REVIEW AND

MODERNISATION OF

SUPPLEMENT FOR

UNDERGRADUATE

MEDICAL AND DENTAL

EDUCATION

(SUMDE)

Executive Summary

1. In order to produce doctors that will serve the community and meet the expectations of our Health Service it is important that methods and systems are in place to deliver high quality medical education across Northern Ireland. This paper sets out proposals for a revised allocation model to distribute Supplement for Undergraduate Medical and Dental Education (SUMDE) funding.

2. Following reviews and reports by Winyard (1995), Chantler (2004) and Tribal Secta (2006), and in light of work being carried out by England, Scotland and Wales, the Medical Student Management Group (MSMG) agreed to request approval for a review of the allocation model currently in use from the Minister.

3. The principle aim adopted is to modernise the way in which SUMDE funding is distributed, and encourage the strategy that funding should 'follow the student', in an accountable, equitable and transparent manner without destabilising Trusts.

4. Since the expansion of the Medical School in 2005 two separate methods have been used to distribute funding for hospital clinical placement, resulting in cumbersome administration. This review sets out proposals to simplify the allocation model to one method.

5. Summary of Proposals:

   That the exercise be cost neutral for the Total SUMDE budget, no extra monies to be bid for and none to be removed;

   (i) That all models be sourced from the 2008/09 SUMDE Circular allocation;
   (ii) That commissioned student numbers be used as the basis to allocate funds;
   (iii) That student : staff ratios remain unchanged;
   (iv) That one unit of measurement, to be known as a 'Teaching Unit', be used as a currency for remuneration;
   (v) In addition to the 'Teaching Unit' there would be a single £ value for 'on' cost;
   (vi) That no weighting be used;

(vii) That any cost incurred be re-distributed from the Infrastructure (Facilities) allocation;

(viii) That a glide-path of 5 years be introduced to ease transition to a new model.

6. Historically the Belfast Trust has been the major recipient of SUMDE funding. It is understood from the outset of this review that the Belfast Trust would be most affected by any change to the allocation method. The models presented in this consultation paper indicate that in the worst case scenario the reduction to the Belfast Trust is in the range of £1.82M to £2.25M per annum, depending on whether or not a top-slice of £0.5M is removed to cover non-recurrent business case bids. Taken over a 5 year transition period this equates to a cumulative reduction of funds to the Belfast Trust in the range of £360K to £450K per annum. Funding for inflationary uplifts plus additional 5th year medical students that require placement only available within the Belfast Trust, will reduce any redistribution further.

7. This review also offers the opportunity to put in place a formal accountability mechanism, to audit funding streams, and provide assurance that value for money is being met.

8. The future of the Joint Appointment model for Clinical Academics is also under review. It has been agreed that this topic should be examined outwith this review, and that a sub-group should be created in order to give the subject the consideration it merits.

9. It is anticipated that any revised model could be actioned through the SUMDE Circular in the 2010/11 Financial Year.

10. This consultation paper invites comment from all interested parties before **20 May 2009.** To this end a questionnaire is attached at Annex 5. The questionnaire may be completed electronically and submitted by email to the address given in Section 14.

1.0 Introduction

1.1 All undergraduate student doctors require clinical placement in order to complete their training and continue on the road to become junior doctors. Clinical placement is only available on the front-line, namely in hospitals and general practices. Supplement for Undergraduate Medical and Dental Education (SUMDE) is a mechanism which is used to fund the additional costs to the Trusts (and hence Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI)) that are associated with medical and dental student teaching in clinical settings.

1.2 Initially introduced in 1992 and known as Supplement for Teaching and Research (STAR), the mechanism was reviewed in 1993/94 and has been known as SUMDE in Northern Ireland (NI) since 1996/97. The apparent discrepancy in the Infrastructure (Facilities) costs between the different Trusts in NI has largely arisen because of historical issues relating to concentration of clinical teaching in the Belfast area. The revision of the curriculum and redistribution of students province-wide, alongside the changing roles of clinical academics and NHS consultants, has highlighted the need to review the possible imbalance between students and funding. Implementation of a revised methodology for the distribution of SUMDE funding should take cognisance of possible financial destabilisation.

1.3 The equivalent funding in England and Wales is known as Service Increment for Teaching (SIFT) and in Scotland it is known as Additional Cost of Teaching (ACT). In 1995 the Winyard Report recommended that SIFT should be divided into two types of funding:

(i) Clinical placements (20%) – education based in NHS hospitals or general practices, and driven directly by the presence of students. Such funding would vary each year;

(ii) Facilities (80%) – to support undergraduate teaching to include other NHS resources which would not be required for healthcare alone and may include tangible assets and human resources. These are typically fixed, though are subject to inflation.

The Winyard recommendations have largely been accepted across the UK and the majority of funding for undergraduate medical education has followed the concept of an 80:20 split of facilities:placements.

1.4 This paper aims to set out the thinking behind the SUMDE review. In the face of a changing world with respect to healthcare needs, and the changing curricula of medical schools, one of the objectives of the DHSSPS is to support high quality medical education across NI. Therefore it is critical that methods and systems are in place in order to train high quality doctors that will serve the community and meet the expectations of our Health Service. The aim of this consultation paper is to find a solution that provides funding to assist with this objective in an equitable and transparent manner for all providers.

Dental SUMDE will not be included in this paper. A review of Dental SUMDE has been ongoing for a period of time and will report separately.

1.5 Comparison with England, Scotland and Wales suggests there is sufficient money in the system to fund SUMDE, the issue is how it is distributed. This exercise is driven by a recognition that we need to get a better match between student numbers and the allocation of funding. We are not driven by a goal of making savings on the SUMDE budget, nor are we in a position where we can commit new resources to SUMDE, other than the growth in funding that has been indentified by Additional Medical Students (refer to Section 3.2).

1.6 It is recognised that the issue at stake is not just an educational one. Other circumstances exist that must be considered when reviewing the existing system. For example, under-investment in the facilities required to deliver the educational curriculum has resulted in a capital deficit in existing facilities.

2.0 Terms of Reference

2.1 To examine the methodology for the SUMDE funding allocation to ensure transparency and consistency, and to agree a 'currency' that would define how SUMDE is valued. The broad principle that funding should 'follow' students should be adhered to.

2.2 Measurement of funding – determine and agree whether any weighting of the agreed 'currency' is required to ensure equity in the application of any new system.

2.3 To determine what amount, if any, should be provided for Infrastructure (Facilities) costs (indirect SUMDE).

2.4 To ascertain if the total spend on SUMDE is appropriate benchmark evidence from England, Scotland and Wales will be drawn upon.

2.5 Consideration of Primary Care costs.

2.6 To review funding control mechanisms.

2.7 To review how teaching is delivered.

2.8 To consider the future of the Joint Appointments system and develop alternative options.

2.9 Management of the transition to the new method of SUMDE to ensure that financial stability of the HSC system is not threatened.

3.0 Background and Current System

3.1 The Medical School

The Queens University, Belfast (QUB) School of Medicine, is a forward-looking Medical School with internationally recognised strengths in both Research and Teaching. The university works closely with Health and Social Services Boards and Trusts, and with General Practices to develop the highest standards of clinical service for the community. QUB has radically changed the organisation of education and has created a new medical school which brings together Medicine, Dentistry and Biomedical Sciences. It is known as the School of Medicine, Dentistry and Biomedical Sciences (SMDBS).

3.2 Medical School revenue funding streams

The main revenue funding stream for the Medical School is the teaching income that the University receives, and which is derived from the number of students in relevant price bandings. Historically (and prior to 2005) the Department for Employment and Learning (DEL) provided funding to QUB for the then full cohort of 154 students. However when it became clear that there was a need to expand the Medical School, the DHSSPS bid for additional funding to cover the cost of 96 new students, with the result that funding was split between DEL and DHSSPS. Technically DHSSPS secures adequate funding to cover institutional costs, student support costs, and SUMDE for 96 'additional' students, and DEL provides for the remaining 154 of the annual 250 cohort. To simplify the process, DEL administers all the funding allocations, other than SUMDE, to QUB, and throughout the year invoices DHSSPS for their contribution. DHSSPS then reimburse DEL through technical transfer of funds.

In addition QUB is reimbursed for 50% salary costs for joint appointment clinical academics via SUMDE Trust allocations.

The current annual target intake for "home and EU" resident medical students is 250, with an additional 12 places for overseas students. Overseas student places arise from Queen's participation in the internationalisation strategy for medical student training. SUMDE is limited to the 250 commissioned places.

3.3 SUMDE – funding to support teaching in HPSS

SUMDE is paid to Trusts and GP practices which incur additional costs associated with teaching medical and dental students. SUMDE has three main categories:

(i) Joint Appointment funding (50% of clinical academics);

(ii) Medical SUMDE;

(iii) Dental SUMDE (not to be included in this Review).

Medical SUMDE has two main elements: Student placement funding, and Infrastructure (Facilities) funding. Student placement funding also encompasses the cost of teaching by GPs.

3.4 SUMDE – application

As a number of institutions have an interest in SUMDE it is essential that the level of funding and its application is straightforward, transparent, and accountable, and that value for money can be demonstrated.

The allocation of SUMDE is based on a historical arrangement to fund the additional costs required by the organisations involved in the provision of teaching. Currently, the use of most SUMDE funding is not transparent. All stakeholders need to be assured that the funding stream can be followed and be satisfied that it being used appropriately.

Detailed work is required to consider the allocation system for current SUMDE. At present funding of around £1.5M associated with New SUMDE for 96 additional medical students (refer to Section 3.2) is distributed in a way that is more transparent and accountable – the New SUMDE figure will rise to around £2m by 2009/10. This review now needs to address clinical placements, capital and other costs associated with both the direct and indirect costs of teaching students under SUMDE.

4.0 SUMDE Review – The need for change

4.1 The method of distributing funds fairly to Trusts must be fit for purpose. The current system that is used to allocate the vast majority of SUMDE funding is overly complex and it is not clear to stakeholders how the funding is used or if it is used appropriately. England, Scotland and Wales are currently reviewing funding for undergraduate medical student placements. These are at various stages with the Scottish model being the most advanced. All the reviews share common objectives.

4.2 The expansion of the medical school allowed for the introduction of a new method of allocating funding – the "teaching unit". New SUMDE costs for clinical placement were the same overall, but the method of distribution was simpler. Importantly, how New SUMDE is used should prove to be more transparent and can be subjected to audit.

4.3 It has become clear that it is inappropriate and inefficient to run two methods for allocating SUMDE funding in the long term. It has been proposed that one, less complex and more straightforward model should be used. This review allows for an in-depth examination of current practice and the development of a new model. It also provides an opportunity to examine the following in more detail:

(i) Joint Appointment system;
(ii) Infrastructure (Facilities) funding;
(iii) An agreed audit programme.

4.4 Following the Department of Health Medical Workforce review in 2003, Sir Cyril Chantler was asked to review the funding levels and relationships in Northern Ireland between the Medical School, DHSSPS, DEL and the Trusts. The Chantler Report of 2004 stated that:

- 'Costs attributed to SUMDE should be subject to audit, and trusts and GP practices should be accountable for their application of SUMDE funding. Furthermore detailed work should be undertaken to consider the allocation system for current SUMDE and also alternative options for the allocation of new SUMDE associated with additional students, including the implications of any proposed change in the system.

- There should be a Joint Management Board to oversee the management of the joint appointment system. This should aim to improve the management, clarity and flexibility of the joint appointment role, and ensure accountability with regard to funding streams.'

4.5 In 2005 the Capitation Formula Review Group (CFRG), which is responsible for researching and recommending updates to the Department's resource allocation formula, commissioned research into 3 aspects of Acute Hospital Costs. One of these strands was undergraduate medical teaching costs. The researchers, Tribal Secta, were asked to provide an analysis of the distribution, allocation and adequacy of SUMDE funding.

