

Undergraduate medical & dental education : interim report of the Steering Group.

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UNDERGRADUATE MEDICAL & DENTAL EDUCATION

INTERIM REPORT OF THE STEERING GROUP

*Chas. Jones**Sybil. Hanson*

Mr. Christopher Jones

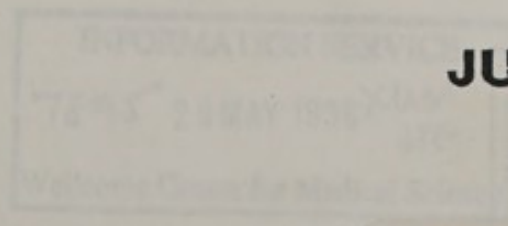
Department Secretary

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Permanent Secretary

Department of Education and Science



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1. The Steering Group on Undergraduate Medical Education was commissioned by Ministers in November 1987 after a Conference of the major bodies with responsibility for Undergraduate Medical Education. The Group's terms of reference were:

"to consider how the current arrangements for undergraduate medical education can be improved to ensure that the policies and programmes of the bodies concerned are properly co-ordinated and directed, reporting as necessary."

2. This remit was widened in April 1988 to include undergraduate dental education.

3. The Group was assisted by two task groups, on planning and information (details of membership are at Annex 3) and we are grateful to all who have contributed to the Group's work.

4. In Paragraph 4.30 of "Working for Patients", the Government affirms its commitment to medical education and says that the Steering Group "will develop its work and make recommendations in the light of the proposals in the White Paper. Work on this is already under way.

5. However, before the publication of "Working for Patients", the Steering Group considered the roles and responsibilities of those involved in undergraduate medical and dental education, received reports on planning and information and, taking into account the changing pattern of medical care and other factors, established important points of principle.

6. This interim report which has been endorsed by a further Conference [of the major bodies responsible for undergraduate medical and dental education] and by the Secretaries of State for Health and Education and Science describes the first phase of the Steering Group's work and makes 14 recommendations which we believe will apply regardless of the organisational changes engendered by "Working for Patients".

7. We believe that the interim report is a helpful document not only for its contents, which we commend highly, but also as a token of the improved communications which the Steering Group has fostered, not least between our two Departments. The Steering Group in its interim report have laid a firm foundation for the next phase of its work.

Chris France.

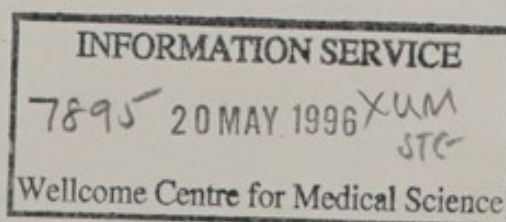
Sir Christopher France

*Permanent Secretary
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Sir David Hancock

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The Board of Health and the Department of Health and Social Security have been asked to consider the possibility of the Department of Health and Social Security taking over the responsibility for the health education of the public.

It is suggested that the Department of Health and Social Security should be responsible for the health education of the public and that the Department of Education should be responsible for the health education of the young.

This report was written in April 1988 to include undergraduate health education.

The Group was invited to two sub-groups on planning and information (which is membership of the Group) and we are grateful to all who have contributed to the Group's work.

In paragraph 4.30 of "Working for Patients", the Government states its commitment to medical education and says that the Group "will develop its work in the light of the proposals in the White Paper". Work on this is already under way.

However, before the publication of "Working for Patients", the Group considered the roles and responsibilities of those involved in medical education and health education, and reports on planning and information and taking into account the changing pattern of medical care and other factors, considered important points of principle.

This interim report which has been adopted by a Joint Committee of the Group is responsible for undergraduate medical and dental education and for the education of those for health and education and health education. The first phase of the Group's work and major recommendations which we believe will apply to the education of the medical and dental professions by "Working for Patients".

We believe that the interim report is a helpful document not only for its own sake, which we commend highly, but also as a basis of the improved communication which the Group has established and which we hope will be a first foundation for the next phase of its work.

Dr. J. H. H. H.

Chris Jones

Dr. J. H. H. H.

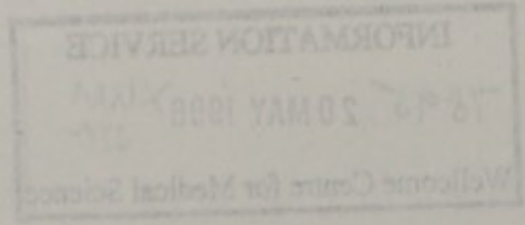
Dr. Christopher Jones

Dr. J. H. H. H.

Permanent Secretary

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FIRST REPORT OF THE STEERING GROUP ON MEDICAL AND DENTAL EDUCATION

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UNDERGRADUATE MEDICAL AND DENTAL EDUCATION 1ST DRAFT REPORT: STEERING GROUP

INTRODUCTION

1. In recent years concern has been expressed about undergraduate medical and dental education. In 1986 the General Medical Council (GMC) warned that present and future standards of medical education were threatened by reductions in the funding of universities and by financial constraints in the NHS. The GMC Education Committee, which carries the statutory responsibility for ensuring high standards of medical education reported in 1987 and 1988 on the difficulties medical schools were experiencing in attaining educational objectives. The General Dental Council (GDC) has expressed similar concern about the standards of dental education. In addition, surveys by the University Hospitals Association (UHA) and the National Association of Health Authorities (NAHA) have also highlighted reductions in clinical academic staffing in both medical and dental schools.

2. However the problems of medical and dental education can neither simply be put down to resources nor to the problems of medical and dental schools alone. Greater emphasis on throughput in hospitals has affected the capacity to provide facilities for teaching. In February 1987 the Croham Report in their review of the University Grants Committee (UGC) drew attention to the need to achieve co-ordination of joint planning at both national and local levels, and funding policies for universities and health authorities. (The Report's recommendations on medical and dental education are set out in Annex 1).

3. In November 1987 the Permanent Secretaries of the Departments of Health and Social Security and Education and Science convened a conference involving the main bodies with direct interests in medical education at which the Steering Group was established with the following remit:

"to consider how the current arrangements for undergraduate medical education can be improved to ensure that the policies and programmes of the bodies concerned are properly co-ordinated and directed".

The remit of the Steering group and of the Task Groups was extended in April 1988 to encompass dental undergraduate education.

NHS REVIEW

4. The Government's White Paper, "Working for Patients" was published on 31 January 1989. We welcome the commitment to medical and dental education given in paragraph 4.30 and the proposal that we should develop our work and make recommendations in the light of the White Paper. The proposals in "Working for Patients" have major implications for undergraduate medical and dental education. The scope of this report is restricted by the need to consider more fully those implications. Notwithstanding this commitment to further work, we feel able to make several recommendations for improving the arrangements in undergraduate medical and dental education. We therefore present this interim report, which looks at the key principles of undergraduate medical and dental education, and propose to make further recommendations based on our considered response to the proposals in the White Paper. Our recommendations are summarised at Annex 2, and information on our method of working is set out in Annex 3.

CHANGING PATTERN OF MEDICAL PRACTICE

5. The need to improve co-ordination has been strengthened by the changing pattern of medical practice, which has affected medical education. We have noted the following major changes:

i. Faster and more accurate diagnostic techniques together with less invasive methods of treatment are leading to shorter though more intensive periods of hospital stay and a higher proportion of patients treated on a day or outpatients basis.

ii. Some specialist work (eg community paediatrics and geriatrics) is developing with few if any inpatient beds. Outpatient work is being devolved to locations convenient for patients whilst inpatient work is being concentrated on fewer sites providing a greater range of services. In the future, medical students will need to spend more time both in the outpatient department and in the primary and community care setting.

iii. Increasing numbers of elderly people in the population will require more care, particularly community based services, to enable them to continue to live at home.

iv. The policy that patients who require continuing care should be provided with services in the local community means that there will be fewer long stay hospitals in future.

v. The current distribution of medical education is partly historical and perhaps relates more to the capacity of universities than to the services provided by the NHS. In London, where 30 per cent of all undergraduate medical education takes place, NHS resources have been reallocated to reflect movements in population away from inner city districts where most of the medical schools are still located. This has led to teaching taking place in hospitals away from major teaching centres.

