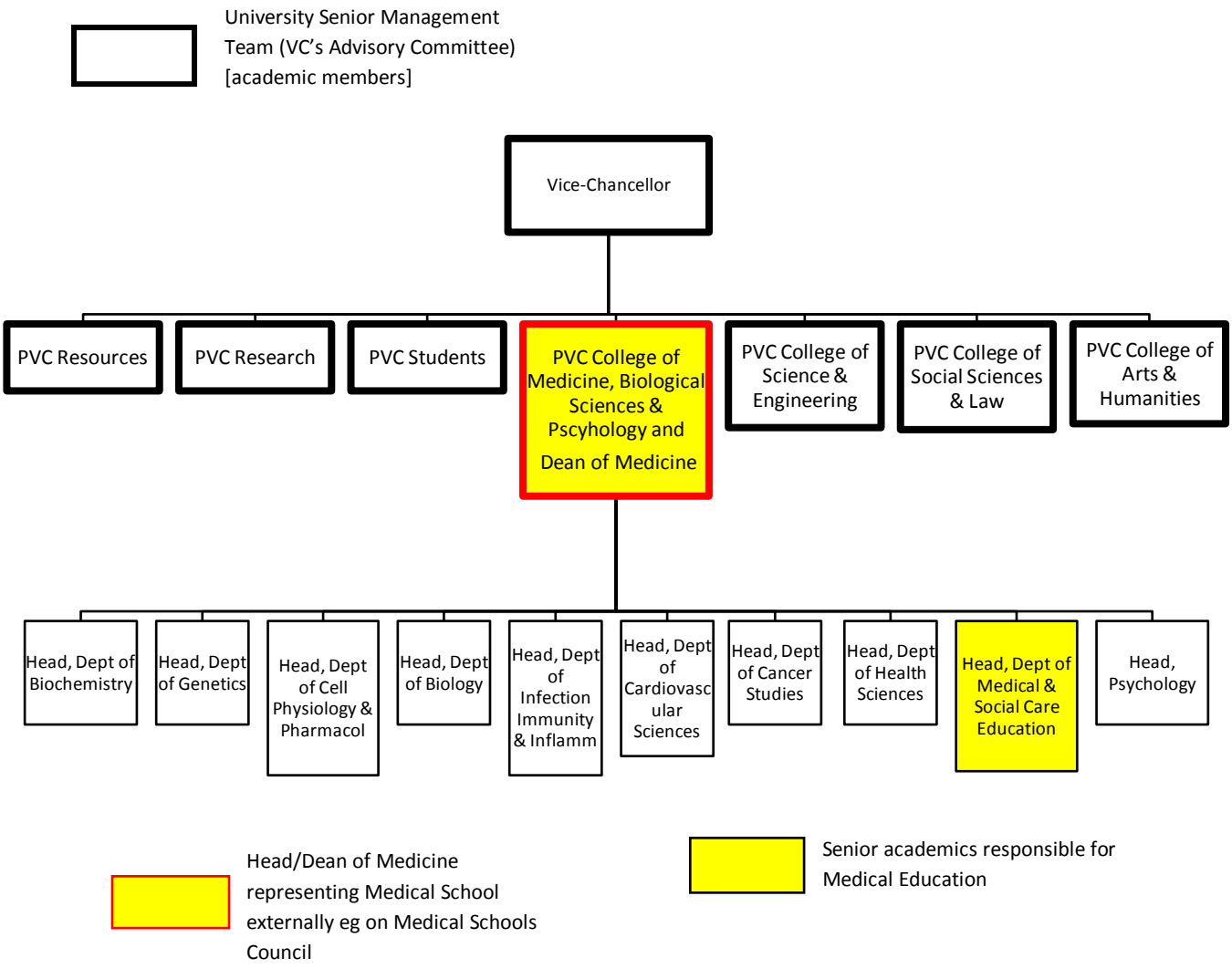
APPENDIX B3

Organogram showing principal reporting lines: University of Leeds



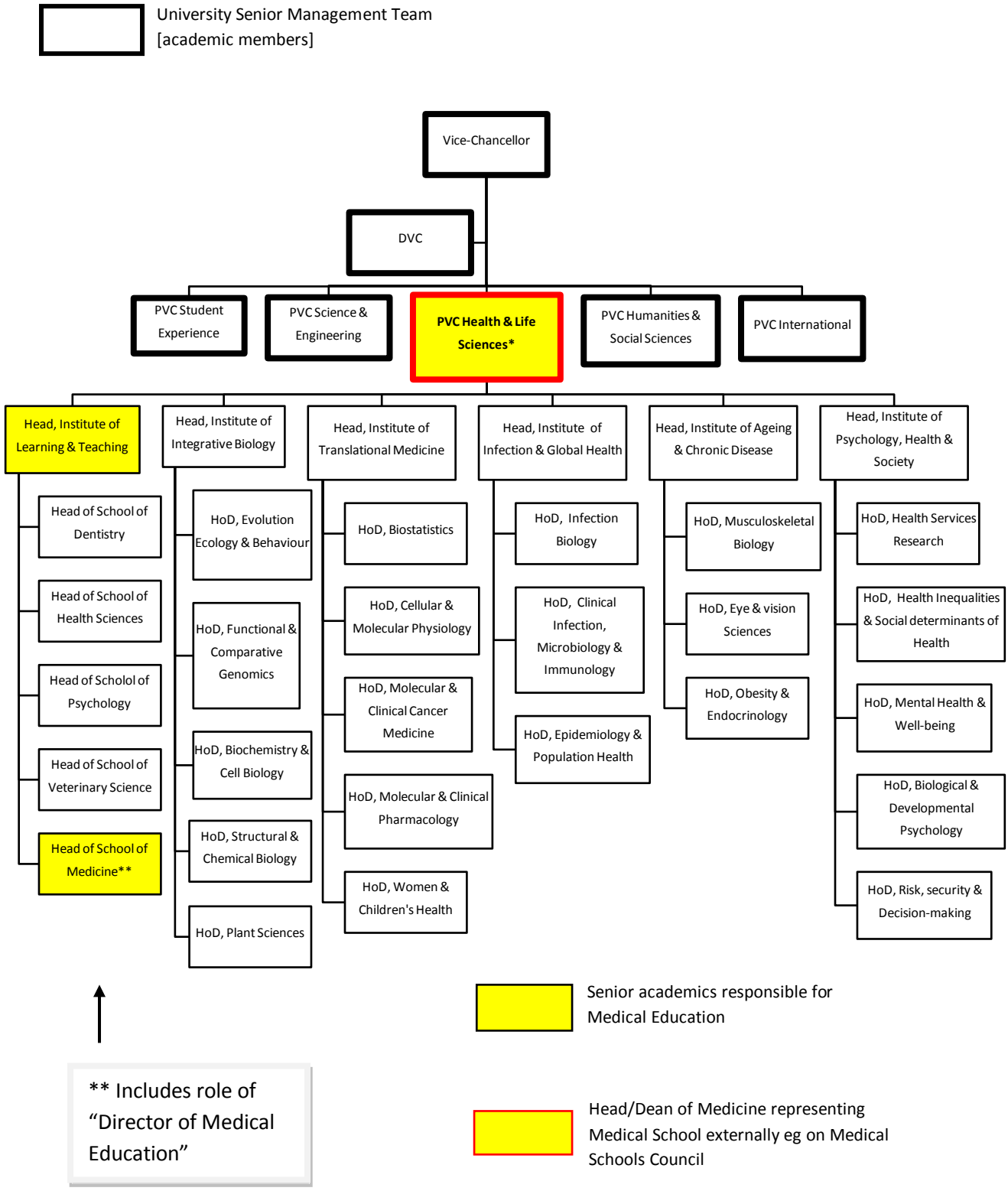
APPENDIX B4

Organogram showing principal reporting lines: University of Leicester



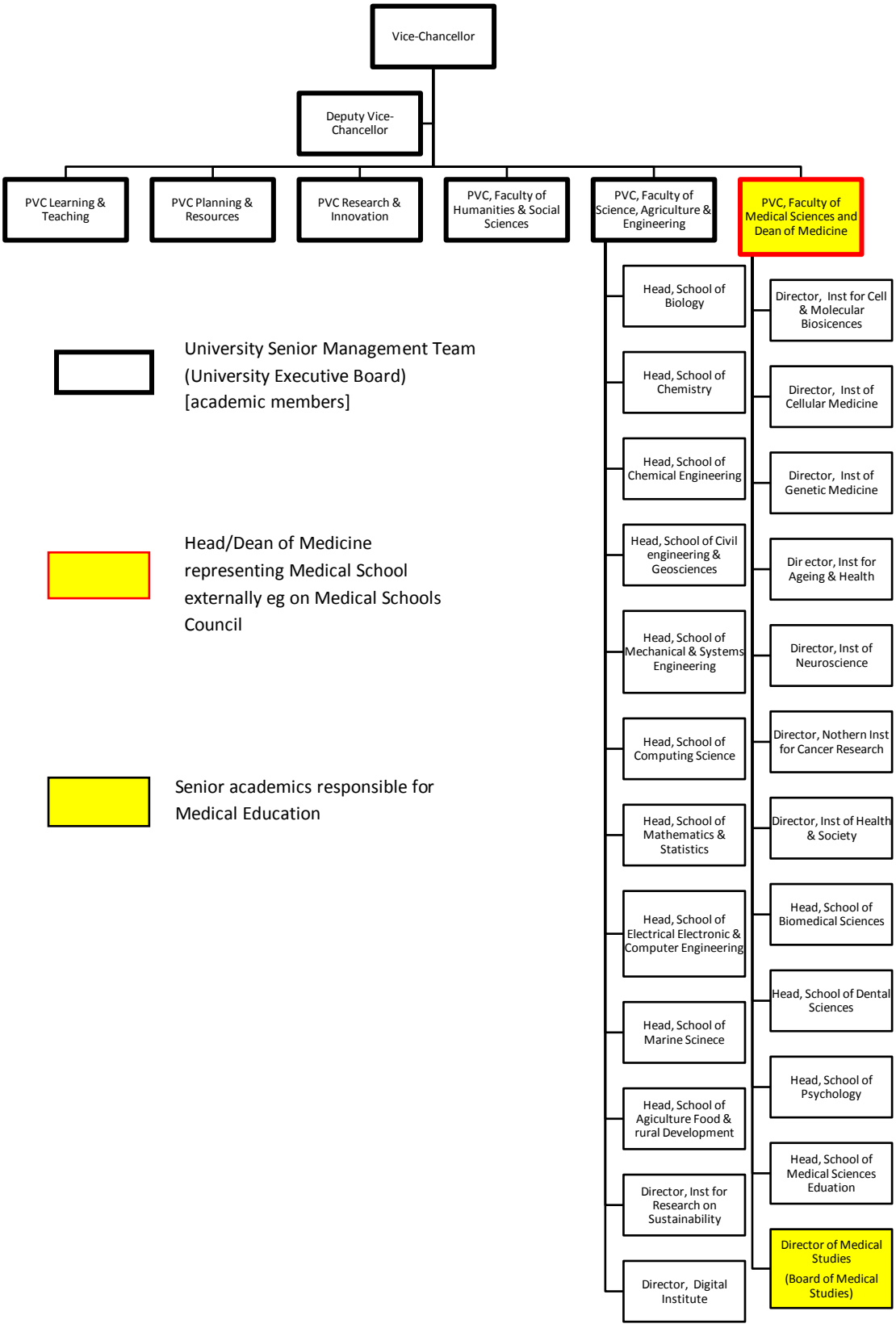
APPENDIX B5

Organogram showing principal reporting lines - University of Liverpool



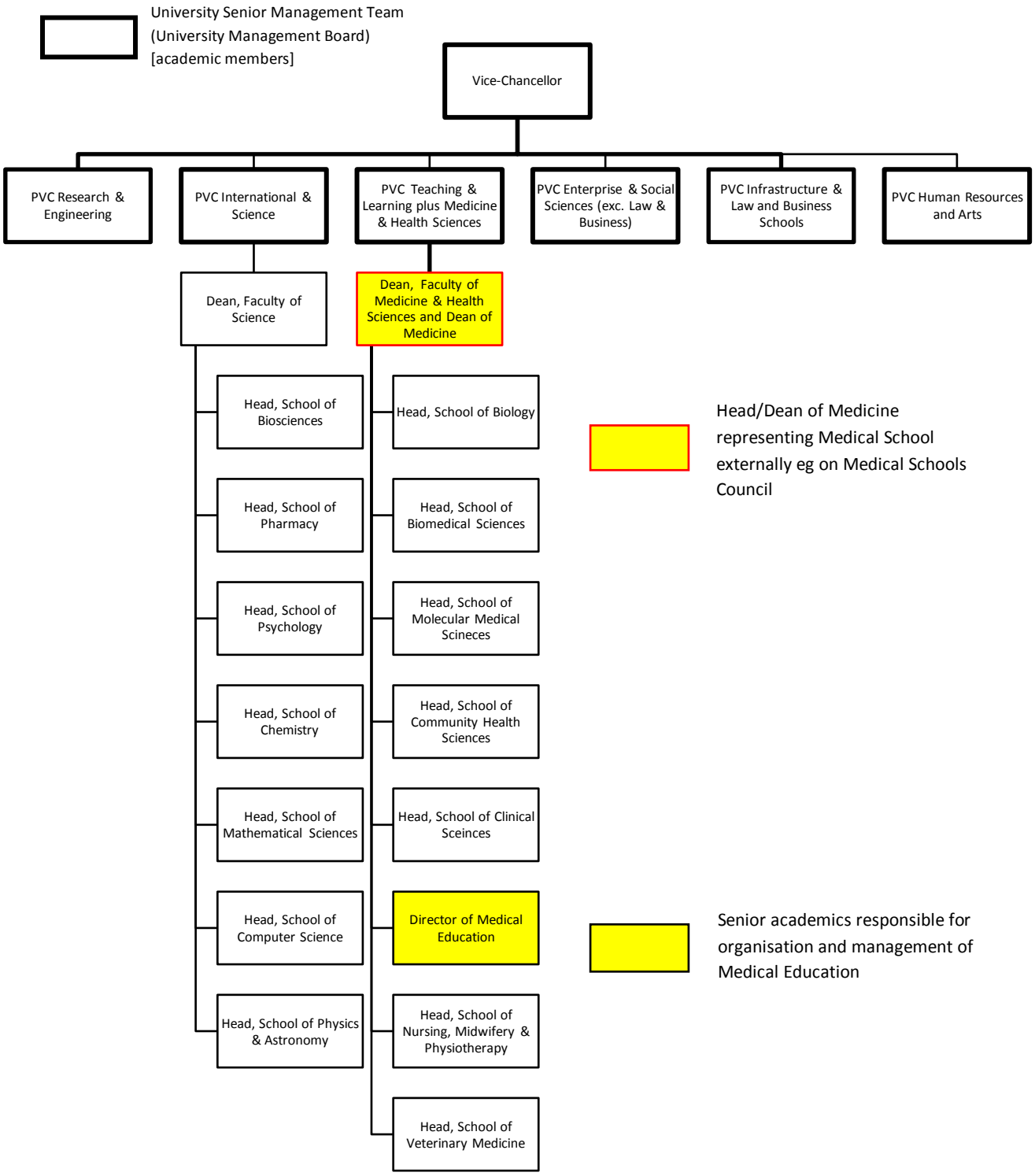
APPENDIX B6

Organogram showing principal reporting lines: University of Newcastle



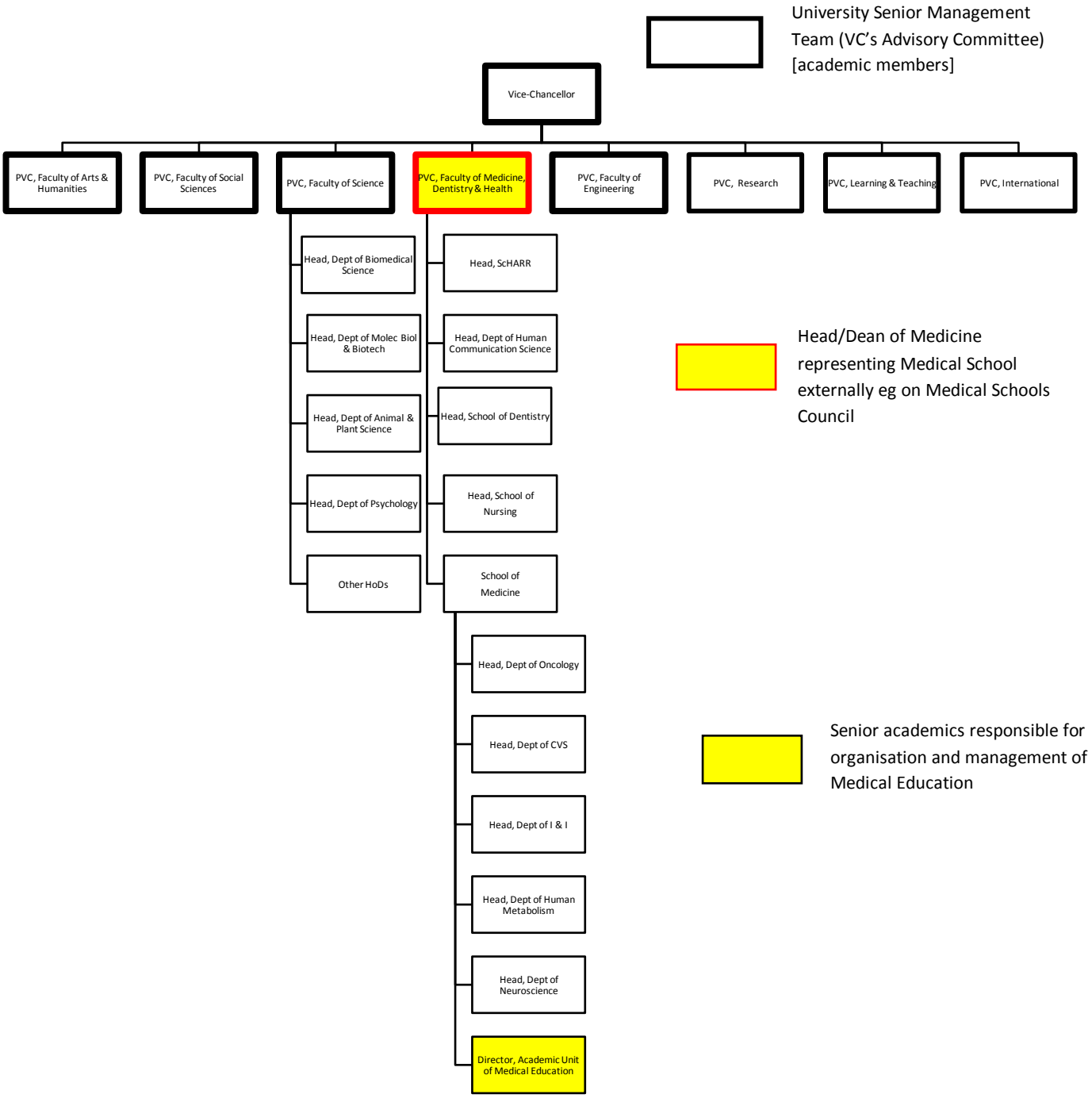