4.5.1 Tribal Secta concluded the following:

- 'In the year of study (2004/05) £24,000 per student per year was distributed by DHSSPS to support undergraduate teaching. This did not include the costs of clinical academics.
- The level of funding could not be assessed as being too high or too low in Northern Ireland as no studies have been conducted locally to map the direct resources used in teaching (staff time, facilities, consumables, etc) to the various teaching related activities (tutorials, assessments and laboratory work supervision).
- In NI 85% of funding of hospitals is fixed – that is, not variable according to the volume of teaching delivered. This favours the two major Belfast-based teaching hospitals, the Royal Victoria and Belfast City. This situation arises mainly because the Royal Victoria and Belfast City receive additional payments amounting to £5m recurrently in 2008/09. This funding was introduced to cover Infrastructure (Facilities) related to teaching at a point when the number of students at these hospitals was reduced. The aim was to give the hospitals time to adjust their costs downwards given the new situation and there is concern that these funds could now be subsidising patient services. The researchers could not make any direct link to additional teaching costs incurred that would warrant payments of this magnitude.

Tribal Secta concluded that there was an inequitable distribution of available SUMDE funding between the providers of undergraduate teaching.'

Note: It has been agreed that the additional £5M payment will not form part of the current SUMDE review and was erroneously labelled within the Tribal Secta report.

4.6 All Reviews commenting on SUMDE have questioned whether there is equity within the distribution of funds.

5.0 Benchmark exercise

5.1 Summary – England (SIFT)

5.1.1 The equivalent of SUMDE in England is Service Increment for Teaching (SIFT) Levy. SIFT has two purposes:

(i) to ensure that the NHS supports undergraduate medical and dental education;

(ii) to ensure that service providers who contribute significantly to undergraduate medical and dental education are not financially disadvantaged.

Funding for Department of Health (DH) education and training in England is issued as part of overall budgets to the Strategic Health Authorities (SHA), and is labelled Multi-Professional Education and Training (MPET).

5.1.2 The MPET budget is the means by which the DH funds the costs of SHA strategic investment in education, training and development of the health and social care workforce. There are various elements to the allocation of the MPET budget, including the distribution of the funding for Student Grants Unit (SGU) (5th year medical education) through Non Medical Education and Training (NMET). The various elements are:

(i) Medical and Dental Education Levy (MADEL): relating to postgraduate education. For 2008/09 this has been based on 2007/08 figures plus incidentals and uplifted for inflation;

(ii) Medical Service Increment for Teaching (Medical SIFT): relating to undergraduate education. For 2008/09 this has been based on 2007/08 figures adjusted for changes in student numbers and uplifted for inflation;

(iii) Dental Service Increment for Teaching (Dental SIFT): allocations based on historical funding levels for students already in training, and by a fixed placement rate of £25K per student commencing study in Autumn 2005, all uplifted by inflation;

(iv) Non Medical Education and Training (NMET): money allocated to SHAs to invest in non medical education and training. Mostly spent on commissioning undergraduate and diploma (pre-registration) education for nurses, midwives, Allied Health Professionals (AHP) and

Health and Social Care workers. It also includes funding for the cost of NHS bursaries paid to health students via the SGU. Allocations are historically based on need measured by numbers in training.

5.1.3 Since April 1996 SIFT has been raised by a national levy on health authorities. SIFT supports the additional costs incurred by NHS organisations in providing clinical placements for medical and dental undergraduates.

5.1.4 A review of MPET is underway and is at the stage of gathering information from SHAs. The review is expected to be completed in time to inform the 2010/11 MPET allocations. It is likely that all SIFT will be rebased as it is clear that SIFT is incorrectly balanced and not appropriately utilised. Much of the SIFT allocations are based on historical bids uplifted by inflation, which has heavily advantaged many large teaching hospitals to the disadvantage of other smaller and more specialised hospitals, and this along with single tariff payments, is being examined by the review team.

5.1.5 The key indicator for England at present is:

(i) 2008/09 Medical SIFT £844.9M with 18,521 students. Average cost per student = £27K

5.2 Summary – Scotland (Medical ACT)

5.2.1 The equivalent of SUMDE in Scotland is Additional Cost of Teaching (ACT), where Medical ACT relates to Medical SUMDE and Dental ACT relates to Dental SUMDE.

5.2.2 A review of Medical ACT was performed by NHS Education for Scotland (NES) and following consultation NES introduced a new allocation model in 2005 and a Performance Management Framework for Medical ACT in 2006. Two components identified by the Framework will in future enable NES to performance manage the significant amounts of Medical ACT funding embedded in historic patterns of service delivery and funding:

(i) Measurement, against national performance standards, of the quality of undergraduate medical teaching delivered within the NHS, through the use of student evaluation of NHS placements and teaching;

(ii) Measurement of the quantum of teaching activity delivered within the NHS to undergraduate medical students.

5.2.3 A range of national quality standards applicable to undergraduate teaching within the NHS have been developed in conjunction with stakeholders taking into consideration:

(i) facilities;
(ii) organisation;
(iii) delivery of scheduled teaching;
(iv) opportunities for learning and clinical experience and to achieve curricular outcomes;
(v) availability of educational and pastoral support;
(vi) assessment;
(vii) overall rating of achievement.

The intention is to monitor the performance of NHS Boards against these standards using existing medical schools' student evaluation systems. During the pilot phase which is now underway, it is hoped that a reporting and audit system can be developed, built upon existing follow-up and review processes.

5.2.4 Measurement of Teaching (MOT) is a term used by NES to allocate a 'currency' for teaching time. Three main types of undergraduate teaching have been identified and it is proposed that a template is agreed for use across Scotland to identify and quantify teaching activity to standardise a consistent methodology, definition of teaching time requirements and enable identification of a minimum level of teaching time that can be built into job plans or other staff dedicated teaching time. Variable weightings will not be given to teaching by different staff groups. Although it is recognised that teaching is delivered on a multi-professional team basis, it will be for NHS Boards to determine the most appropriate staff to deliver the teaching.

5.2.5 Medical ACT allocation is delivered using a two stage model:

(i) Stage 1 – allocates total Medical ACT funding to University teaching regions based on the total number of students.

(ii) Stage 2 - allocates total Medical ACT funding within a University teaching region to NHS Boards delivering teaching to students from that University based on student week data on teaching activity produced by ACT officers.

5.2.6 Pilot study reports will be available from NES during 2008/09.

5.2.7 The key indicator for Scotland at present is:

2008/09 Medical ACT £69.8M with 3645 funded medical students.
Average cost per student = £19K

5.2.8 It is to be noted that in Scotland there are 5 medical schools which therefore presents associated differences in structures, however there are many similarities and the challenge in NI is similar to that of NES, e.g. the principle that funding should follow the student.

5.3 Summary – Wales (SIFT)

5.3.1 Similar to England, the equivalent of SUMDE in Wales is SIFT and was introduced to the NHS in 1976 when it was recognised that the running costs of 'teaching' hospitals was more that those of 'non-teaching' hospitals.

5.3.2 In Wales SIFT is divided into;

(i) Medical SIFT – further divided into Hospital SIFT (covering placement and facilities SIFT and management costs) and General Practice SIFT;
(ii) Dental SIFT;
(iii) Medical SIFT for dental students.

5.3.3 Medical SIFT

Management costs – staff and office expense costs for four members of staff (3 FTEs) employed by the University but funded by the Welsh Assembly Government. They are involved in the generation of student week's data and carry out the process for student evaluation of clinical placement teaching. Also

includes student consumables, such as white coats etc, agreed by the Assembly.

General Practice SIFT – sessions are delivered at agreed prices, depending on type of session and Year of curriculum (some payments also cover student residential costs). Funding is distributed by the Department of General Practice within the School of Medicine at Cardiff University.

5.3.4 Dental SIFT – paid by the Welsh Assembly to Cardiff and Vale Trust for undergraduate dental education provided by the Trust. This funding is subject to a separate Service Agreement and has separate monitoring, review and reporting arrangements between the Trust and the Assembly.

5.3.5 Medical SIFT for Dentistry – supports teaching in human diseases and dentistry in the wider community.

5.3.6 Payment process – the Welsh Assembly Government is responsible for the SIFT allocation in any one year by:

(i) setting the overall level of SIFT funding available in Wales;
(ii) allocating that funding between Medical and Dental SIFT;
(iii) dividing Medical SIFT between Hospital, General Practice and Management costs;
(iv) dividing Hospital SIFT into placement and facilities SIFT;
(v) allocating the various amounts of Hospital SIFT to the relevant NHS Trusts in Wales.

This process is supported by a SIFT Working Group which consists of representatives from the Deanery, Health Service and Welsh Assembly.

All SIFT funding is paid by the Welsh Assembly Government directly to the relevant NHS Trusts in Wales with the exception of:

(i) General Practice SIFT – paid to Cardiff University and then by the University to the relevant GP practices in Wales

(ii) 'management costs' – recovered by the University from the Welsh Assembly Government, quarterly in arrears, on the basis of actual expenditure incurred.

5.3.7 Wales calculates the average cost per student per year from student week figures, as there are different systems running according to the location of placement and the type of course taken (5 year, 4 year shortened course or intercalated course). The key indicator for Wales for 2008/09 is:

Total Medical SIFT of £50.6M.

Student week cost £572 per student.

350 students per year, of which 70 are taking a 4 year course and a number taking intercalated courses.

The overall cost is estimated to be £25.7K per student for 2008/09 (45 x £572).

5.4 Summary – Northern Ireland (SUMDE)

5.4.1 The Background and current system is already outlined in Section 3, however a more detailed description is provided in this section.

5.4.2 Allocations to the Trusts and QUB are summarised in the SUMDE Circular (Annex 1) and issued annually. Total SUMDE accounts for:

(i) Dental SUMDE;
(ii) GP SUMDE;
(iii) Medical SUMDE;
(iv) Joint Appointments;
(v) QUB Administration.

5.4.3 Dental SUMDE is a fixed sum uplifted annually by inflation and top-sliced from Total SUMDE. In addition Dental SUMDE is awarded Joint Appointment costs. The 2008/09 SUMDE Circular allocates £4,869,434 to Dental SUMDE (£3,958,928 + £910,506). Dental SUMDE is not subject to this review.

5.4.4 GP SUMDE is based on a fixed session rate uplifted annually by inflation and top-sliced from Total SUMDE. GP SUMDE takes into account agreed Infrastructure (Facilities) costs (refer to section 9.1) and Joint Appointment

costs. The 2008/09 SUMDE Circular allocates £1,257,853 to GP SUMDE (£867,869 + £61,500 + £328,484).

5.4.5 Medical SUMDE accounts for the remaining SUMDE funding and for the purpose of this review can be summed up as follows:

Medical SUMDE = Total SUMDE minus Dental SUMDE minus GP SUMDE minus QUB Administration minus Joint Appointments

5.4.6 Medical SUMDE is then divided into the following categories:

Old SUMDE Relates to commissioned 154 medical students and consists of columns 1 to 6 in the Circular (annex 1);

New SUMDE Relates to commissioned 96 medical students funded through the expansion of the Medical School (refer to section 3.2) and consists of columns 1 & 2 and columns 8 to 12 in the circular (annex 1). (Note that for the financial year shown, New SUMDE has yet to be allocated for additional 5th year students).

Infrastructure (Facilities) A fixed sum uplifted annually by inflation and top-sliced from Total SUMDE and represented in column 7 in the circular (annex 1).