6. At the local level it is clear that a main teaching hospital needs to accommodate a number of the specialties required for teaching. If the catchment population served by the teaching hospital is insufficient to generate enough patients to meet the needs of the medical school, other hospitals are likely to play a more important part in teaching. Indeed many medical schools find that experience in district general hospitals is a valuable way to teach the clinical student the skills to enable him to continue to learn throughout his career.

7. In higher education we attach great importance to the current developments in the sciences, especially in cell and molecular biology. The knowledge base in medicine is so large that the undergraduate curriculum cannot be comprehensive; doctors require postgraduate education before they can practise in the NHS, and it is clearly desirable that medical and dental students should receive a good scientific grounding which will prepare them to undertake postgraduate education, to evaluate their future practices and to cope with further changes in medical knowledge. To secure such a background undergraduates require access both to basic science and clinical academic departments and to patients in a wide variety of specialties inside and, increasingly, outside the hospital environment.

8. Many of the comments made to us, both in written representations and in the course of visits to medical schools, have been concerned with the curriculum and the content of medical education. It is not within our remit to pursue these issues in detail, beyond noting that the way that curriculum needs are met is a matter for the medical school and the GMC. But there may be several ways of meeting requirements and providers of services should be consulted to ensure that the method of choice is cost effective from the service point of view. We would emphasise that the changes which are taking place in medical education are important and will have to be recognised as planning proceeds. We have drawn attention to changes taking place in medicine, and give our wholehearted support to the GMC's recommendations on basic medical education (1980) that medical students should develop an understanding of health and illness in the community and of primary health care.

SPECIAL CHARACTERISTICS OF DENTAL EDUCATION

9. Dental education has certain special characteristics which we introduce here. Clinical education is much more concentrated, in being largely confined to dental teaching hospitals associated with each dental school. These hospitals are the only dental hospitals and much of their service work would otherwise be carried out in the General Dental Service, and not in hospitals. District General Hospitals normally have only a few beds for dental in-patients, and provide a dental out-patient service.

10. The dental student has to be able to practise independently on graduation whereas a doctor will have not only a pre-registration year but (for NHS practice) further years of training. Moreover, the dental student operates on patients, thus requiring a high level of supervision which is reflected in the staff/student ratio. Students' clinical practice provides relatively simple treatments - which would otherwise be provided by the General Dental Service - but at appreciably higher costs. It also includes instruction in more complex and time-consuming procedures. Both aspects are considered necessary to the development of practical expertise and this has significant organisational implications, not least for the definition of Dental SIFT (Service Increment for Teaching) allocations, which need to reflect this pattern.

11. *For these reasons we recommend that a common database of information concerning undergraduate dental education should be established as part of the future work on information for management planning (see paragraphs 53-58 below).*

12. The pattern of dental practice is changing. The population's standard of dental health and their expectations have increased. Dental care should make it possible for most people to retain their natural teeth throughout their life, as the UGC's Dental Review Working Party noted. Moreover costs are rising, particularly with respect to the complex forms of restorative dentistry required in the whole mouth care of the adult population.

13. Finally, it is worth noting two points of similarity between dental education and medical education:

- i. Dental education, like medical education, is affected by scientific advances. The UGC Dental Review Working Party concluded "The opportunity should not be lost to look initially at the steps needed to improve care, the capacity to solve clinical problems and the understanding of the scientific basis of dental disease".
- ii. Dental education is also directly affected by factors which restrict the numbers of hospital patients available for medical teaching purposes (eg shorter in-patient episodes), since dental students require clinical instruction in medicine and surgery.

ROLES AND RESPONSIBILITIES

14. We first set out to establish the roles and responsibilities of the bodies concerned with medical and dental education since we felt that these were sometimes imperfectly understood. It is clear that the DES and Health Departments each play a role at national level and the universities and the NHS both have responsibilities at local level. Medical education must cover the curriculum recommended by and must meet the standards set by the GMC, and similarly dental education is subject to the General Dental Council (GDC). More detail on the roles and responsibilities of each of the bodies concerned is set out in Annex 4.

15. The Secretary of State for Health has statutory responsibility for ensuring that clinical facilities are made available for medical and dental education, while the Secretary of State for Education and Science makes available to the Universities Funding Council (UFC) funds which are then allocated to universities, and within universities, to medical and dental schools.

16. The responsibilities of the universities and the NHS for medical and dental education are not symmetrical:

- i. **universities** with medical/dental schools have a formal responsibility to the GMC and/or the GDC, and the medical and dental schools are an integral and substantial part of the university system. The Dean of the Medical or Dental school is accountable to the University Vice-Chancellor.
- ii. **The NHS's** role is as a provider of patient care and a sponsor of good health. It provides essential clinical facilities for the education of doctors and dentists but these represent a small proportion of its total budget.

17. However we would stress that in practice the staff of the medical and dental schools and the medical and dental staff of the NHS are engaged in teaching, research and patient care - many individuals providing all three services. In addition many general medical practitioners (GPs) are involved in undergraduate medical education as well as providing general medical services. Similarly general dental practitioners participate in various ways in teaching dental undergraduates.

ACCOUNTABILITY

18. We considered the question of accountability against the background of the potential problems which a divided responsibility may create for the allocation of resources. We do not discuss here arrangements in the NHS, which will change in the light of proposals in the NHS Review.

19. The details of accountability in universities depend to some extent on each institution's own arrangements, although staff appraisal and individual performance review are now being introduced generally. Vice-Chancellors have responsibility to the GMC and GDC respectively for providing education of at least the required standard. Annex 5 describes the lines of accountability.

ORGANISATION - KEY PRINCIPLES

20. When we have considered more fully the implications of the NHS Review, we expect to make recommendations on possible models for change in the organisation of undergraduate medical and dental education. In the meantime we have looked at the present arrangements and have concluded that, the future shape of the NHS notwithstanding, there are key principles which will continue to apply, and improvements which should be made. *We recommend that the following principles are fundamental to medical and dental education:*

- i. medical and dental students must be educated both in terms of promotion of good health and treatment of illness to meet the future needs of health services and to maintain the standards of their professions, as represented by the guidance and by the standards of the GMC and GDC;
- ii. medical and dental education as part of the programmes of universities and the Health Service must be provided efficiently and in a cost effective way taking account of the available resources; and
- iii. the partnership between medical and dental schools and health authorities requires reciprocity in their dealings and planning with an appreciation of the other's needs.

ORGANISATION AT NATIONAL LEVEL

21. The paper on "Roles and Responsibilities in Medical Education" (Annex 4) sets out the broad division of responsibility for medical education. This complexity was recognised by the Croham Report which noted that "The triple commitment of clinical academic staff to teaching, research and patient care and the diversity of the medical schools' sources of funding make for administrative complexity". The more rigorous financial climate in recent years has exposed organisational weaknesses and this has heightened the need for the funding departments to co-ordinate their activities and consult each other about the effect of the policies pursued. The same problem has applied at local level.

22. The Croham Report concluded that "under the arrangements now prevailing between the DES and the Health Departments (HDs), neither party is in a position to take full responsibility for the funding of medical education". This is a view which has been echoed in submissions to the Steering Group and in the course of our visits to medical and dental schools.

23. As we have already noted, Health Departments' resource allocation policies have tended to be geared to meeting the defined needs of a specific population, which has involved some redistribution of resources away from the inner cities, where the population is decaying, while the provision of medical education depends on the distribution of medical schools, which tend to be in urban centres.

24. We note that action has already been taken to alleviate these concerns:

- i. the Health Departments, and Department of Education and Science and the UGC have forged closer links with regular meetings taking place;
- ii. the UGC in its grant letter of February 1987 advised universities that there should not be a disproportionate loss of staff in clinical academic medicine, and that decisions on freezing vacant posts should be the subject of close consultation with the relevant health authorities;
- iii. the planning guidance issued to NHS authorities in February 1987 pointed out the importance of taking account of the needs of undergraduate medical education in managing change, and of joint planning and consultation. The need for joint planning was confirmed in the joint guidance letter issued in March 1987.

25. However, it has been suggested that a formal unification of responsibility at national level should be considered. We have considered the implications of such a measure, and identified three possible ways in which it could be implemented:

- i. by DES taking total responsibility;
- ii. by Health Departments taking total responsibility;
- iii. by a third party taking responsibility.

26. Assumption of responsibility by the DES might be expected to ensure that undergraduate medical education would become explicitly academically led. The Health Service budget at present used by the health authorities for medical and dental staff in the hospitals, together with SIFT, would be transferred to the DES which would allocate these funds and have management responsibility for teaching hospitals.