APPENDIX B7

Organogram showing principal reporting lines: University of Nottingham



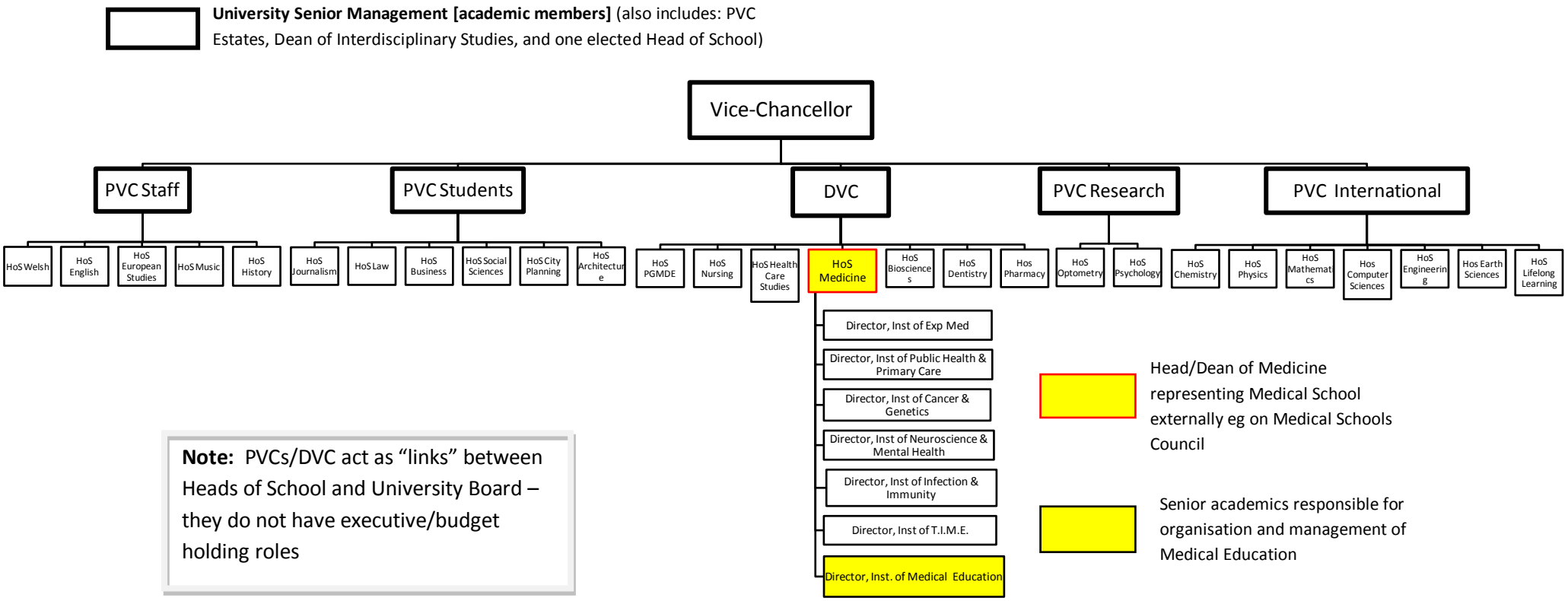
APPENDIX B8

Organogram showing principal reporting lines: University of Sheffield



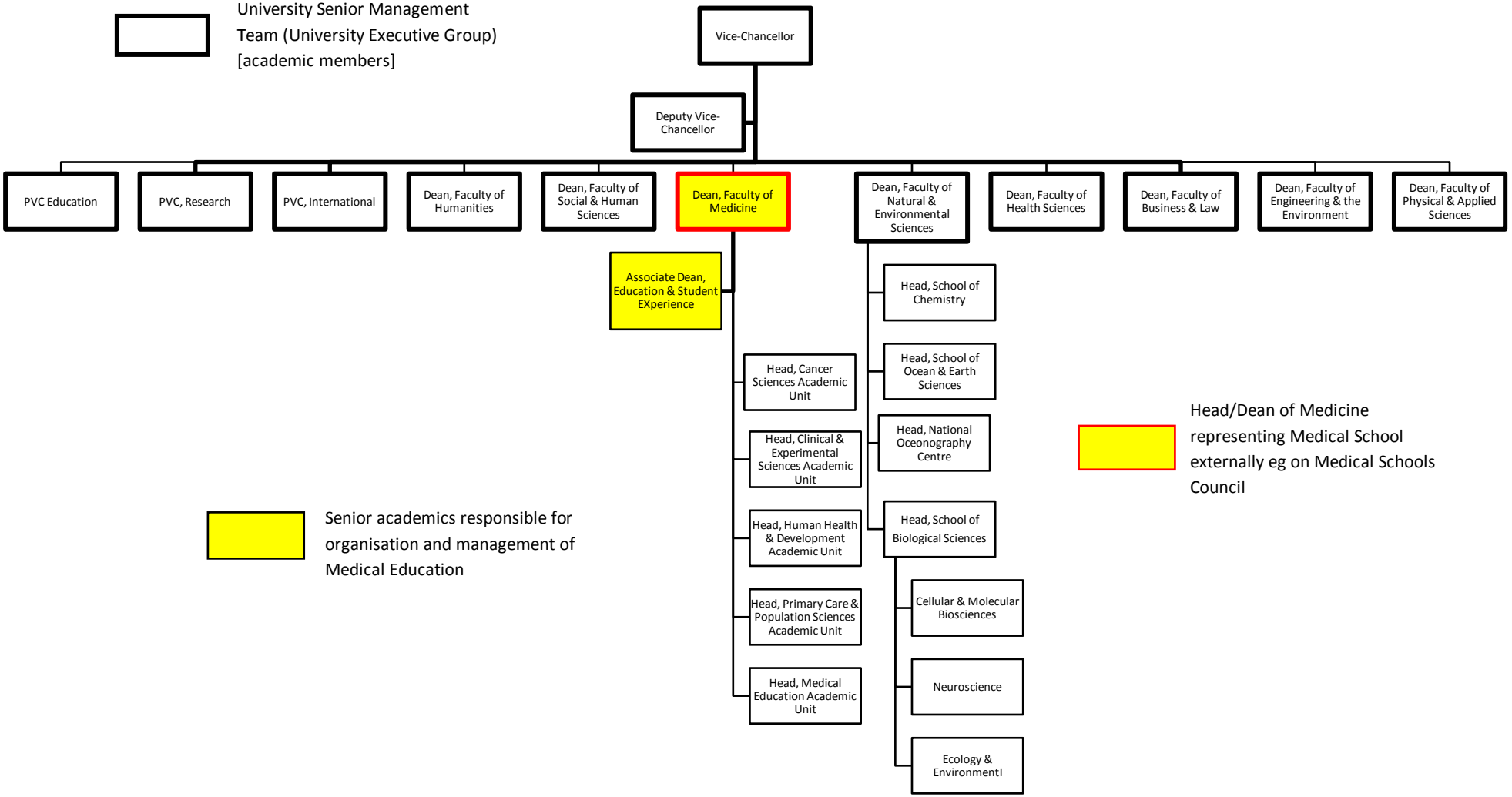
APPENDIX B9

Organogram showing principal reporting lines: Cardiff University



APPENDIX B10

Organogram showing principal reporting lines: University of Southampton



APPENDIX C

Questionnaire sent to Heads of Medical Schools +/- senior administrators

UNIVERSITY / MEDICAL SCHOOL ORGANISATION & MANAGEMENT PROFORMA