5.4.7 Explanation of SUMDE Circular (Annex 1) by column:

Column 1 Five NI Trusts;

Column 2 Hospitals within each Trust;

Column 3 Student weeks =
Number of students x amount of time spent in a clinical setting

Student weeks are measured in clinical weeks. A clinical week is assigned a value of 1.0 and represents 10 sessions of teaching, i.e. 5 morning and 5 afternoon teaching sessions. This can be represented as:

10 sessions X 0.1 morning or afternoon = 1.0 week

Column 4 Weighted clinical weeks – weighting assigned to intensity of teaching. The weighted values are 1, 2, & 3, and recognise the differing amounts of supervision and direction of students required depending on year of study;

Column 5 Percentage of Old SUMDE (hospital) placement allocation;

Column 6 Clinical placement funding – the amount of funding that individual hospitals receive in relation to Old SUMDE;

Column 7 Infrastructure (Facilities) budget – the actual amount that is awarded to those hospitals in receipt of Infrastructure (Facilities) funding;

Columns 8-12 New SUMDE - broken down to detail the amount of funding allocated per year of placement, and Totalled in column 12;

Column 13 Joint appointments – the actual amount awarded with respect to this category.

5.4.8 The QUB Administration staff are involved in generation of SWF and TU allocations used as the basis of SUMDE distribution by DHSSPSNI. They also undertake the work required to Quality Assure the delivery of the Service Level Agreements set with each Trust and General Practice. This includes clinical teaching delivery and provision of appropriate facilities for undergraduates. In addition provision has been made within the SUMDE budget to share the costs of the Clinical Skills Facility (£420K in 2008/09).

5.4.9 The overall cost for 2008/09, excluding dental, is estimated to be £25.7K per student (£29.6M /1,154).

5.5 Overall summary

Methods for allocating funding towards the additional costs associated with medical and dental student teaching in clinical settings differs in each of the UK regions. However, taking the total allocations for medical and dividing by student numbers averaged over a typical 5 year medical course, figures in the following table (table 1) can be estimated:

Region	Acronym	Total budget £000,000	Number of students	Cost per student per year £000
England	SIFT	844.9	18,512	27.3
Scotland	Medical ACT	69.8	3,645	18.7
Wales	SIFT	50.6	1,750	25.7
Northern Ireland	SUMDE	29.6	1,154	25.7

Table 1: Comparison of funding for medical students with the four UK nations based on 2008/09 figures (please note these figures are approximate and are subject to change).

6.0 Examination of Methodology for 'Currency' value

6.1 Several measures need to be defined to understand the current distribution of SUMDE funding:

(i) Student Weeks (SW) – 'one student multiplied by the number of clinical sessions' (where 0.1 = one morning or afternoon). No weightings are applied. Currently, no payment is made on the basis of SW.

(ii) Student Week Figures (SWF) – these are the weighted Student Week. Table 2 indicates weightings that are applied. Old SUMDE is created from the 'leftover SUMDE' after all top-slicing. Rates are derived from dividing Old SUMDE by the total number of SWF (i.e. weighted). The 2008/09 SWF rate (derived) is £237.

Year of study	Weighting
First	**X 3**
Second	**X 3**
Third	**X 2**
Fourth	**X 1**
Fifth	**X 1**

Table 2: Value of weightings applied to Student Weeks.

(iii) Teaching Units (TU) - 'one member of staff teaching 6 students for 1 session'. New SUMDE is paid on the basis of Teaching Units paid at an agreed rate. The 2008/09 TU rate is £151.

6.2 The two methods in operation at present dictate the amount of SUMDE funding each Trust receives for clinical placement. Small changes can have great financial repercussions for Trusts. Increasing SWF does not necessarily mean that a hospital will receive extra funding, whereas increasing TU does.

6.3 It is recommended that SUMDE funding should 'follow the student'. To this end the currency to be used should be transparent and readily understood, however the most suitable currency needs to be determined and agreed.

6.4 A currency for TU of £260, being an approximate mid-point consultant salary cost, is proposed as an appropriate rate. Any models presented in this paper will be based on the rate of £260.

Question 1: Is this rate to be fixed, if not, how should it be uplifted? Should the rate be linked to annual cost of living uplift?

7.0 Measurement of Funding, Weighting of 'Currency'

7.1 SWF uses a weighting system, where intensity of teaching is measured within the formula. This recognises that greater input is required during the earlier years of teaching due to the fact that students require more direction and supervision. Currently calculations are mutually agreed from timetables and discussion with course co-ordinators.

7.2 The 2008/09 SUMDE allocation for clinical placements (including GP teaching) is approximately:

(i) Old SUMDE, attributed to SWF, £5.18M

(ii) New SUMDE, attributed to TU, £1.24M (up to year 4 only).

Totalling £6.42M this represents 21.7% of Medical SUMDE (Total Medical SUMDE = Total SUMDE minus Dental SUMDE = £29.64M).

7.3 Other weightings in addition to year of study could also be considered. Suggestions of weightings on the basis of specialty-teaching requirements (e.g. 1:1 teaching), geographical location, productivity loss, running costs of facilities, have all been proposed. However, without substantial evidence the choice and application of weighting values would be arbitrary and could lead to a reduction of transparency. After careful consideration, development and use of a weighting system has not been used in any proposed models presented in this paper.

7.4 This review will determine how to apply a fair distribution of existing funding. There will be no extra money available but a transition period will be determined to ensure that no Trust is financially destabilised in the short term.

Question 2: Is there value in undertaking such a costing exercise to determine a weighting system that may take many years to accomplish?

Question 3: Can those Trusts who may potentially benefit from re-distribution of funding demonstrate that any extra monies they receive will be spent on undergraduate medical education? How are they coping now?

8.0 Infrastructure (Facilities) Costs

8.1 Infrastructure (Facilities) has never been formally defined in NI and provision varies across hospitals. It is usually taken to include provision of residential and on-call accommodation, lecture theatres, teaching rooms, library and ICT access, audiovisual equipment, lockers, swipe cards, pagers, and other provision required to manage students whilst on placement at a hospital.

The Chantler report states, 'The segment of SUMDE that is difficult to determine is that element related to facilities and services. This includes the additional costs arising from teaching in a clinical setting, the excess costs of providing facilities, the indirect support costs of enlarged accommodation e.g. catering, portering, electricity, and the indirect cost of teaching support.'

8.2 2008/09 Infrastructure (Facilities) costs are approximately 65% of Medical SUMDE, representing £19.26M.
(Total Medical SUMDE = Total SUMDE minus Dental SUMDE = £29.64M).
Table 3 shows the 2008/09 Infrastructure (Facilities) allocations

TRUST	HOSPITAL	ALLOCATION
Belfast	**Royal Victoria**	**£9,544,112**
	Belfast City	**£5,778,928**
	Mater	**£482,471**
	TOTAL Belfast	**£15,805,511**
South Eastern	**Ulster**	**£822,002**
Southern	**Craigavon**	**£684,606**
Northern	**Antrim**	**£464,866**
Western	**Altnagelvin**	**£923,887**
QUB Admin		**£ 80,218**
Clinical Skills		**£419,840**
GP Facilities		**£ 61,500**
		£19,262,430

Table 3: SUMDE (Infrastructure (Facilities) allocations for 2008/09.

8.3 From 1995/96 Old SUMDE Infrastructure (Facilities) costs were awarded to hospitals achieving a minimum 5% share of Student Weeks. At that stage, seven hospitals were eligible for Infrastructure (Facilities) costs. By 1999/2000 it

became apparent that some hospitals were at risk of not receiving Infrastructure (Facilities) funding in a given year due to small fluctuations in student load resulting in the 5% threshold not being achieved. At this point, the DHSSPS fixed the existing Infrastructure (Facilities) budget for each hospital and now applies an inflationary uplift annually. As teaching methods change and clinical treatment patterns move toward Day Case, Outpatient and Primary Care, continuing these levels of Infrastructure (Facilities) funding has been questioned.

8.4 New SUMDE Infrastructure (Facilities) costs related to the medical school expansion are being awarded on a business case basis.

8.5 It is recognised that not all Infrastructure (Facilities) funding can be applied in 'currencies', however careful consideration needs to be given to the management of Infrastructure (Facilities).

Question 4: Should the historic application of a 5% threshold of student weeks, used to determine Infrastructure (Facilities), be re-introduced?

9.0 Primary Care Funding

9.1 Funding for General Practice (GP) teaching is top-sliced from the SUMDE budget. In 2008/09 total GP funding amounted to £1.26m (Table 4).

Element	Description	Amount
Clinical Placement Funding	Funding awarded to GPs involved in teaching activities	£867,869
Joint Appointment Funding	5 Joint Appointees	£328,484
Infrastructure (Facilities) Costs (i)	Start up grants	£10,000
Infrastructure (Facilities) Costs (ii)	CCTV Installation	£12,000
Infrastructure (Facilities) Costs (iii)	CCTV Maintenance	£4,500
Infrastructure (Facilities) Costs (iv)	Accommodation and subsistence	£35,000
Total		£1,257,853

Table 4: SUMDE General Practice teaching allocations for 2008/09.

The Infrastructure (Facilities) costs are agreed annually following consultation with the QUB course co-ordinators and the DHSSPS. Joint Appointment Funding is based on salary costs. Clinical Placement funding is calculated on the basis of SWF for the Old SUMDE portion and TU for the New SUMDE portion.

9.2 The GP session rate is uplifted by inflation each year by the DHSSPS. The session rate for 2008/09 is £31.91. Some recognition is made of the student load and the need for a minimum payment for locum costs. This is dependent on the teaching type (Table 5): The 'base rate' of 6 x £31.91 (=£191.50) is broadly equivalent to the cost of a locum for a session.

Teaching Type	Remuneration Rate
1st & 2nd year Introductory Clinical Skills Programme Groups of 6 students attend GP surgeries for direct teaching for 1 session each week. Locum required to cover clinical duties while GP teaching.	6 students x £31.91 for each session taught
1st year Family Attachment Scheme. Groups of 6-10 students attend GP surgeries for direct teaching for 2 sessions per semester. Locum required to cover clinical duties while GP teaching.	6-10 students x £31.91 for each session
4th year Module in Primary Healthcare Single student on placement for approx 3 weeks. Student integrated into GP team. No locum cover required.	1 student x £31.91 x 3 weeks
5th year Specialty teaching in Primary Healthcare 1-2 week placement Student integrated into GP team. No locum cover required.	1 student x £31.91 x 1-2 weeks
Examinations GPs participate in clinical and other examinations. Locum required to cover clinical duties while GP examining.	6 students x £31.91 for each session
Preparation GPs participate in training/education sessions. Locum required to cover clinical duties while GP participating in training session.	6 students x £31.91 for each session

Table 5: SUMDE General Practice remuneration rate for Clinical Placements for 2008/09.

9.3 SWF or TU can be used to calculate GP allocations. The currency chosen simply dictates whether the money comes from the Old or the New SUMDE stream.

9.4 GPs may receive a 'start-up' fund which is a one off payment to provide new GP trainers with a communication grant, book grant and basic teaching equipment.

9.5 CCTV equipment is installed in GP practices in the Greater Belfast area to assist 4th year teaching sessions. The equipment has been funded by DHSSPS and maintenance contracts are in existence between QUB and the 'Production Company' (CCTV) to service the equipment. QUB are reimbursed by the DHSSPS on receipt of invoices.

9.6 Residential accommodation and subsistence for students undertaking Primary Healthcare attachments is estimated each year by QUB, who then re-charge DHSSPS when the actual costs are submitted.

9.7 Accountability within GP SUMDE is good and spend is clearly visible. The method may be a pointer towards the overall SUMDE budget in relation to audit/accountability reports. There is no recommendation to change the distribution or management of GP SUMDE monies.

Question 5: What lessons can be taken from the accountability of GP SUMDE?