27. We believe that this would entail divisions within the provision of health care. Indeed, a significant and increasing proportion of medical and dental education takes place away from the teaching hospital, at other hospitals and in the community, and in our visits to medical and dental schools we have seen that clinical experience away from the main teaching

hospital, is widely seen as a highly desirable component of medical education in particular. Passing control of teaching hospitals to DES would not, therefore, mean that medical education was entirely academically led. There would still be the need to collaborate with the NHS on the allocation of students to community placements and to placements in non-teaching General Hospitals. We also do not believe that the NHS would be willing to see many of its leading hospitals cease to be accountable to the Health Departments.

28. Assumption of responsibility for undergraduate medical education by Health Departments was mentioned in the Croham Report as a possibility. Certainly such a scheme would in theory unify much of the responsibility for medical education, and would mean that there would be a strong incentive to match medical education to service need. However, universities play a crucial role in the delivery of medical education. For example, at the pre-clinical stage there are links with other areas of biological science; there are links between medical physics and mechanical engineering, and between clinical departments and computing sciences and statistics. Also, increasing importance is attached to the study of social sciences and psychology, especially by those wishing to pursue careers in general practice. In other words there would be a continuing need for co-operation and joint planning within universities and therefore medical education would still not lie entirely within the remit of one department.

29. Moreover, apart from the need to continue to co-operate with the universities, clinical academic staff have expressed the fear that medical and dental education, if placed under the aegis of the Health Departments, might be vulnerable to the expediencies of service need. Certainly the budget, scale and range of activity of the NHS dwarfs that of the schools. We believe that such a danger exists and that there would need to be compelling potential benefits to justify a shift in the current statutory responsibilities.

30. A third "single funding" option would involve a third party taking on responsibility for the management of medical and dental schools. Under such a system, either single authorities would be set up to oversee medical and dental education throughout England, Scotland, Wales and Northern Ireland or a single UK authority would be created.

31. However we do not believe that such authorities would remove the need for medical and dental education to link into the NHS and the universities. The same complexities would continue to exist at local level, but the lines of accountability would be further complicated: the NHS, primarily responsible to the Health Departments, would, in this area, have a separate responsibility to a new authority, and the Universities with medical and dental schools, would *mutatis mutandis*, be in a similar position. In addition, the status and accountability of the education authorities would be a potential source of further confusion. Either they would need to report to either the Health Departments or DES, or both, or would be directly accountable to Parliament. In neither case can we see that the organisation of medical and dental education would be simplified at national or local level.

32. For the reasons outlined above, we do not feel able to recommend a unification of responsibility at national level. However we do believe that the arrangements for co-ordination of policy and funding at national level have not in the past been satisfactory. One of the key elements in our report is the need for universities and the NHS to improve consultation, joint planning and information at local level and we believe that this is more likely to be achieved if a lead is given at national level. *We therefore recommend that departmental policies for medical and dental education should be co-ordinated, and that published guidance relevant to medical and dental education should be consistent with these policies.*

33. We do not feel that a unification of responsibility for funding and managing undergraduate medical and dental education would be practical. But it has been argued that one of the two Departments should take a "lead" responsibility for policy, and be accountable for medical and dental education as a whole. This would however cut across normal lines of public accountability and across the responsibilities of the Cabinet Ministers involved. The proposal therefore, raises machinery of Government issues and is not for the Steering Group to determine.

ORGANISATION AT LOCAL LEVEL

34. One of the differences between individual medical and dental schools is their relationship locally with health authorities. Some, as a matter of policy, send clinical students throughout the Region. Others especially in London, focus on one or two districts. In the following section, we have looked at the key issues for planning and have identified as potential problems the following issues:

- i. resource allocation;
- ii. joint planning;
- iii. staffing and appointments; and
- iv. information for management and planning.

35. In considering organisation at local level, we considered a number of possible organisational models (which we summarise in Annex 6) but felt that we should take fully into account the proposals in "Working for Patients" before making specific recommendations. In the course of our work we have seen great commitment to undergraduate medical and dental education, both in the medical and dental schools and in the NHS, but this has often been overshadowed by the need for one, or both, to make difficult choices over the use of scarce resources and by the unavoidable differences in priorities between education and service provision. From this we derive one key principle which guides our thinking throughout the report: that in difficult circumstances the need for effective collaboration becomes even greater than normal.

RESOURCE ALLOCATION

36. No one person or institution decides how much university money or how much Health Service money is to be spent on medical and dental education. As medical and dental education are part of the larger programmes of universities and of the Health Service, so the allocation of resources to it has been dependent on these bodies. In the past, reliance on informal funding arrangements may have been to the benefit of medical education but in recent years it has been argued by the GMC and GDC that medical and dental education has suffered from the resource allocation systems of both sides.

37. For their part the universities have had to make savings in the 1980s and often have found it easiest to do so by not replacing staff who leave. Medical and dental schools suffered disproportionately within the universities because of their high proportion of short-term posts and the greater mobility of their staff, given their ability to move into NHS employment. Reductions in medical and dental school manpower have had a knock on effect on NHS services in a number of areas. On the Health side, for quite different reasons eg population changes or changes in patterns of care particularly the reduction in the number of in-patients and the increasing emphasis on day-care, the level of clinical facilities may have been reduced. Many teaching hospitals are in inner city areas, where utilisation of hospital services is relatively high and population is declining, while the effect of the National and Regional resource redistribution policies of the UK Health Departments, has been to move funds away from teaching districts, especially from those in inner London. Overall, however, Health Service activity has increased, with rapid rates of increase in numbers of day cases and developments in services for the elderly, mentally ill and the mentally handicapped, and academic staff who do clinical work have contributed to this increased activity.

38. In order to assist collaboration, greater clarity in the resource allocation policies of universities and of the NHS is desirable so that each may have a firmer idea of what the other will be contributing. If they are to plan together each side should have a budget of its own and some reasonable degree of confidence in its resources over the planning horizon. The Jarratt Report on the universities called for the devolution of budgetary responsibilities to individual faculties. Some universities have already implemented this and, as we consider it essential to co-ordination at local level that both medical and dental schools should have devolved budgets, *we recommend that this practice should be extended to all universities with medical and dental schools (or both).*

39. The Health Departments recognise the higher costs of teaching hospitals through the service increment for teaching (SIFT). Medical SIFT has been distributed as an element within total revenue allocations, but it has not otherwise been earmarked. Dental SIFT, by contrast, amounts to the major part of the cost of out-patient services of dental hospitals. We note the proposed improvement to SIFT outlined in "Working for Patients".

40. As has been mentioned, universities employ staff who spend a significant part of their time providing patient care and similarly health authorities employ staff who provide much of the clinical teaching of undergraduate students. The costs traditionally have thus been shared between universities and health authorities without any attempt to attribute all the costs of teaching to one side or of patient care to the other. Other costs, such as running costs of shared buildings, may have been apportioned, but not necessarily on the basis of a strict functional analysis.

41. In the course of our work, and our visits to medical and dental schools, we have encountered substantial support for these "knock for knock" arrangements on the grounds that they are based on a sharing of costs in which both sides make substantial and broadly equitable contributions, and the arrangement keeps administrative costs to a minimum. However, in the light of the NHS Review, and in particular the proposed extension to all major acute units of the Resource Management Initiative (RMI) we recognise that the future of existing "knock for knock" arrangements is uncertain. We will, as part of our second phase of work, consider the likely nature of financial arrangements between universities and the NHS in the light of "Working for Patients". However, in view of the growth of resource management, we *recommend that all new initiatives with financial implications for both sides should be costed and an apportionment agreed.*

JOINT PLANNING

42. The planning systems of the NHS and of the universities are described in Annex 5. Briefly, NHS short-term programmes are drawn up annually in response to Health Department guidelines and within the framework of strategic plans. Universities have not yet devised such well-developed planning mechanisms but are currently working in the UGC's four-year planning exercise. Another difference is that whereas NHS planning is based on a financial year ending 31 March, academic plans are based on the academic year August to July. We accept that this may be unavoidable, but it need not be a bar to effective planning provided that proper consultations and joint planning take place.

43. Our researches, including visits and questionnaires addressed to Regional Health Authorities (in 1987) and medical and dental schools (in 1989) have suggested that considerable consultation and collaboration occur in planning services where there are issues of mutual concern. Much effective co-operation is achieved through informal means, and we wish to avoid disturbing arrangements which appear to work well. However, difficult times for either or both sides impose strains on relationships and co-operation becomes both more necessary and more prone to difficulties.