Name of University: Click here to enter text.

1. Resources

1.1 To what level are financial resources (budgets) devolved within the University ?

Examples:

College/Faculty, School, or Department

Response: Click here to enter text.

1.2 How is the annual allocation to the above unit(s) determined ?

Examples:

a) on a historical basis, adjusted through an annual "bidding" process managed by a central University budget-setting group, or
b) by a formula-driven Resource Allocation Model linked tightly to the devolved "unit's" financial forecasts of income and expenditure (HEFCE T and QR income etc)

Response: Click here to enter text.

1.3 Once the annual budget is set, what degree of flexibility / autonomy does the devolved unit (and its head) have in deciding how to spend it?

Examples:

a) freedom to spend non-staff as appropriate, but use of staff budget restricted to specific posts approved by "central" university group, or

b) freedom (within the agreed strategic plan for the "unit") to decide on use of all budgets, including changing the "mix" of posts in the staff establishment, and virement from staff to non-staff budgets

Response: Click here to enter text.

1.4 Specifically to what extent does the Dean of Medicine have executive powers over staff budgets?

Response: Click here to enter text.

2. Strategy

How is strategy developed in the University and its Colleges/Schools/Departments?

2.1 At what level in the organisation are key decisions on strategic priorities taken (eg deciding which research fields to focus on - and conversely which to disinvest in; deciding whether to develop a major new teaching programme etc) ?

Examples:

University, College/Faculty, School or Department

Response: Click here to enter text.

2.2 If strategic decisions are devolved (eg to Schools), how are the resulting multiple strategies integrated across the University?

Examples:

a) a "centralised" model – while "wish-list" plans may be solicited from component parts of the organisation, a single University Strategy is produced, with all decisions taken at the "centre" (eg by a University Board or Strategy sub-committee), or

b) a "devolved" model – at the agreed level of devolution (eg School) there is wide freedom to develop strategy (within the devolved budget). The "centre" takes only a light-touch overview to ensure general compatibility with the mission of the University. Apart from special pan-university initiatives, the strategy of the University is largely made up of the sum of the individual unit strategies.

Response: Click here to enter text.

2.3 Specifically, what part does the Dean of Medicine play in strategy development ?

Response: Click here to enter text.