10.0 Funding Control Mechanisms (Performance Management)

10.1 Following the securing of finance for additional medical students, and following the recommendation of Chantler, the Medical Student Management Group (MSMG) was established in June 2005. The group's brief is to monitor the medical school expansion and how it could maximise existing SUMDE investment, review existing SUMDE, and determine how to audit SUMDE in the future. The MSMG meets quarterly.

10.2 Funding is held by DHSSPS, with a total 2008/09 spend of approximately £35.8M. A circular detailing allocation to the Trusts is sent annually to the Chief Executives of each Trust, Board, and the Central Service Agency; the Dean of the Faculty of Medicine; and the Heads of Medical Education of each Trust. It had been proposed that the Education and Training function and SUMDE would move to the HCA Authority. Under the revised RPA structures, it will now remain in the Department, and be subject to scrutiny in the normal way.

10.3 Currently audit procedures for New SUMDE are being developed and tested. It is envisaged that these will be transferable to any agreed new model, with associated Service Level Agreements.

10.4 An opportunity now exists to discuss and develop funding control mechanisms such as those being developed, or are already in place, in other countries within the United Kingdom. Reporting structures already exist in Wales and standardisation such as that being introduced in Scotland could be integrated into an efficient and effective methodology for accountability. Wales mirrors the situation in NI, in that there are 6 Trusts, and until recently only 1 medical school with annual commissioned student numbers of 360. Wales also has a formal mechanism for accountability which is briefly summarised in table 6.

Question 6: Should the Trust's Financial General Ledger allocate cost centre and nominal codes specifically for monitoring SUMDE allocations in order to increase accountability?

When	What	Who	Why	Outcome
Jan - Dec (throughout the year)	Annual UG Teaching Review Meetings arranged by SIFT Co-ordinator	SIFT team, Medical School Deanery, Trusts (Honorary Senior Lecturers/ Chief Executives / Senior Managers/ Librarians-University and Trust).	To discuss quality and quantity of clinical teaching, and to account for funding. Assess learning opportunities, areas of expansion, capacity constraints in Trust.	Trust Teaching Review Meeting Report including Action points for relevant parties.
March / April	SIFT Meeting (Informal)	Welsh Assembly Government (WAG) and SIFT team.	To discuss the forthcoming agenda items at Annual Accountability meeting, highlight new initiatives, early indication of funding constraints/ opportunities.	Draft principles and parameters for SIFT funding in next fiscal year.
April	Annual SIFT Teaching Census produced by SIFT Co-ordinator	Based on the previous academic year prepared by SIFT team and issued to WAG in April.	To inform WAG of the distribution of medical students in NHS Wales to assist in appropriate distribution of Clinical Placement SIFT funding 'to follow the student'.	WAG indicative calculations of total Hospital Placement SIFT for fiscal year.
May	Annual Accountability Meeting (WAG All Wales SIFT Working Group) Arranged by SIFT Co-ordinator who is also Secretary to meeting	Welsh Assembly Government, Trust Finance Directors, Medical Directors representing Trusts, SIFT team, Finance representation from Local Health Boards, Dean of Medicine from both Cardiff and Swansea University, Sub Deans of Medicine, Dean of Dental School, representation from Gwent, Swansea and North Wales Clinical Schools, Head of Primary Care.	To discuss and approve SIFT Teaching Census + GP SIFT Report + Medical SIFT for Dental Students Report + All Wales SIFT Annual Accountability Report. Also opportunity to discuss any new initiatives that may impact on future SIFT funding e.g. curriculum review or NHS reorganisation.	SIFT funding for fiscal year agreed and educational experience for previous year reviewed.
June	SIFT Allocation letter to Trusts prepared by WAG.	Welsh Assembly Government issue allocation letter	Based on student weeks produced within the SIFT Census and agreed at the Annual Accountability Meeting.	Trusts notified of SIFT funding for current fiscal year.
June/July	Service Level Agreements prepared by SIFT Co-ordinator.	Sent by SIFT team on behalf of the Welsh Assembly Government. Agreement to be reached and signed by Welsh Assembly Government, Trusts and Universities.	Service Level Agreement prepared annually. Includes Purchaser and Provider responsibilities, quality assurance processes, funding provided, detailed student week calculations (as per SIFT Census) and a template SIFT Expenditure Schedule for Trusts to complete.	WAG and Trusts sign SLA for current fiscal year.

Input information provided by Mrs Sue Williams, SIFT Co-ordinator for Wales, All Wales SIFT Co-ordinating Unit. 13th January 2009.

Table 6: Welsh Assembly Government formal mechanism for accountability for SIFT.

11.0 Delivery of Teaching, Joint Appointments and alternatives

11.1 At present Joint Appointment clinical academics secure a contract which typically provides for 50% of their time spent in a clinical environment performing hospital work, and 50% of their time spent at the University completing academic work.

11.2 Joint Appointment salaries are paid jointly by QUB and SUMDE. QUB pay the full salary to each Joint Appointment and then recoup the clinical element (typically 50%) from the Trusts, who receive Joint Appointment funding through their SUMDE allocation.

11.3 A paper (Annex 2) entitled 'The Future of Clinical Academia in Northern Ireland' prepared by QUB has been included in this consultation document, the summary of which is quoted below.

'Summary

There are very many demanding challenges and increasing pressures on clinical academics that are currently required to fulfil multiple roles as clinicians, teachers, researchers, administrators and professional leaders. These increasing demands have been paralleled by the lack of a clear career structure, financial disincentives, very long training programmes and decreased levels of support.

This serious situation facing UK clinical academia is particularly evident in Northern Ireland, where unlike other UK medical schools the clinical academic is funded equally by the University and the Trusts. Unlike their colleagues in the rest of UK who are full time academics, Northern Ireland clinical academics are called Joint Appointments, which in reality means they are effectively part-time clinical academics. This has led to a failure to recruit and retain clinical academics in Northern Ireland with the result that academic medicine has become an unattractive career for the vast majority of clinicians practising here.

In order to reverse this trend and to re-invigorate clinical academia in Northern Ireland the following recommendations are made:

Recommendations:

i. *Clinical academics should work as part of clinical teams with Academic and NHS colleagues.*
ii. *The university should determine the teaching and research components of job plans for clinical academics.*
iii. *The clinical academic SUMDE funding provided in relation to HSC trusts in respect of teaching and research should revert to the University*
iv. *The clinical commitments of clinical academics should be determined by joint job planning by the Trusts and the University.*
v. *Clinical academic consultants should have equal access as NHS consultants to pay, merit and distinction awards.*
vi. *There should be incentives and a clear training programme for young clinicians seeking a career in clinical academia.'* "end quote".

11.4 Delivery of teaching is fundamental to SUMDE and requires compatibility, flexibility and partnership between QUB and the Trusts in order to deliver Flexible Academic and Clinical Teaching (FACT). Team job plans which support clarity should be promoted and this may be included in a new Memorandum of Understanding.

11.5 It is the view of the Department that control of SUMDE funding (including FACT) should remain with the Department. There is a recognition however, that the method of allocating financial support for Joint Appointment / Clinical Academics may need to be reviewed in light of developments.

11.6 In consideration of the importance and wide ranging implications of any change to the current Joint Appointment arrangements, it is proposed that a separate group be convened to consider teaching delivery and the future of the Joint Appointment system, and to develop alternative options.

Question 7: What are the Service implications should the Joint Appointment model change?

12.0 SUMDE Formula Development

12.1 The establishment of the Medical Student Management Group (MSMG), in response to the Chantler Report (Sections 4.4 and 11.1), has facilitated this consultation paper to be formulated through discussion and presentation of various methodologies to the group.

Experience has shown that it is extremely difficult to work out the actual cost of training medical students in hospital. The MSMG decided at the outset that it can not practically go down this route; instead it has developed a proxy for costs. The proxy has two elements, the first is based upon a consultant salary cost and the second is a small amount for 'on' costs.

In order to develop a robust model for future distribution of SUMDE funding that will provide a simple and transparent process for allocation, the MSMG agreed the following set of principles upon which all models presented in this paper have been based.

12.2 Principle 1: Student Cohorts

Actual student numbers in each academic cohort vary from commissioned numbers for several reasons, typically academic progression, student ill–health, etc. As a result distribution models for SUMDE will vary according to whether actual or commissioned numbers are used. The models developed have been based on commissioned numbers, with the proposal to periodically review to account for fluctuations. This will help provide Trusts with planning stability, in particular financial calculations and projections.

12.3 Principle 2: Student : Staff ratios

The application of Teaching Units (TU) in the current model for distribution of New SUMDE uses a ratio of six students to one member of staff for clinical teaching. This is based on the premise that no more than six students can comfortably fit around a bed for teaching purposes. Some specialties (e.g. Psychiatry, Paediatrics) have a natural limitation on the number of students acceptable to a patient in a teaching situation. These are mainly, but are not limited to, Fourth Year specialties. While it is acknowledged that not all clinical teaching occurs at the bedside, it is agreed that to provide accurate student-staff

ratios would require detailed and lengthy analysis of teaching styles in each specialty in each hospital, and these figures could vary on a sessional basis. The developed models continue to use the 6:1 ratio.

12.4 Principle 3 – Teaching Unit Remuneration Rate

In light of the transparency offered by the TU, this currency rather than Student Week Figures (SWF) is used for model development. The current TU (2008/09) remuneration rate is £151.

Merging Old and New SUMDE funding streams would enable the remuneration rate to increase. It should be noted that a remuneration rate above £160 requires some Infrastructure (Facilities) money to be transferred to the Clinical SUMDE stream.

In order to meet the future needs of medical students, teaching should be both consultant-led and delivered, written into job plans, and acknowledge that the ultimate objective is to produce competent, well trained doctors. In financial terms, and for the purpose of model development, these aims have been approximated to a consultant midpoint salary plus 20% for superannuation and National Insurance Contributions. A rate of £260 has been deemed appropriate for model development.

Other options have been considered, e.g. redistribution of a percentage of existing Infrastructure (Facilities) funding on the basis of TU, effectively increasing the TU remuneration rate. However, as no clear benefits have emerged from these options and the potential to cause destabilisation exists, they have been rejected.

12.5 Principle 4 – On Cost

It is evident that assessment and/or definition of 'on' cost would be a long and complex process, subject to a wide variety of factors. A reasonable remuneration rate has been used in the development models, avoiding the process of defining on cost and unnecessarily complicating a model which, by definition, should be simple and easy to understand. The use of a nominal

percentage amount of 'on' cost is considered as an acknowledgement of costs incurred beyond salary.

12.6 Principle 5 - Weightings

Over a long period of time, many suggestions in favour of weighting influencing the distribution of SUMDE have been made, e.g. specialty, nature of teaching input, geography. Discussion on the relative advantages and disadvantages of weighting being endless and counterproductive, a pragmatic approach recognises that application of weighting further complicates model development. As overall balance is the end result of any weighting applied, the conclusion is that weighting should not be applied to model development unless supporting evidence is supplied.

12.7 Principle 6 – Infrastructure (Facilities) Funding

Infrastructure (Facilities) monies constitute the majority of SUMDE funding. All external reports have concluded that they can find no evidence to justify the difference in levels of funding in certain hospitals (namely Royal Group and Belfast City Hospitals) and have recommended a more equitable distribution. Equally important, the possibility of removing a portion of funding from the hospitals concerned and redistributing to other hospitals may lead to destabilisation and may not necessarily add any additional quality outcome to undergraduate teaching. It is critical that model development evaluates and balances the two conflicting areas.