44. In attempting to achieve a common purpose, it is necessary to bear in mind that some differences of priority cannot be eradicated. For example, as their prime function health authorities have to provide a range of services to meet the needs of their patients. Similarly medical and dental schools have to educate their students to the professional standards set down by the GMC and GDC. Under tighter financial control, there is pressure on both to carry out their functions in the most cost-effective and efficient way, and this leads to conflicting sets of priorities.

45. However, common interests considerably outweigh these contradictions and at present health authorities and medical schools are expected to find their own solutions through joint planning.

46. In the aftermath of the Jarratt report universities are in the process of streamlining their management structure with the Vice-Chancellor assuming many of the functions of a Chief Executive. Crucial resource allocation decisions are often made in a planning and resources committee which includes lay members. *We recommend that the Dean, or equivalent officer responsible for medicine and dentistry should be a member of this committee and should take cognisance of the views of Health Service Managers.*

47. Bearing in mind that current arrangements are likely to continue in the short term and to some extent in the longer term, it is necessary to consider ways of improving collaboration within existing systems. We have already commented on the challenge to strike a balance between teaching, research and service provision. But this can never be static and the continuing need to keep this balance under review argues strongly for effective co-ordination between those involved. Such co-ordination needs to be set in the context of agreed local policy for medical education. The key principles on which such a policy should be based are:-

- i. the agencies share a common objective to provide the best possible patient care, medical and dental education and opportunities for research;
- ii. the continued supply of sufficient numbers of well-trained doctors and dentists is essential to the future of the NHS;
- iii. joint resource planning is necessary to ensure that in doing so the best use is made of available resources, ie good quality medical and dental education and research to serve both patient care and education; and
- iv. there is a need for management of individual agencies to balance the quality and quantity of services they provide in seeking the optimum use of resources.

48. To strengthen this co-ordination we *recommend* that there should be a "common agenda" for planning which embraces the need for those involved to share information and views on:-

- i. existing services and plans;
- ii. current issues and progress;
- iii. future prospects.

Annex 7 provides a note to expand on these headings, and a checklist, which medical/dental schools and health authorities should use to measure the effectiveness of their local collaborative arrangements.

49. We further *recommend* that, as part of their wider planning responsibilities, those responsible for providing undergraduate medical and dental education should periodically issue joint statements of their planning aims and objectives for medical and dental education, and reports on performance and achievements.

50. The main formal agency for consultation at Regional level at present is the Regional University Liaison Committee (RULC). The broad remit of a RULC, as defined in HSC(IS)85, is "to advise the Regional Health Authority and the university or universities concerned on collaboration in the medical, dental and associated scientific fields (other than the postgraduate training of NHS doctors and dentists)." This remit includes advice on the needs of universities to use NHS facilities for medical and dental education. *RULC's have not been very effective in carrying out this part of their remit but we accept the need for a mechanism at RHA/University level for considering issues affecting medical and dental education. We recommend that a more specific approach should be defined in the context of work on implementing "Working for Patients".*

STAFFING AND APPOINTMENTS

51. In recent years the numbers of clinical staff wholly funded by the universities have reduced, while the numbers from non-Exchequer sources have increased rapidly. Many of the new staff are funded by medical research foundations or charities, and are thus principally concerned with research, rather than teaching. The support of the charities must be welcomed, but their priorities in research may be different from those of the NHS and of the medical and dental schools. In these circumstances the need for a better mutual understanding of existing and planned staffing is self evident. *We recommend that this problem should be investigated further.*

52. Changes in the staffing of medical and dental schools are a major element in universities' Academic Plans on which they consult with their corresponding health authorities; Districts similarly consult universities on their short term programmes including their manpower proposals. A change in the nature of a post may be as important as the decision to establish or close a post. NHS staff provide much of the clinical teaching of undergraduates and the medical or dental school therefore has the right to participate in the appointment of NHS consultants in teaching hospitals. Similarly a new professor or senior lecturer could be chosen on grounds of research potential and leadership rather than his specific clinical interest, which might differ from that of his predecessor. The special interest of a new university appointee can bring unplanned pressures on a health authority for clinical developments. We note that this question is currently being addressed as part of the work of a group set up under the aegis of the Department of Health's Manpower Planning Advisory Group. We also have seen that most schools already consult NHS colleagues about academic appointments. *We commend this and we recommend that providers of health care should be consulted on the nature and special interest of academic appointments and health authorities should be represented in the process of making academic appointments.*

INFORMATION FOR MANAGEMENT AND PLANNING

53. A successful organisation must have adequate information in order to be able to:

- i. plan sensibly;
- ii. manage efficiently;
- iii. provide effective services; and
- iv. be accountable.

Medical and dental education are no exception. Their particular needs cover the following information:

- i. where medical/dental education takes place, in particular the hospitals and other bodies involved in each school;
- ii. the numbers of students, and numbers successfully qualifying, at different levels;
- iii. the number of staff available for teaching and research, with details of clinical experience and specialism;
- iv. funds available from all sources (including NHS) and budgets for each school; and
- v. expenditure by each school under different heads.

54. Information is needed both at local level by those planning and delivering education, and at national level by Government, who are ultimately responsible for policy and funding. The GMC and GDC are responsible for monitoring standards of education; any additional information required for this purpose would be obtained from discussions with the schools.

55. We note that a considerable amount of information is already collected. For example, most universities collect data on their students, staff and expenditure in each cost centre. The cost centres for pre-clinical and clinical studies normally constitute the medical and dental schools. Similarly the health departments collect information on all medically qualified academic staff (including teaching staff with honorary appointments) by specialty and grade. Annex 8 describes in more detail the main available information, and identifies areas where more or different data are needed.

56. Much of the available information is not in a form which is coherent or complete enough to meet in full the needs of the schools and the NHS. More detailed information may be needed, and at a more disaggregated level than the university cost centres. A common planning system will require monitoring of the resources involved in teaching and research at medical and dental schools - in particular the net staff efforts provided by the university and the NHS, the use of hospital facilities, and financial flows. At present there is no integration between university and NHS information, although some initiatives are under way. Further work is needed to determine in more detail the information appropriate for each purpose, the frequency of data collection, and the definitions to be applied. In this way a common data base can be established, using existing information to greater effect and taking in new data only when their role in the planning process is clear.

57. Medical and dental schools are mainly Government funded and there is a public interest in monitoring how this funding is used. At the local level, Deans should publish summary statistics and indicators each year. National summary statistics should likewise be produced by Government, to monitor trends over time and to provide national indicators.

58. *We recommend that:*

- i. *current data collection and assembly procedures be amended to meet the special demands of planning medical and dental education;*
- ii. *new information should be collected where "gaps" currently exist - notably in the areas of sources of funding, staff teaching load, and students' courses and deployment across hospitals;*
- iii. *key summary statistics should be published annually by each medical and dental school as should comparable national statistics by Government;*
- iv. *a standing working group should be set up to maintain and monitor the information systems.*

FURTHER WORK

59. In the main body of this interim report, we have identified the complexities of the organisation of undergraduate medical and dental education and have recommended ways of resolving difficulties and clarifying uncertainties. In this section we identify issues which will require our attention in the next phase of our work. Some of these are made clear in the report. Our major task will be to make recommendations in the light of "Working for Patients" which has implications for the funding, planning and management of undergraduate medical and dental education. We have identified in the preceding paragraphs the need to develop a common database which will identify and define information requirements and to maintain and monitor information systems.

POSTGRADUATE MEDICAL AND DENTAL EDUCATION AND RESEARCH

60. Our remit was to look at undergraduate medical and dental education, but from the start we have recognised that the providers, medical and dental school staff and NHS staff, are also involved in postgraduate education and research. The divisions of responsibility for postgraduate and undergraduate education have been criticised by the General Medical Council. Research is closely allied to teaching. Academic staff are at the leading edge of developments in their field, and naturally wish to contribute to the advancement of science. The link with research helps to maintain the high quality of teaching, and we would wish to see maintained the attractiveness of clinical research as part of a medical or dental academic career. It is practicable for us to consider postgraduate education and research only insofar as they affect undergraduate education. We have been acutely aware of the importance of maintaining the high standards of clinical research in this country.