Consideration has been given to distributing the Infrastructure (Facilities) funding stream on the basis of TU (weighted and un-weighted) or by business case. However, as little or no evidence exists to suggest that this would be beneficial it has been agreed to develop a model based on Principles 1-5, accepting the consequent reduction in the Infrastructure (Facilities) Funding stream. The creation of a fund (£0.5M) which Trusts could bid for via business case on a non-recurrent basis would provide a mechanism for improving teaching facilities, especially in those Trusts relatively new to large cohorts of medical student clinical placement. The remaining Infrastructure (Facilities) budget would be distributed on the current basis.

12.8 Following agreement of the Principles outlined above, financial models for the allocation of SUMDE have been developed on the basis of:

- TU calculated on commissioned student numbers for Years 1-5 students;
- Basic remuneration rate of £260 per TU;
- 'On' cost values of 0%, 10%, 15%, 20% and 30% applied;
- Models are compared to the 2008/09 circular values.

These are summarised in Table 6 below as:

Option	Rate	'On' Cost
Option 1	£260	No On Cost
Option 2	£260	+10% of £260
Option 3	£260	+15% of £260
Option 4	£260	+20% of £260
Option 5	£260	+30% of £260

Table 6: Summary of options selected for SUMDE model development.

12.9 Financial models applying Options 1-5 are presented in Annexes 3 and 4. Variance in distribution for Options 2, 3 and 4 are so small as to be negligible. Option 5 is the only model that illustrates any substantive change in line with the more equitable distribution recommended by the Chantler and Tribal Secta reports. The overall reduction of annual SUMDE allocation to the Belfast Trust would be phased in over the agreed glide-path period, i.e. 5 years (Section 13.2).

12.10 Financial Model 1 (Annex 3) demonstrates redistribution of clinical and Infrastructure (Facilities) funding to each Trust based on the five options identified in Table 6 above. Option 5 represents the maximum redistribution proposed. With this option Belfast Trust's funding would reduce by £1.8M after 5 years (a reduction of £365K per annum). By the end of the 5 years this would be skewed as follows: Northern Trust (£576K), South Eastern Trust (£463K), Southern Trust (£419K), and Western Trust (£364K).

12.11 Financial Model 2 (Annex 4) follows the method for Financial Model 1, minus an additional £0.5M top-sliced from the initial pot. Again, using Option 5 for

demonstration purposes, Belfast Trust's funding would reduce by £2.25M after 5 years (an annual reduction of £450K over the transition period). This would be skewed as follows: Northern Trust (£564K), South Eastern Trust (£441K), Southern Trust (£401K), and Western Trust (£339K). Although these figures seem skewed, it must be remembered that the changes are proportional to the initial £0.5M reduction.

12.12 Annual inflationary uplifts, plus additional 5th year medical students requiring placement within core and specialty training which is only available within the Belfast Trust, would reduce any reduction in funding further, lessening the pressure of destabilisation to the Trust.

Option 5 would appear to represent the best way forward as it could provide adequate resources for Trusts outside Belfast to supply teaching that is of acceptable quality. At the same time when all of 'New SUMDE' funding comes into play in 2009/10 the estimated loss to the Belfast Trust would be reduced significantly.

Question 8: Which Option meets our objectives, and why?

13.0 Management of Transition / Implementation Arrangements - Glide-path

13.1 In order to create a smooth transition to any new model it is imperative that the financial stability of the Trusts is considered. However this must not leave NI at a disadvantage with the rest of the UK, who are also reviewing their equivalent funding streams.

13.2 To this end a glide-path sensitive to the risk of destabilisation, but also recognising the need to implement the proposals as quickly as possible, should be formulated to accomplish the transition. This should set a timeframe for implementation, typically 5 years, mirroring the length of the medicine degree, so that as one method is phasing out the new can be phased in. Glide-paths for changes arising from Option 5, with and without £0.5M top-slice, are illustrated in Annexes 3 and 4.

13.3 The transition to the new revised model must also take into account the QUB Medical School aims within its mission and strategy to be *'a forward-looking Medical School with internationally recognised strengths in both Research and Teaching',* and assure the continued quality of teaching medical students we have come to expect in NI.

Question 9: Is 5 years an appropriate transition period?

Question 10: Do any of the recommendations or proposals outlined in this document have a potential impact on equality of opportunity for any group of people? Please indicate any evidence – quantitative or qualitative – that would suggest a potential adverse effect.

Question 11: The creation of any new model affords new opportunities to promote transparency and equality, how can the HSC best realise such opportunity?

Question 12: Do you agree that appropriate key issues have been identified, and conclusions drawn for each of the main sections of the review?

Question 13: Have appropriate recommendations been identified to progress action?

14.0 Feedback & Contact Details & Enquiries – questions

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15.0 Membership

As per MSMG

Mr David Bingham	DHSSPS
Mr Peter Gregg	DHSSPS
Ms Lynn Campbell	DHSSPS
Mrs Helena Brown	DHSSPS
Prof Patrick Johnson	QUB
Prof Maurice Savage	QUB
Mrs Edel O'Hara	QUB
Mr Norman Bennett	QUB
Dr Tony Stevens	Belfast HSC Trust
Dr Mark Gormley	Belfast HSC Trust
Dr William Dickey	Western HSC Trust
Dr Calum MacLeod	Northern HSC Trust
Dr Colin Weir	Southern HSC Trust
Dr Ian Taylor	South Eastern HSC Trust

15.0 Glossary of Terms

ACT	Additional Cost of Teaching.
Circular	Details of SUMDE allocations issued by DHSSPS.
Clinical Academic	Clinicians who treat patients but also teach within their specialty.
Clinical Placement Funding	Funding to Trusts to cover the extra costs of students when on placement.
Clinical Week	The period of time a medical student spends in placement, given a value of 1.0 and divided into 10 equal sessions (i.e. 10 mornings/afternoons during a week consisting of 5 working days.
Currency	Measurement used to allocate funds.
DEL	Department for Employment and Learning.
DHSSPS	Department Of Health, Social Services and Public Safety.
EU	European Union.
Glide-path	Mechanism used to smooth a transition period.
HSC	Health and Social Care.
ICT	Information and Communication Technology.
Infrastructure (Facilities)	Facilities and Infrastructure are used synonymously throughout the document and are not formally defined. However they are usually taken to include other resources which would not be required for healthcare alone, e.g. residential/on call accommodation, lockers, pagers, swipecards.
Joint Appointments	Clinical Academics
NES	NHS Education for Scotland.
New SUMDE	That stream of SUMDE associated with the introduction of Additional Medical Students through the expansion of the QUB Medical School. Allocation of SUMDE funding is derived differently to that of Old SUMDE.

NI	Northern Ireland
Old SUMDE	Original funding put in place to cover the extra cost to Trusts incurred through teaching medical students.
Primary Care	General Practice (GP).
QUB	Queen's University of Belfast.
SIFT	Service Increment for Teaching.
Student Week (SW)	Number of students times the amount of time spent in placement.
SUMDE	Supplement for Medical and Dental Education. The Statutory fund in NI used to offset the cost of having medical and dental undergraduates taught within the Health Service.
Teaching Unit (TU)	Measurement used to allocate funds.
UK	United Kingdom, includes England, Northern Ireland, Scotland, and Wales.
WAG	Welsh Assembly Government.
Weighting	Measurement applied to 'currency' when allocating funds.

ALLOCATION OF SUMDE FUNDS - 2008/09

MEDICAL SUMDE

Trust	Hospital	Student Weeks	Weighted Clinical Weeks	Clinical Placement Funding	Infrastructure budget	New SUMDE 1st year	2nd year	3rd Year	4th year	Totals	2008/09 Allocation	Joint Appts
BELFAST	based on old SUMD fig * WCW/total WCW											
Royal Group of Hospitals	RVH/RMH/RBHSC	3783.6	5255.2	**1,244,315**	**9,544,112**	5134	19630	159230	101759	***285,752***	11,074,179	1,780,193
Belfast City Hospital	BCH	2154.3	2908.8	**688,739**	**5,778,928**		10268	79502	50011	***139,781***	6,607,448	1,218,742
Mater Infirmorum Hospital	MIH	983.1	1443.9	**341,884**	**482,471**	4530	6946	35334	18241	***65,051***	889,406	268,687
Green Park	Musgrave Park	560.7	975	**230,858**			2416	57078	2114	***61,608***	292,466	263,702
North & West Belfast*	Muckamore	49.8	49.8	**11,792**					4379	***4,379***	16,171	
	Community Trust	135.1	189.1	**44,775**						***0***	44,775	
South & East Belfast	Knockbracken	66.9	66.9	**15,840**					8381	***8,381***	24,221	
	Shaftesbury Square	1.9	1.9	**450**						***0***	450	
				2,578,653	**15,805,511**	9,664	39,260	331,143	184,884	**564,951**	**18,949,115**	**3,531,324**
SOUTH EASTERN												
Ulster Community & Hospitals	Ulster	1322.7	1718.1	**406,808**	**822,002**	2416	2114	46206	39109	***89,845***	1,318,655	
	Ards	33.6	33.6	**7,956**					1857	***1,857***	9,813	
Down Lisburn	Lagan Valley	235.7	314.6	**74,490**		2416	302		9226	***11,944***	86,434	
	Downshire	25.2	25.2	**5,967**					3730	***3,730***	9,697	
	Downe	35.6	35.6	**8,429**					1314	***1,314***	9,743	
				503,650	**822,002**	4,832	2,416	46,206	55,236	**108,690**	**1,434,342**	
SOUTHERN									108,690			
Craigavon Area Hospital Group	Craigavon AH	979.7	1290.2	**305,491**	**684,606**			43715	32978	***76,693***	1,066,789	
	South Tyrone	22.4	44.8	**10,608**					1465	***1,465***	12,072	
Armagh & Dungannon	St Luke's	32.6	32.6	**7,719**					1857	***1,857***	9,576	
Craigavon & Banbridge Community	Craigavon Psychiatric	55.8	55.8	**13,212**					1857	***1,857***	15,070	
Newry & Mourne	Daisy Hill	387.8	504.8	**119,525**				17667	12307	***29,974***	149,499	
				456,555	**684,606**	0	0	61,382	50,464	**111,846**	**1,253,006**	
NORTHERN												
United Hospitals Group	Antrim	883.1	1205.3	**285,388**	**464,866**			43715	23632	***67,346***	817,600	
	Whiteabbey	117.8	117.8	**27,892**					4107	***4,107***	32,000	
	Mid Ulster	18.8	18.8	**4,451**					649	***649***	5,101	
	Braid Valley	15.6	15.6	**3,694**					2612	***2,612***	6,306	
Causeway	Causeway	657.9	780.3	**184,758**				18573	28192	***46,765***	231,522	
Homefirst	Holywell*	87.6	87.6	**20,742**					13968	***13,968***	34,709	103,981
				526,925	**464,866**	0	0	62,288	73,160	***135,447***	**1,127,238**	**103,981**
WESTERN												
Altnagelvin Group of Hospitals	Altnagelvin	1156.8	1538.4	**364,259**	**923,887**			55493	34504	***89,996***	1,378,142	
Foyle	Gransha	17.8	17.8	**4,215**						***0***	4,215	
Sperrin Lakeland	Tyrone County	81.7	121.3	**28,721**				5889	2794	***8,683***	37,404	
	Erne	143.8	178.9	**42,360**				2945	14466	***17,410***	59,770	
	Tyrone & Fermanagh	33.6	33.6	**7,956**					1857	***1,857***	9,813	
			19061	**447,510**	**923,887**	0	0	64326	53620	***117,946***	**1,489,343**	
				4,513,294	**18,700,871**					1,038,880		
General Practice Teaching		1414.1	1455.6	**666,175.20**		63957	42322		95415	**201,694**	**867,869**	**328,484**
Queen's University of Belfast	Admin				**500,058**						**500,058**	
	GP Facilities				**61,500**						**61,500**	
	SUB TOTAL		20517	**5,179,469**	**19,262,429**					**1,240,574**	**25,682,471**	**3,963,789**

DENTAL SUMDE

Trust	Hospital	Hospital Share	Joint Appts
Royal Group of Hospitals	Belfast Dental Hospital	**3,958,928**	**910,506**
	SUB TOTAL	**29,641,400**	**4,874,295**

GRAND TOTAL	**34,515,695**

Annex 2 – page 1

'The Future of Clinical Academia in Northern Ireland' by Professor Patrick Johnston, Queens University of Belfast.

Summary

There are very many demanding challenges and increasing pressures on clinical academics that are currently required to fulfil multiple roles as clinicians, teachers, researchers, administrators and professional leaders. These increasing demands have been paralleled by the lack of a clear career structure, financial disincentives, very long training programmes and decreased levels of support.

This serious situation facing UK clinical academia is particularly evident in Northern Ireland, where unlike other UK medical schools the clinical academic is funded equally by the University and the Trusts. Unlike their colleagues in the rest of UK who are full time academics, Northern Ireland clinical academics are called Joint Appointments, which in reality means they are effectively part-time clinical academics. This has led to a failure to recruit and retain clinical academics in Northern Ireland with the result that academic medicine has become an unattractive career for the vast majority of clinicians practising here.

In order to reverse this trend and to re-invigorate clinical academia in Northern Ireland the following recommendations are made:

Recommendations.

Clinical academics should work as part of clinical teams with Academic and NHS colleagues.

The university should determine the teaching and research components of job plans for clinical academics.
The clinical academic SUMDE funding provided in relation to HSC trusts in respect of teaching and research should revert to the University
The clinical commitments of clinical academics should be determined by joint job planning by the Trusts and the University.
Clinical academic consultants should have equal access as NHS consultants to pay, merit and distinction awards.
There should be incentives and a clear training programme for young clinicians seeking a career in clinical academia.

Introduction

In modern medicine there are very many demanding challenges and increasing pressures on clinical academics that have been required to fulfil multiple roles as clinicians, teachers, researchers, administrators and professional leaders. However, the pivotal role of clinical academics in clinical leadership and in training the next generation of doctors at undergraduate and postgraduate level has never been more important. Indeed the contribution they make to clinical training, the development of professionalism in clinical skills, the training to use basic and clinical trial data for evidence based treatment decisions is enormous. These alongside critical appraisal of literature, the development of the skills and intellectual framework to innovate in healthcare have never been more essential.

In the current competitive environment these require more selective focus to ensure high quality delivery in each of these areas. These increasing demands have been paralleled by the

lack of a clear career structure, financial disincentives, very long training programmes and decreased levels of support. Unfortunately this has led to a failure to recruit and retain clinical academic staff throughout the UK and in particular in Northern Ireland with the result that academic medicine has become an unattractive career for the vast majority of clinicians (1).

It is now impossible for a single individual to excel in all aspects of clinical care, clinical research, teaching and management. As a result, there needs to be clear recognition of the role of the consultant clinical academic as one that is different but complementary to that of an NHS consultant. It is also important that we recognise the importance of those unique facets of clinical academic work which may range from clinical practice, clinical research, to advising government and industry all of which are currently at the forefront of medical science and its impact on clinical care and society in the UK and globally. This will require a new approach to the clinical academic career that recognises their unique contribution to clinical leadership, high quality clinical research, education and support of innovation (2, 3).

The situation in Northern Ireland

The serious situation facing UK clinical academia is particularly evident in Northern Ireland, where unlike other UK medical schools the clinical academic is funded equally by the University and the DHSSPS(NI) through SUMDE (4. Chandler Report). Unlike their colleagues in the rest of UK, Northern Ireland clinical academics are called Joint Appointments, which in reality means that they are part-time clinical academics. Joint Appointment staff hold a contract which typically provides for 50% of their time spent in a clinical environment performing hospital or board work and notionally 50% of their time spent at the University doing academic work. Queen's University pay the full salary to each joint appointment and then recoup the clinical element from the Trusts who receive the joint appointment funding through their SUMDE allocation. This results in lack of transparency with regard to the clinical academic's salary and also results in a situation where the acute needs of the clinical service largely determine the clinical function and weekly activity of the clinical academic. The current 2008/09 SUMDE costs are approximately £5 million pounds and represent 13% of the total SUMDE budget.

In the rest of the UK academic colleagues are employed as full-time clinical academics appointed to the university with honorary contracts to the NHS. As a result it is the clinical academic component and not the clinical service that largely drives their clinical activities and how they are assessed. Despite this a recent survey by the Royal College of Physicians demonstrated that academics in all sub-specialties appear to be spending significantly more hours per week on NHS service with less time devoted to academic activities. In recognition of the problem The Academy of Medical Sciences recommended that much more streamlined and transparent job plans need to be developed for clinical academics; one where their role and contribution as clinical academics both to the academic education and research effort as well as clinical service is clearly defined (5.6).

The Role of the Clinical Academic – UK

In order to achieve a balanced and deliverable contribution both to the academic education and research effort as well as clinical service the Academy has recently recommended that clinical academics should work as part of clinical teams where they provided leadership in aspects of training and development in the clinical specialty as well as translational research and clinical

Annex 2 – page 3

trials. They also recommended that clinicians continue to use their practical clinical skills as part of their overall contribution in particular in craft specialties and that this should be achieved

by combining clinical work with educational and research leadership but in a balanced portfolio. Therefore, the primary role of clinical academics must be to lead on aspects of clinical curriculum development and clinical and translational research (6). While this already happens in a small number of clinical areas within Northern Ireland, this pattern of working must be strengthened and improved.

For the diminishing number of clinicians in training who wish to pursue a clinical academic career there are significant challenges as the training period for their development is significantly more arduous and longer. They need to pursue not only a PhD degree but also a further three to four years in postdoctoral work in order to become competitive. This substantial barrier acts as a disincentive to many individuals and effective role models through whom they can actually begin to develop their career are hard to find. They also require protected time in order to combine and balance the competing interests of clinical practice and further training in research which are so necessary for their career (7, 8).

Recommendations

So, what are the solutions to ensuring that clinical academia begins to re-emerge in Northern Ireland? They fall under the following headings:

The scrapping of the joint appointment system which is out-dated and creates the part-time clinical academic. This is the biggest obstacle to the further development of clinical academia and the creation of a competitive Medical School in Northern Ireland.

The transfer of the full Joint Appointment SUMDE salary costs 5 million to the University and the creation of a full time clinical academic contract with the University and an Honorary contract with the Trust.

The recruitment and retention of clinical academics to be seen as a priority in the University and Trusts.

The creation of medical teams within which clinical academics work, in contrast to working in isolation and carrying the same clinical workload as their NHS colleagues.

The creation of an agreed job plan and appraisal process that reflects the clinical academic role. These should be clear and include protected time for research and educational activities. Job planning should be the responsibility of the University in partnership with the HSC Trusts.

Improved support for clinical academics in training such as those currently registered in the Walport Scheme. There is a significant requirement for more appointments to be made under this scheme which has now commenced under the leadership of Professor Stuart Elborn. There needs to be flexibility in approach as the issues and solutions may differ depending on the individual clinicians, their level of seniority and also their sub-specialty.

Annex 2 – page 4

The need for an increase in NHS engagement in teaching undergraduate students.

The development of a clear understanding and partnership between the University and the NHS Trusts to deliver teaching, clinical work, training and research undertaken by each other's staff.

The acknowledgement and recognition of the importance of clinical academia to clinical medicine here. This will be achieved by recognising the value of the contribution of clinical academics to research, leadership, the breadth of medical training, clinical practice and innovation.

Conclusion

Finally, NHS clinicians and clinical academics must be effective role models who inspire the next generation. They must all be empowered to contribute to the wider medical effort including medical education and research. The key to this is a very close partnership working arrangement between the Trusts and the medical school as both are important to each other's success. If these issues are addressed then the medical school and Northern Ireland's medical education and research effort will begin to develop at pace and will rise to the level of comparator universities within the UK in a relatively short period of time.

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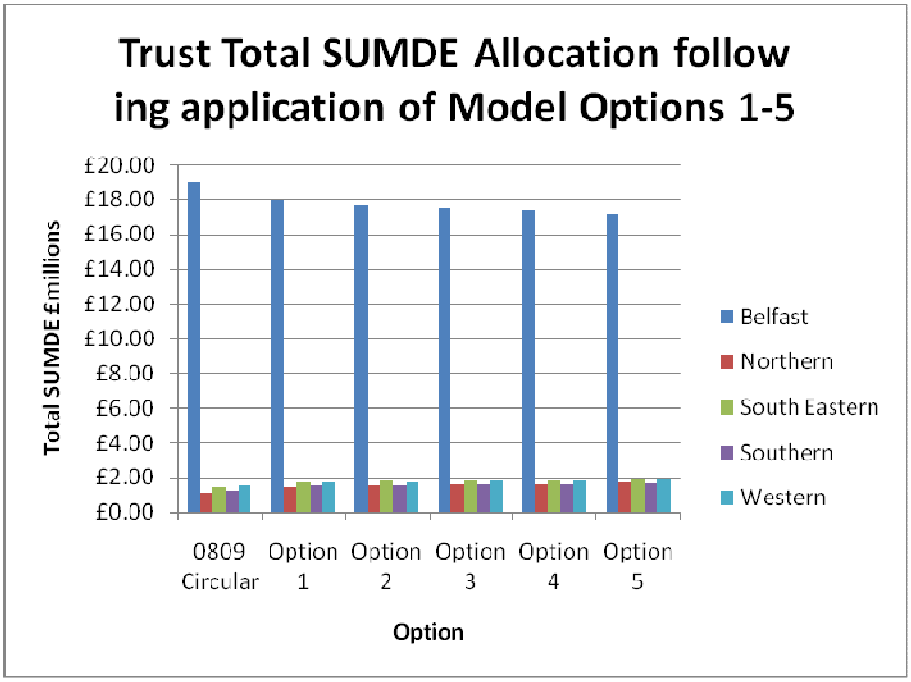
Annex 3 – page 1

Development of Financial Model 1.

Trust	2008/09 Circular	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	£18,949,115	£17,904,260	£17,644,879	£17,515,189	£17,385,499	£17,126,118
Northern	£1,127,238	£1,449,556	£1,534,223	£1,576,557	£1,618,890	£1,703,558
S Eastern	£1,434,342	£1,705,715	£1,769,682	£1,801,665	£1,833,648	£1,897,615
Southern	£1,253,006	£1,491,157	£1,551,487	£1,581,651	£1,611,816	£1,672,146
Western	£1,489,343	£1,702,470	£1,752,899	£1,778,113	£1,803,328	£1,853,757
Total	£24,253,044	£24,253,158	£24,253,170	£24,253,175	£24,253,181	£24,253,192

Annex 3 - Table A



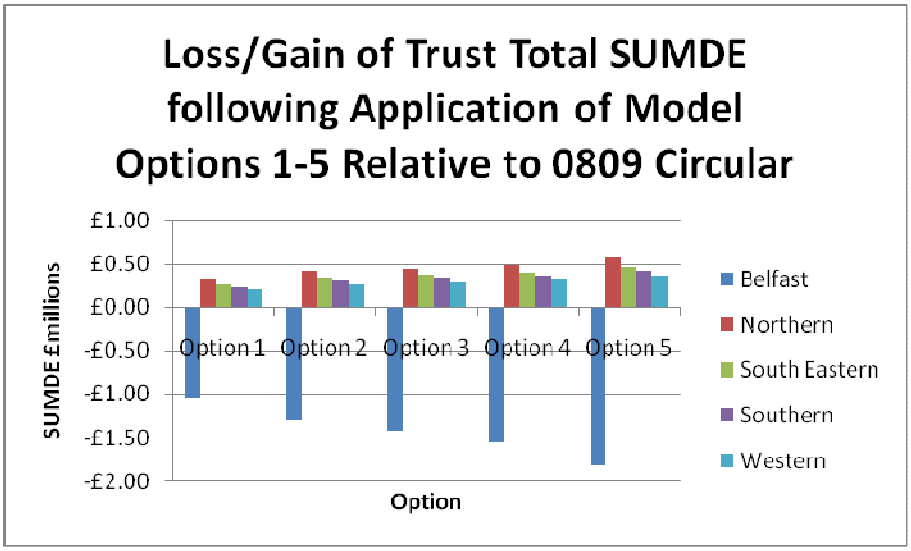
Annex 3 - Graph A

<u>Annex 3, Table A and Graph A:</u> These show the redistribution of Trust Medical SUMDE Allocations following Options 1-5. The source values were taken from the 0809 Circular.