61. It has not yet been possible for us to consider in depth postgraduate education and research. We recognise the related work on these issues taking place elsewhere - the House of Lords Select Committee, the new Standing Committee on Postgraduate Medical Education (SCOPME), and the vigorous debate on the educational implications of "Achieving A Balance". We also recognise that much postgraduate medical education is essentially "hands on" experience and that the issues are largely concerned with the interface between service and training.

62. As a preliminary to this work, we are interested in identifying the effects of research on NHS costs. A small case study sponsored by the Department of Health looked at service costs associated with clinical research in Oxfordshire. Although the results do not claim to be precise, they indicate that an appreciable proportion of the District's annual revenue budget is spent on research, and the costs appear to affect teaching districts more than non-teaching districts. There is also an important role for universities in postgraduate medical education and *we therefore recommend that further work is undertaken to consider postgraduate education and research insofar as they are linked to and affect undergraduate education.*

TEACHING IN GENERAL PRACTICE AND COMMUNITY CARE

63. Our report has identified the increase in primary and community care as one of the major changes in patterns of medical service. The implications of this for the costs and management of education should be considered and *we recommend that we undertake further work in this area.*

CONCLUSION

64. In compiling our report we have made 14 recommendations, but we stress that the evidence of our work and of our visits to medical and dental schools is that medical and dental education in this country remains fundamentally strong.

65. At the conclusion of the first stage of our work, we believe that our interim report will help to reduce the complexities perceived in the current organisation of undergraduate medical and dental education. We appreciate that there is inevitably some uncertainty for the moment while the implications of "Working for Patients" are fully explored in respect of undergraduate medical and dental education but we believe that the principles of joint planning and improved information will underpin medical and dental education regardless of the organisational details.

THE CROHAM REPORT ON THE REVIEW OF THE UGC RECOMMENDATIONS ON MEDICAL EDUCATION

- i. "It is important that at least one full member of the [UGC] should have had first hand experience of medical matters, and in particular of the interface with the NHS." (paragraph 4.16)
- ii. "The current mechanisms for joint policy development between the DES, the Health Departments and the UGC are weak, with the result that too much is left to chance. That is a matter which needs urgently to be tackled by the departments concerned." (paragraph 6.32)
- iii. "Within the planning framework we have set out, we recommend that the academic and financial plans submitted to the UGC by universities should, in respect of medical and dental schools, be the outcome of specific consultation with the relevant health authorities." (paragraph 6.34)
- iv. "We are in little doubt that UGC will require a subordinate committee or committees charged with overseeing its responsibilities for medical and dental education, and providing advice." (paragraph 6.37)
- v. "We recommend also that the General Medical Council and, depending on the composition and remit, the General Dental Council should be invited to nominate assessors." (paragraph 6.37)
- vi. "We recommend that the Council take an active interest in the funding of medical schools, and that the subordinate structure it sets in place be competent to ensure that all relevant considerations, including the pursuit of value for money, are taken into account." (paragraph 6.39)
- vii. "If the Health Departments and the DES require co-ordinated advice, in order to formulate guidance to the UGC and to determine funding policy more widely, there may be a case for a consultative body, on which not only the funding agencies, but also the CVCP and the GMC, would have seats." (paragraph 6.41)

6. We recommend that the Dean, or equivalent officer responsible for studies and teaching should be a member of the Universities Planning and Resources Committee and that the committee should take cognisance of the views of Health Service Managers. (Paragraph 40)

7. We recommend that there should be a "common agenda" for planning which embraces the need for those involved to share information and views on:

- i. existing services and plans;
- ii. current issues and programs;
- iii. future prospects. (Paragraph 40)

8. We further recommended that, as part of their planning processes, providers of undergraduate medical and dental education should have joint planning with those of their aims and objectives for medical and dental education, and reports on performance and achievements. (Paragraph 40)

9. We recommended that the future name and membership of National University Liaison Committees should be determined in the context of "Working for Patients". (Paragraph 50)

10. We recommended that the scope for restructuring the interface of undergraduate medical and dental education with those of doctors who fund staff should be investigated, further. (Paragraph 50)

11. We recommended that providers of health care should be consulted on the nature and special interests of academic appointments and health authorities should be represented in the process of making academic appointments. Medical and dental schools have the right to participate in the appointment of their consultants to teaching hospitals. (Paragraph 50)

12. We recommended that:

- i. current data collection and assembly procedures be amended to meet the special demands of planning medical and dental education;
- ii. information should be collected which "gaps" currently exist - notably in the areas of sources of funding, staff training costs, and medical research and development across disciplines. (Paragraph 50)

SUMMARY OF RECOMMENDATIONS

1. We recommend that a common database of information concerning undergraduate dental education should be established as part of the future work on information for management planning. (Paragraph 11)
2. We recommend that the following principles are fundamental to medical and dental education:
 - i. medical and dental students must be educated both in terms of promotion of good health and treatment of illness to meet the future needs of health services and to maintain the standards of their professions, as represented by the guidance and by the standards of the GMC and the GDC;
 - ii. medical and dental education as part of the programmes of universities and the Health Service must be provided efficiently and in a cost effective way taking into account the available resources; and
 - iii. the partnership between medical and dental schools and health authorities requires reciprocity in their dealings and planning with an appreciation of the other's needs. (Paragraph 20)
3. We recommend that departmental policies for medical and dental education should be co-ordinated, and that published guidance relevant to medical and dental education should be consistent with these policies. (Paragraph 32)
4. We recommend that medical and dental schools should have devolved budgets. (Paragraph 38)
5. We recommend that all new initiatives with financial implications for both sides should be costed and an apportionment agreed. (Paragraph 41)
6. We recommend that the Dean, or equivalent officer responsible for medicine and dentistry should be a member of the Universities Planning and Resources Committee and that this committee should take cognisance of the views of Health Service Managers. (Paragraph 46)
7. We recommend that there should be a "common agenda" for planning which embraces the need for those involved to share information and views on:-
 - i. existing services and plans;
 - ii. current issues and progress;
 - iii. future prospects. (Paragraph 48)
8. We further recommend that, as part of their planning processes, providers of undergraduate medical and dental education should issue joint planning statements of their aims and objectives for medical and dental education, and reports on performance and achievements. (Paragraph 49)
9. We recommend that the future remit and membership of Regional University Liaison Committees should be determined in the context of "Working for Patients". (Paragraph 50)
10. We recommend that the scope for reconciling the interests of undergraduate medical and dental education with those of charities who fund staff should be investigated, further. (Paragraph 51)
11. We recommend that providers of health care should be consulted on the nature and special interest of academic appointments and health authorities should be represented in the process of making academic appointments. (Medical and dental schools have the right to participate in the appointment of NHS consultants in teaching hospitals.) (Paragraph 52).
12. We recommend that:
 - i. current data collection and assembly procedures be amended to meet the special demands of planning medical and dental education;
 - ii. new information should be collected where "gaps" currently exist - notably in the areas of sources of funding, staff teaching load, and students' courses and deployment across hospitals;

- iii. key summary statistics should be published annually by each medical and dental school as should comparable national statistics by Government;
 - iv. a standing working group should be set up to maintain and monitor the information systems. (Paragraph 58)
13. We recommend that we should be commissioned to go on to consider postgraduate education and research, insofar as they are linked to, and affect, undergraduate education. (Paragraph 62)
 14. We recommend that we undertake further work to explore the implications of an increase in primary and community care as part of the changing pattern of medical services. (Paragraph 63).

MEMBERSHIP, METHODOLOGY AND SUBMISSIONS RECEIVED

1. Membership of the Steering Group as follows:

Chairman: Sir Christopher France (Permanent Secretary, DOH)

University Grants Committee

Sir Colin Dollery (Chairman, Medical Sub-Committee)
Mr J Gooderham (Secretary, Medical Sub-Committee)

Committee of Vice-Chancellors and Principals

Professor T J H Clark (Dean, United Medical and Dental
Schools of Guy's and St Thomas's
Hospitals)

Sir Herbert Duthie (Provost, University of Wales College of
Medicine)

Professor P D Griffiths (Dean, of Medical and Dental Schools
Dundee University)

Professor R Storer (Dean, Dental School Newcastle
University)

National Health Service

Mr T Hunt (Regional General Manager,
North East Thames RHA)

Dr M O'Brien (Regional Medical Officer,
East-Anglian RHA)

Department of Education and Science

Mr J Vereker (Deputy Secretary)
Mr W B Wakefield (Director of Statistics)

Department of Health

Mr B Rayner (Deputy Secretary)
Dr A J Isaacs (Senior Principal Medical Officer)
Dr G Winyard (Senior Principal Medical Officer)
Mr N Glass (Assistant Secretary)
Mrs P Petrie (Assistant Secretary)

Scottish Home and Health Department

Mr K J MacKenzie (Under Secretary)
Dr G Scott (Deputy Chief Medical Officer)

Observers

Mrs J Gordon (Assistant Registrar, General Dental
Council)

Mr P Towers (Registrar, General Medical Council)

Secretariat

Mr D Lye (DOH)
Mr M Hipkins (DES)
Mr J Hunt (DOH)

2. The following also served as members of the Steering Group:
 - Mr M Partridge, Second Permanent Secretary, DHSS until the Departments were split in July 1988, was Chairman of the Group;
 - Mr R Bird, DES, was a member until January 1989.

Methodology

3. In compiling this report the Steering Group met four times. It set up two task groups; an Information Task Group (ITG), whose remit was to seek improvement in the medical information base; and a Planning Task Group (PTG), whose remit was to recommend arrangements for reconciling and promoting the planning of educational and service needs at local and national levels.
4. The Scottish Home and Health Department has been represented on both Task Groups, and papers have been copied to the Welsh Office and to DHSS Northern Ireland. References to institutional arrangements in the report are normally to those in England, but we have borne in mind the different organisational planning and information systems in the UK.
5. Membership of the Task Groups was as follows:

i. INFORMATION TASK GROUP

Chairman:	Mr W B Wakefield*	Director of Statistics, DES
CVCP	Dr A W Roberts	Registrar, University of Wales College of Medicine
	Mr K Davies	Principal Assistant Secretary, CVCP
NHS	Mr J Bacon Mr K McLean	Director of Information, NETRHA Treasurer, Leicestershire HA
UGC	Mr J Gooderham*	Secretary, UGC Medical Sub-Committee
	Mr M Hutcheson	Statistician
DES	Mr H M Dale	Statistics Branch Principal
	Mr M Hipkins	Principal, Steering Group Secretariat
SHHD	Dr D Adams-Jones (alternative Mr G Mitchell)	Director, Information Services Division, Common Services Agency
DOH	Mr R Willmer	Statistics and Research Division
	Mr R Rogers	Health Services Information Division
	Dr J Lissamore Mr D Lye	Medical Manpower & Education Division Steering Group Secretariat
GMC*/GDC*	Observer status	
Secretariat	DES	

* Indicates member of the Steering Group

ii. PLANNING TASK GROUP

Chairman:	Mrs P Petrie*	Assistant Secretary, DOH
CVCP	Professor T J H Clark*	Medical Dean, UMDS
	Professor D Shaw	Medical Dean, Newcastle University
	Professor P D Griffiths*	Medical Dean, Dundee University
	Professor R Storer*	Dental Dean, Newcastle University

NHS	Mr T Hunt*	RGM, NE Thames RHA
	Dr M O'Brien*	RMO, East Anglian RHA
UGC	Mr J Gooderham*	Secretary, UGC Medical Sub-Committee
DES	Mr M Hipkins Mr W B Wakefield*	Principal Director of Statistics
SHHD	Mrs N Munro	Assistant Secretary
	Dr G Scott (alternate Dr A B Young)*	Deputy Chief Medical Officer
DOH	Mr M Dunning	NHS Planning Division
	Mr N Glass*/Mrs E Hunter-Johnston	Regional Liaison Division
	Dr P Doyle	Medical Division
	Dr J Lissamore	Medical Manpower & Education Division
	Mr M Gayton	Regional Liaison Division
GMC*/GDC*	Observer status	Mr P Towers Mrs J Gordon
Secretariat	Mr J Hunt Mr F Brewis Mr D Lye Mr M Rayson	Department of Health

* Indicates members of the Steering Group.

6. In addition, questionnaires were sent to all medical and dental schools, seeking details of their organisation and arrangements for co-operation with health authorities. As Chairmen of the Steering Group, Mr Partridge and Sir Christopher France visited 13 medical and dental schools, and other members of the Steering Group and Secretariat visited most of the remaining schools.

7. The Group received oral submissions from:

the CVCP;

representatives of the lay Chairmen of Councils of Universities with Medical Schools; and

Dr C Paine and Mrs C Craig, authors of a study of NHS costs of local research.

8. Written submissions were received from:

the CVCP;

the Academic Medicine Group;

the University Hospitals Association;

the Standing Conference of National and University Libraries*;

the General Medical Council;

the Royal College of Radiologists;

the Royal College of General Practitioners;

the Royal College of Obstetrics and Gynaecology;

the Association of University Teachers of General Practice;

the British Medical Association;

the Scottish Council for Postgraduate Medical Education;

the Association for the Study of Medicine;

Alcohol Concern.

9. The Steering Group gratefully acknowledges all these contributions.

ROLES AND RESPONSIBILITIES

- i. A number of bodies are involved nationally in arrangements for the funding, management, content and provision of medical and dental undergraduate education and each of these has a distinctive role to play viz:
- ii. The Secretary of State for Education and Science does not have a statutory duty to provide universities or other institutions of higher education, nor does he control such institutions. There is thus no place for a duty on him to provide medical and dental education comparable with that of the Secretary of State for Health to provide facilities for clinical teaching under section 51 of the NHS Act 1977. However, consistent with the general duty in section 1 of the Education Act 1944 "to promote the education of the people of England and Wales", successive Governments have long accepted a role in helping higher education institutions make adequate provision for higher education, principally through public funding. That role is given explicit statutory recognition in section 131 of the Education Reform Act 1988 in its provision for the Universities Funding Council to administer funds made available by the Secretary of State for the support of university education. The Act makes similar provision in respect of polytechnics and colleges.
- iii. The Secretary of State has a range of policies for higher education, which apply to the medical and dental schools, as to any other faculty. These include policies which are educational in their nature, such as the response of higher education to changes in the school curriculum and examinations; policies directed at improving efficiency in the use of resources; policies designed to promote improvements in quality; and policies for research aimed at greater selectivity and the more effective use of resources.
- iv. The Secretary of State does not directly fund medical and dental education. He determines the total level of public funding for the universities but, by convention, accepts the UGC's advice on its distribution and the priorities to be given to different subject areas. That arm's-length relationship was given statutory force from 1 April 1989, when the new Universities Funding Council took over from UGC its powers to make grants to universities.
- v. The UGC is responsible for the distribution of funds made available by the Secretary of State. Through its Medical Sub-Committee, it advises on the funding of medical and dental schools and in so doing also exercises an overview of the development of medical education. With effect from April 1989 a new Universities Funding Council (UFC) replaced the former non statutory UGC arrangements (see Annex 5)
- vi. Present practice is for the greater part of each university's recurrent funding to be paid in the form of a block grant: the UGC does not specify the component attributable to medical and dental education, although universities know the underlying student planning numbers and may be given specific guidance especially on new developments.
- vii. The potential influence of both the Secretary of State and UGC/UFC is constrained in ways which are particular to medical and dental education, although some of the features are shared by other professional subjects. Intakes are fixed by reference to manpower reviews conducted by Health Departments. The curriculum has to meet the requirements of the General Medical or Dental Council. Clinical salaries follow the recommendations of the Doctors' and Dentist's Review body (with the provision by the Secretary of State of additional funding as appropriate). The capacity of the UGC/UFC unilaterally to alter the distribution of provision is severely limited by the complexity of the curriculum, the scale of physical plant associated with medical education, and the reliance on supporting NHS resources.
- viii. The medical schools may also be directly affected by the policies or actions of other arms of Government, principally the Health Departments. A current example is the restructuring now under way in the hospital medical staffing structure.

- b. provides training for clinical practice which reflects the needs of the National Health Service; and
- c. sustains high quality research to advance the treatment of patients.