Annex 3 – page 2

Trust	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	-£1,044,855	-£1,304,236	-£1,433,926	-£1,563,616	-£1,822,997
Northern	£322,318	£406,985	£449,319	£491,652	£576,320
S Eastern	£271,373	£335,340	£367,323	£399,306	£463,273
Southern	£238,151	£298,481	£328,645	£358,810	£419,140
Western	£213,127	£263,556	£288,770	£313,985	£364,414

Annex 3 - Table B



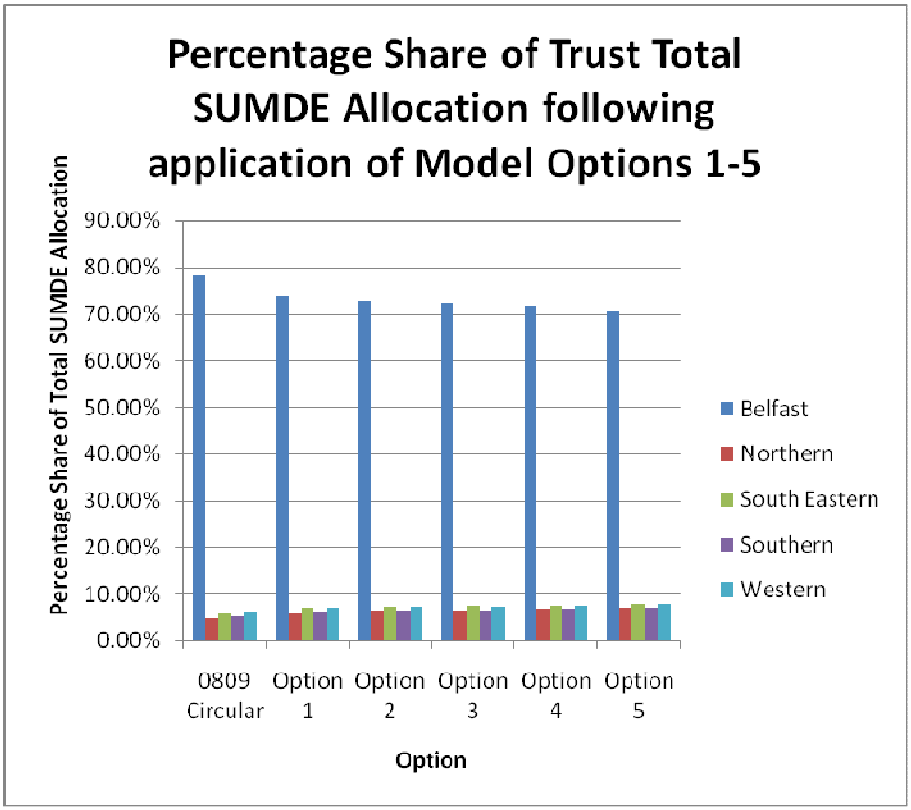
Annex 3 - Table B

<u>Annex 3, Table B and Graph B</u>: These show the Loss/Gain to Trust Medical SUMDE Allocations following Options 1-5.

Annex 3 – page 3

Trust	2008/09 Circular	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	78.13%	73.82%	72.75%	72.22%	71.68%	70.61%
Northern	4.65%	5.98%	6.33%	6.50%	6.67%	7.02%
S Eastern	5.91%	7.03%	7.30%	7.43%	7.56%	7.82%
Southern	5.17%	6.15%	6.40%	6.52%	6.65%	6.89%
Western	6.14%	7.02%	7.23%	7.33%	7.44%	7.64%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Annex 3 - Table C



Annex 3 - Graph C

<u>Annex 3 Table C and Graph C:</u> These show the Percentage Share of Trust Medical SUMDE Allocations following Options 1-5.

Annex 3 – page 4

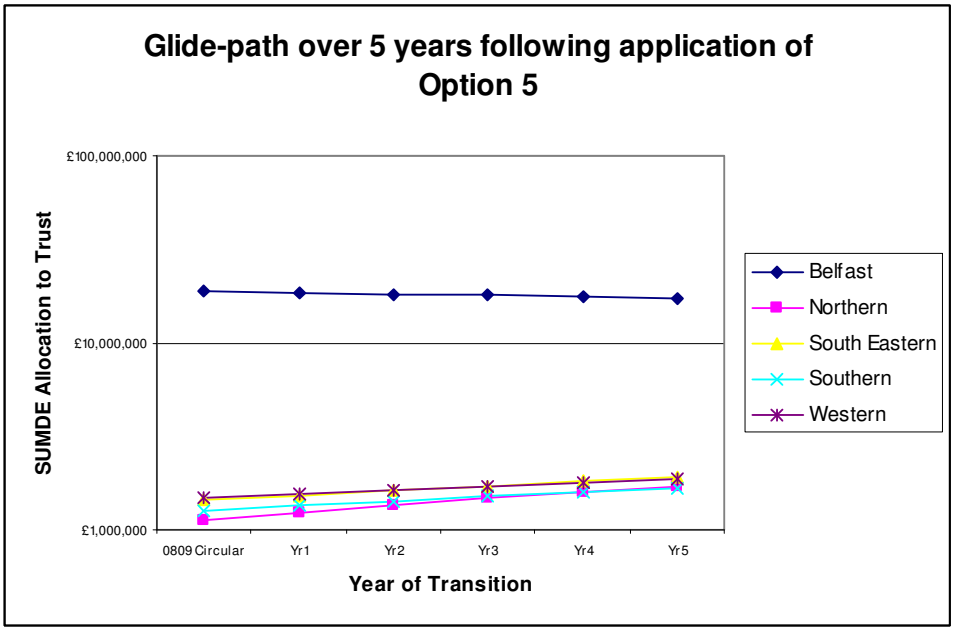
Glidepath

Trust	2008/09 Circular	Change per annum
Belfast	£18,949,115	-£364,599
Northern	£1,127,238	£115,264
S Eastern	£1,434,342	£92,655
Southern	£1,253,006	£83,828
Western	£1,489,343	£145,304

Annex 3, Table D: Annual Change to Medical SUMDE for each Trust following application of Option 5.

Trust	2008/09 Circular	Yr1	Yr2	Yr3	Yr4	Yr5
Belfast	£18,949,115	£18,584,516	£18,219,916	£17,855,317	£17,490,717	£17,126,118
Northern	£1,127,238	£1,242,502	£1,357,766	£1,473,030	£1,588,294	£1,703,558
S Eastern	£1,434,342	£1,526,997	£1,619,651	£1,712,306	£1,804,960	£1,897,615
Southern	£1,253,006	£1,336,834	£1,420,662	£1,504,490	£1,588,318	£1,672,146
Western	£1,489,343	£1,562,226	£1,635,109	£1,707,991	£1,780,874	£1,853,757
Total	£24,253,044	£23,888,445	£23,523,845	£23,159,246	£22,794,646	£24,253,192

Annex 3 - Table E



Annex 3 - Graph E

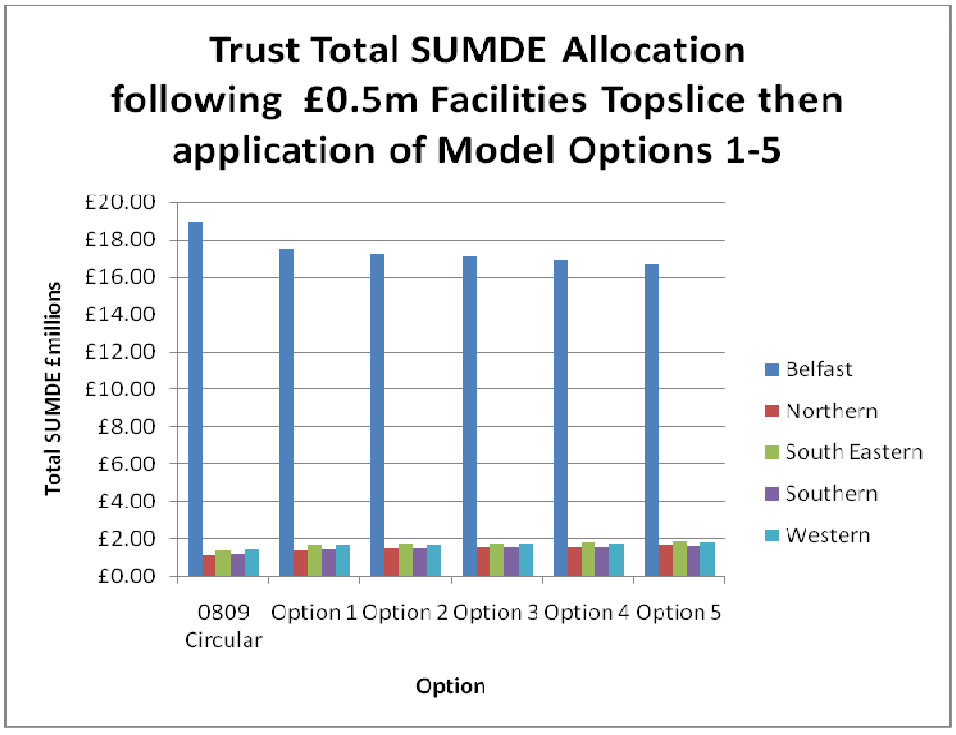
<u>Annex 3 Table E and Graph E:</u> These show the incremental change to Medical SUMDE Allocation for each Trust over Glide-path, following application of Option 5.

Annex 4 – page 1

Development of Financial Model 2

Trust	2008/09 Circular	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	£18,949,115	£17,481,673	£17,222,292	£17,092,601	£16,962,911	£16,703,530
Northern	£1,127,238	£1,437,127	£1,521,794	£1,564,128	£1,606,461	£1,691,129
S Eastern	£1,434,342	£1,683,737	£1,747,704	£1,779,687	£1,811,671	£1,875,637
Southern	£1,253,006	£1,472,853	£1,533,182	£1,563,347	£1,593,512	£1,653,842
Western	£1,489,343	£1,677,769	£1,728,197	£1,753,412	£1,778,626	£1,829,055
Trust Total		£23,753,158	£23,753,170	£23,753,175	£23,753,181	£23,753,192
Top-slice	£0	£500,000	£500,000	£500,000	£500,000	£500,000
Total	£24,253,044	£24,253,158	£24,253,170	£24,253,175	£24,253,181	£24,253,192

Annex 4 - Table A



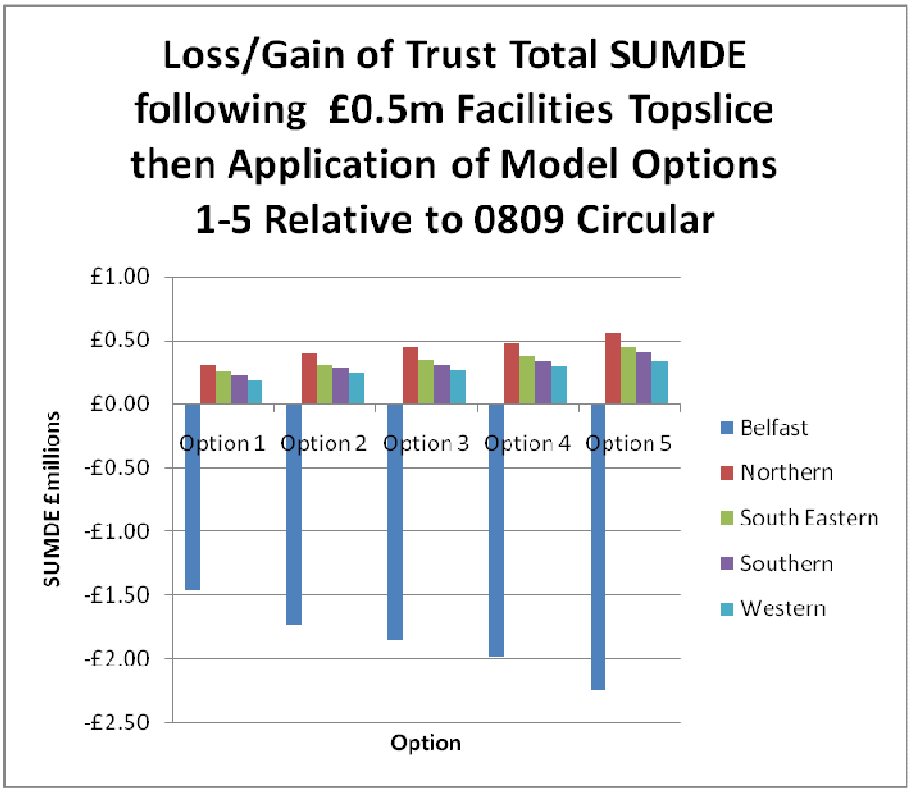
Annex 4 - Graph A

<u>Annex 4, Table A and Graph A</u>: These show Trust Medical SUMDE Allocations following £0.5m Facilities Top-slice then application of Model Options 1-5.

Annex 4 – page 2

Trust	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	-£1,467,442	-£1,726,823	-£1,856,514	-£1,986,204	-£2,245,585
Northern	£309,889	£394,556	£436,890	£479,223	£563,891
S Eastern	£249,395	£313,362	£345,345	£377,329	£441,295
Southern	£219,847	£280,176	£310,341	£340,506	£400,836
Western	£188,426	£238,854	£264,069	£289,283	£339,712

Annex 4 - Table B



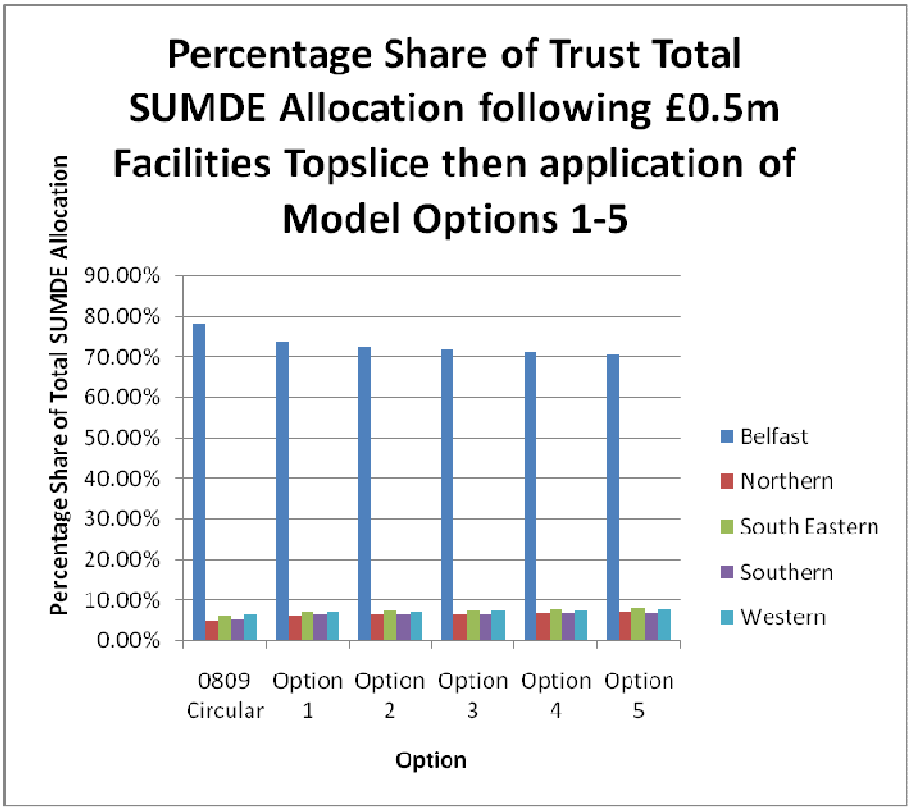
Annex 4 Graph B

<u>Annex 4, Table B and Graph B</u>: These show Loss/Gain of Trust Medical SUMDE Allocations following £0.5m Facilities Top-slice then application of Model Options 1-5 Relative to 0809 Circular.

Annex 4 – page 3

Trust	2008/09 Circular	Option 1 Total Allocn £260 per TU	Option 2 Total Allocn £260 + 10% on cost per TU	Option 3 Total Allocn £260 + 15% on cost per TU	Option 4 Total Allocn £260 + 20% on cost per TU	Option 5 Total Allocn £260 + 30% on cost per TU
Belfast	78.13%	73.60%	72.51%	71.96%	71.41%	70.32%
Northern	4.65%	6.05%	6.41%	6.58%	6.76%	7.12%
S Eastern	5.91%	7.09%	7.36%	7.49%	7.63%	7.90%
Southern	5.17%	6.20%	6.45%	6.58%	6.71%	6.96%
Western	6.14%	7.06%	7.28%	7.38%	7.49%	7.70%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Annex 4 - Table C



Annex 4 Graph C

***Annex 4,Table C and Graph C:** These show the Percentage Share of Trust Medical SUMDE Allocation following £0.5m Facilities Top-slice then Application of Model Options 1-5.*

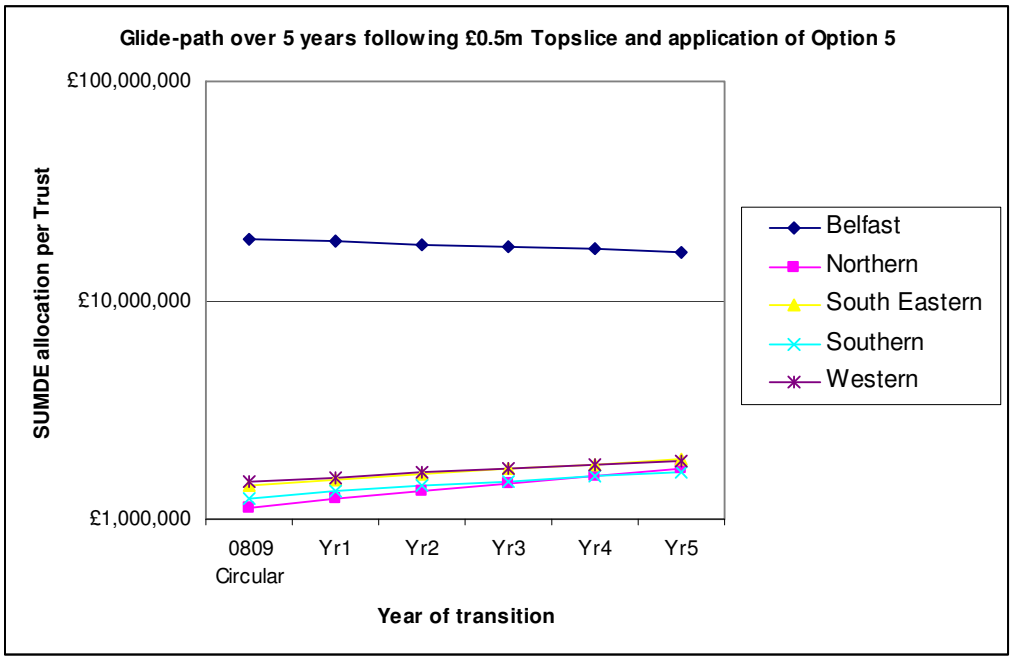
Annex 4 – page 4 — Glide-path

Trust	0809 Circular	Change per annum
Belfast	£18,949,115	-£449,117
Northern	£1,127,238	£112,778
South Eastern	£1,434,342	£88,259
Southern	£1,253,006	£80,167
Western	£1,489,343	£67,942

Annex 4, Table D: Annual Change to Clinical & Infrastructure (Facilities) (Facilities) (Facilities) SUMDE for each Trust following £0.5m Top-slice and application of Option 5.

Trust	0809 Circular	Yr1	Yr2	Yr3	Yr4	Yr5
Belfast	£18,949,115	£18,499,998	£18,050,881	£17,601,764	£17,152,647	£16,703,530
Northern	£1,127,238	£1,240,016	£1,352,794	£1,465,572	£1,578,350	£1,691,129
South Eastern	£1,434,342	£1,522,601	£1,610,860	£1,699,119	£1,787,378	£1,875,637
Southern	£1,253,006	£1,333,173	£1,413,340	£1,493,507	£1,573,674	£1,653,842
Western	£1,489,343	£1,557,285	£1,625,228	£1,693,170	£1,761,112	£1,829,055
Trust Total	£24,253,044	£24,153,074	£24,053,103	£23,953,133	£23,853,163	£23,753,192
Facilities Top-slice	£0	£500,000	£500,000	£500,000	£500,000	£500,000
Total	£24,253,044	£24,253,158	£24,253,170	£24,253,175	£24,253,181	£24,253,192

Annex 4 - Table E



Annex 4 Graph E

<u>Annex 4 Table E and Graph E:</u> These show the incremental change to Medical SUMDE Allocation for each Trust following £0.5m Top-slice and application of Option 5 over Glide-path.

Annex 5

Table for Comment on questions asked in the consultation document entitled:

'Review and Modernisation of Supplement for Undergraduate Medical and Dental Education (SUMDE)'

Question	Comment
1. Section 6 Is this rate to be fixed, if not, how should it be uplifted? Should the rate be linked to annual cost of living uplift?	
2. Section 7 Is there value in undertaking such a costing exercise to determine a weighting system that may take many years to accomplish?	
3. Section 7 Can those Trusts who may potentially benefit from re-distribution of funding demonstrate that any extra monies they receive will be spent on undergraduate medical education? How are they coping now?	
4. Section 8 Should the historic application of a 5% threshold of student weeks used to determine Infrastructure (Facilities) eligibility be re-introduced?	
5. Section 9 What lessons can be taken from the accountability of GP SUMDE?	
6. Section 10 To what level should Trust Finance Departments allocate a budget code specifically for SUMDE allocations in order to generate accountability and provide easy access for examining?	

7. Section 11 What are the Service implications should the Joint Appointment model change?	
8. Section 12 Which Option meets our objectives, and why?	
9. Section 13 Is 5 years an appropriate transition period?	
10. Section 13 Do any of the recommendations or proposals outlined in this document have a potential impact on equality of opportunity for any group of people? Please indicate any evidence – quantitative or qualitative – that would suggest a potential adverse effect.	
11. Section 13 The creation of any new model affords new opportunities to promote transparency and equality, how can the HSC best realise such opportunity?	
12. Section 13 Do you agree that appropriate key issues have been identified, and conclusions drawn for each of the main sections of the review?	
13. Section 13 Have appropriate recommendations been identified to progress action?	