Section 51 of the National Health Service Act 1977 places an obligation on the Secretary of State for Health to make such facilities available - an obligation which is met primarily through the provision of teaching hospitals.

x. **The National Health Service** provides the facilities in which clinical teaching takes place and employs staff who provide a large part of the clinical teaching. Academic staff who are clinicians do much of their teaching (as well as their service work and much of their research) in NHS buildings and with the support of NHS staff. NHS managers are involved in funding and planning decisions which affect the provisions of staff, beds and other facilities for clinical teaching.

xi. **The General Medical Council (GMC) and the General Dental Council (GDC).** The GMC's Education Committee has a statutory function under the Medical Acts to promote high standards and to co-ordinate all stages of medical education. It oversees medical school curricula and examinations. Ultimately the Council could make representations to the Privy Council that a course falling below its minimum standards should no longer be recognised as being suitable to produce medical practitioners qualified to practise clinical medicine. At approximately 10-yearly intervals, the GMC publishes recommendations on basic undergraduate medical education, setting out a framework for the medical courses which are devised by individual universities. The latest recommendations were published in 1980, and the Education Committee has recently published recommendations on the training of specialists and on general clinical training. The GDC has a statutory responsibility to promote high standards of dental education at all its stages and the GDC's current recommendations on the dental school curriculum were published in 1985.

xii. **The Committee of Vice Chancellors and Principals (CVCP)** has no statutory function, but provides a forum in which matters of common interest to Universities can be aired and drawn to the attention of Government, and it exercises on behalf of the universities certain common functions, including in particular national salary negotiations. The CVCP has two committees with an interest in medical education. The medical sub-committee, which is made up of the Vice-Chancellors and Principals of universities with medical schools, meets from time to time to discuss matters of policy and principle where there are implications for universities as a whole. The medical advisory committee, which consists of Deans of Medicine nominated by universities with medical schools, meets each term to consider policy issues and technical matters affecting medical education, particularly in the context of relationships between the universities and the NHS.

THE PLANNING OF MEDICAL EDUCATION THE UNIVERSITIES

- i. Under the Education Reform Act, 1988, the distribution of public funds to universities will fall to a new Universities Funding Council (UFC) from 1 April 1989. Until that time, the University Grants Committee (UGC) will fulfil the role described in paragraph ii-vii below.
- ii. The Secretary of State is advised by the UGC, and is represented on the UGC by an assessor. The UGC in turn is advised by its specialist sub-committees, including the Medical and Dental Sub-Committees, on which the Health Departments have assessors. DES is not represented in the sub-committees (other than Education).
- iii. The UGC current planning period extends over four academic years, 1986-87 to 1989-90. The block allocations made to each university represent an aggregation of funding decisions made primarily in the sub-committees about individual subject-related cost centres. The process starts with the determination of the relative unit funding entitlement of each cost centre, which is historically derived but which may be amended from time to time. When applied to the load derived from planned student numbers, these units of resource produce a packet of resources for each cost centre, which is sub-divided on the basis of the judgement of the relevant sub-committee, for attribution respectively to teaching and research. The teaching element is distributed in line with the load derived from planned student numbers, weighted over different levels of student. The implication is that, by the end of the planning period (1989-90), all universities will receive the same amount of funding per student within any particular cost centre. The research element is distributed partly in line with weighted student numbers and partly on a selective basis, which has regard to UGC research ratings, together with universities' income from outside research grants and contracts.
- iv. The UGC's current calculations were based on the end of the planning period, ie 1989-90; grants for the intervening years were arrived at by a process of interpolation. The allocation of teaching resources implies a process of equalisation; the allocation of research resources a process of differentiation. Within an individual university, these processes may operate in contrary directions.
- v. Universities have drawn up academic plans and financial forecasts to the end of the current planning cycle, 1989-90. The academic plans include the forward staffing intentions of universities, and within them of medical schools.
- vi. The output of the funding process is a block grant; the UGC does not at present disclose the way that grant is made up. Specific or earmarked funding is employed only at the margins, normally as a pump-priming device, and never as a means of long-term support for particular subjects.
- vii. In contrast to the UGC, which has an advisory role, the UFC is a statutory body with executive power to distribute to universities funds which the Secretary of State will make available. The Council may attach terms and conditions to those funds provided these do not relate to universities' use of private income. It is for the Council to determine its own method of distributing grant among institutions, but for 1989-90 it will take over the allocations recommended by the UGC. The grant from the Secretary of State to the UFC may be subject to general conditions, but these may not relate to the making of grants by the UFC to any specified institution. The Secretary of State has indicated to the Council that he expects it to establish a medical committee.
- viii. The 27 medical schools and 16 dental schools in the United Kingdom are an integral part of the university system. Their general expenditure is financed by the universities, and represents between a quarter and a third of the general expenditure of the universities concerned: about £300 million a year in all. An increasing proportion of their income is derived from external sources, principally in the form of research grants and contracts awarded by the research councils and the medical charities.
- ix. The special partnership between the university system and the NHS in medical and dental education has been exemplified by the system of mutual uncosted assistance or "knock for knock" arrangement. This recognises that, in addition to their teaching activities, clinical academic staff salaried by the universities make a significant contribution towards patient care likewise. Many NHS consultants in teaching (and non-teaching) hospitals spend a proportion of their time teaching students. Rather than institute a complex accounting system which would attribute teaching and service costs to the universities and health authorities respectively, it traditionally has been the practice to allow costs to lie where they fall on a knock for knock basis.

x. Universities' internal planning mechanisms were scrutinised in the report of a steering committee for efficiency studies (the Jarratt Report) published in 1985. The Jarratt Committee recommended in particular the development of rolling academic and institutional plans and the establishment of a planning and resources committee within universities, reporting to both Council and Senate. The evidence available to the UGC indicates a wide measure of acceptance of these recommendations. In January 1988 universities were asked to submit annual reports starting in July 1988 detailing the improvements and gains achieved since the Jarratt Report in the areas of management structure and administrative systems; financial management; purchasing; and building, plan, works allocation and use of space.

THE NATIONAL HEALTH SERVICE

i. The NHS planning system has three main elements: strategic planning: the planning of capital developments: short-term programmes. The system is outlined here as it operates in England: similar systems with local variations exist in the other countries of the UK. The planning system is likely to remain, although in a changed form, after the implementation of the White Paper, "Working for Patients".

The current system is described below.

ii. Strategic Planning: The main stages in the strategic planning round are:

- DoH guidance which provides the policy framework for planning and which contains long term revenue and capital assumptions for each Regional Health Authority.
- RHAs issue guidance to district health authorities on the objectives for the planning period.
- DHAs prepare strategies for each major patient service.
- RHAs consolidate the Districts' plans and submit regional strategic plans to DoH.

A key part of the process is to ensure that service activity, manpower and finance are co-ordinated. University medical schools and many clinical academics are involved in the planning process. The strategic plans provide a background against which subsequent, shorter-term planning work takes place.

iii. Capital Developments: The realisation of capital developments is part of the implementation of a strategic plan, but each major project is subject to an option appraisal. A teaching hospital scheme will often involve medical school accommodation, and agreement between the parties on the content of the scheme and the UGC contribution to the overall cost is required. The commissioning process for a teaching hospital development involves close working together between health authority and university staff in detailed planning of the use of the building.

iv. Short-term Programmes: Each year the DoH issues to health authorities a circular setting out service priorities and resource assumptions for the subsequent year or two years. On this basis health authorities prepare short-term programmes on the development of services for patients. These show considerable detail for the next financial year, while being less firm for the second year. These programmes are checked by RHAs for their coherence with the strategic plans; RHAs use district plans to prepare regional short-term programmes which are then checked by DoH. Actual activity is monitored through reports on the implementation of short-term programmes, and health authorities' performance is subject to formal review by Ministers and the NHS Management Board.

v. Relationship with medical and dental schools: Medical and dental education are unusual among university disciplines in that they also rely on support from the NHS for the facilities necessary for clinical teaching and research. The financial consequences of this for DHAs with responsibility for support for teaching are recognised in the DoH resource allocation process. The Service Increment for Teaching (SIFT) is protected within English Regional Health Authority allocations on a pro rata basis according to the number of additional service costs attributable to teaching although SIFT is not itself regarded as an adequate basis for local planning. The joint note of guidance issued in 1987 stressed the need for RHAs to have plans which would be manageable and sensitive to factors affecting service provision locally and for allocations to be based on these plans. It also drew attention to the importance of planning explicitly for all the service costs associated with teaching and research. Regions were asked to review their resource allocation policies and those of District Health Authorities with teaching hospitals with this in mind. As noted in paragraph 39 of the report, dental SIFT amounts to the major part of the cost of out-patient services of dental hospitals. Medical and Dental SIFT are to be increased in line with the recommendations of the NHS Management Board Review of RAWP, which was published in July 1988.

vi. Co-ordination: The questionnaire put to RHAs in 1987 revealed general satisfaction over the existing co-ordination arrangements for the management of medical education, which had been strengthened in recent years. Problems tended to arise with changes in resource levels: for health authorities from resource constraints and unplanned short-term changes in universities, and similarly, for medical schools, from short-term measures such as temporary closures of acute wards by health authorities. The health authorities reported that they had consulted their associated universities on their short-term programmes, and had usually been consulted on academic plans affecting them.

vii. The Health Service perspective: Health Service planning and resource allocation is driven by three main aims:

1. a commitment to directing resources to the needs of people;
2. a hierarchy of services, such that the most common problems are treated in local hospitals, usually district general hospitals, while rare and/or complex cases are referred to specialist centres; and
3. emphasis on community care and prevention.

Given the historic concentration of health care resources in Inner London and other city centres, and the movement of population out of city centres in the past three decades, resource allocation involves a shift of facilities and services from the main centres of medical education. The principle of specialisation still requires health authorities to have major sites for services, and many of the specialist services are provided by teaching hospitals. Districts, and even Regions are not required to be self-sufficient in acute services, but must aim for the most co-effective pattern of health care. For a variety of reasons (patients' wishes, less invasive therapies and financial pressures) patients are increasingly treated and cared for out of hospital, and numbers of acute services beds have been reduced. In consequence, medical students are taught in an increasing variety of settings, although the main teaching hospital remains central.

MODELS FOR ORGANISATIONAL CHANGE

1. There are two key principles against which any models needed to be considered:
 - i. the Group did not favour unification of national responsibility for funding and management within one Government Department; and
 - ii. there were major differences, both in the internal organisation and in relationships between individual medical and dental schools, and health authorities, and the differences between London and provincial schools were particularly noticeable.
2. The models were considered under two general headings:
 - i. pooled resources; and
 - ii. apportioned resources.

POOLED RESOURCES

3. Pooled resources models ranged from a total integration of management of the medical/dental school and the hospital, to the less radical use of a Joint Liaison Group specifically to co-ordinate management of medical and dental education.
4. Possible integrated management models for schools and teaching hospitals were:
 - i. a unified management structure;
 - ii. parallel management systems unified at the highest levels; and
 - iii. different and separate management systems unified at the highest levels.
5. Within these models, there were questions of balance, for example:
 - i. whether there should be an explicit academic lead;
 - ii. how far other bodies, for example, health authorities, FPCs, and the community, all of whom have important interests in service and/or teaching, would need to be represented; and
 - iii. how to encompass the increasing amount of teaching which takes place away from the main teaching hospital.
6. For the Joint Liaison Group model, there were questions as to its possible remit and composition. For all models, there were questions of accountability for the use of pooled funds.

APPORTIONED RESOURCES

7. The current "knock for knock" arrangements formed the basis of the apportioned resources models. There were two basic variations:
 - i. making no change to current arrangements; and
 - ii. refining knock for knock, for example by specifying consultants' responsibilities.

The Group considered a third apportionment option: that of replacing informal arrangements with formal contracts specifying what each side would contribute.

8. Among the issues arising from these models were:
 - i. how to balance the existing support for knock for knock against the trends towards more explicit costings;
 - ii. whether clarification of consultants' responsibilities, for instance through the use of A plus B contracts, was reflected in actual practice; and
 - iii. what would be the administrative and financial consequences of moving to contract-based funding.
9. It was agreed that further consideration of such models and any recommendations arising from them should await fuller analysis of the proposals in the NHS White Paper.

MODELS FOR ORGANIZATIONAL CHANGE

1. The purpose of this study was to identify and describe the various models of organizational change that have been used in the health sector. The study was conducted in a systematic manner, involving a search of the literature, interviews with experts, and a review of organizational documents. The results of the study are presented in this report.

2. There were three main differences between the models. First, the models differed in their approach to the identification of the problem. Some models focused on the individual level, while others focused on the organizational level. Second, the models differed in their approach to the implementation of change. Some models emphasized the importance of top-down change, while others emphasized the importance of bottom-up change. Third, the models differed in their approach to the evaluation of change. Some models used quantitative methods, while others used qualitative methods.

3. The models were based on three main assumptions. First, the models assumed that change was necessary for improvement. Second, the models assumed that change could be planned and controlled. Third, the models assumed that change could be implemented through the use of various strategies.

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ANALYSIS AND RESULTS

9. The current "best practice" model of organizational change is based on the following assumptions: change is necessary for improvement; change can be planned and controlled; and change can be implemented through the use of various strategies.

10. The current "best practice" model of organizational change is based on the following assumptions: change is necessary for improvement; change can be planned and controlled; and change can be implemented through the use of various strategies.

11. The current "best practice" model of organizational change is based on the following assumptions: change is necessary for improvement; change can be planned and controlled; and change can be implemented through the use of various strategies.

12. The current "best practice" model of organizational change is based on the following assumptions: change is necessary for improvement; change can be planned and controlled; and change can be implemented through the use of various strategies.

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15. The current "best practice" model of organizational change is based on the following assumptions: change is necessary for improvement; change can be planned and controlled; and change can be implemented through the use of various strategies.

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MEDICAL AND DENTAL EDUCATION: COMMON AGENDA FOR PLANNING

1. A common agenda is intended to identify the factors that agencies need to know about one another and provide a framework for the exchange of information at all levels. It is based on three principles:-
 - i. planning by individual agencies should reflect a knowledge of the objectives of, and constraints on the others;
 - ii. problem should be shared before all changes that impact on the other agencies are introduced;
 - iii. agencies should consider **together** opportunities for the future and the optimum deployment of resources.
2. Identification of the topics on agenda can be constructed under 3 main topic headings:-
 - i. **Existing services and plans:** what is being provided now or planned (education, health care and research); where medical education is provided (medical schools, health authorities and FPCs); who is providing and receiving medical education; and how the agencies are funded;
 - ii. **Current Issues and Progress:** the current problems and the progress being made;
 - iii. **Future Prospects:** the problems that are emerging; and the need to identify and agree ways to use resources more effectively (taking into account developments in patient care, developments in the curriculum, resource prospects and research opportunities).
3. The attached check-list has been devised to help agencies consider and measure their arrangements for collaboration over local policy, information, consultations and planning.

Planning

- i. Do you have arrangements to explore together opportunities for and constraints on the future:-
 - a. at a formative stage in planning, ie before detailed objectives have been agreed? or
 - b. opportunity to comment on developed plans?
- ii. Do you have arrangements to consider together the results of research projects which could influence service provision and proposals for new research studies?

INFORMATION FOR PLANNING MEDICAL AND DENTAL EDUCATION REPORT OF THE INFORMATION TASK GROUP

Background

1. The Information Task Group (ITG) was set up by the Steering Group on Medical Education with a remit to 'seek to improve the information base on undergraduate medical education'. The coverage was taken as Great Britain although it was understood that a separate Scottish exercise had been set up. It was agreed that the group could not restrict its work to undergraduate teaching but must consider certain wider aspects of medical education. It was later confirmed that the information requirements for dental education should also be covered.
2. There was close liaison with the Planning Task Group (PTG) set up to 'survey the planning processes on the health and education sides and to identify compatible arrangements for the future against a background of changing patterns of medical teaching and service requirements'.
3. Whatever the organisation set up for planning medical and dental education, the system will rely on information on students, staff, and finance. Even if the precise approach varies from place to place, universities and health authorities will need to feed off a common information base compiled in accordance with consistent ground-rules. This report makes recommendations on the types of information likely to be required, and how the data might be collected. There is a public interest in this information, both at local and national level. We therefore make recommendations on how the information base should be managed in the future, and on how key summaries might be published.

Coverage of existing data systems

4. Annex A lists current sources of data with a brief indication of their coverage. Universities provide information on their student load, staff and departmental expenditure in each cost centre. Pre-clinical and clinical education is provided primarily in the pre-clinical and clinical cost centres, though some may be made available in cost centres dealing with studies related to medicine/dentistry. The annual flow and stock of medical and dental students, university clinical academic staff and university departmental expenditure in medical/dental cost centres are all recorded in well established statistical series. In addition the Health Department collects information on all clinically qualified academic staff (including some teaching hospital staff with honorary university appointments) by specialty and grade. It also makes additional financial resources available to teaching authorities, via an agreed formula, to take into account the additional costs associated with medical and dental teaching.
5. Annex B illustrates the currently available information. It can be seen that a considerable amount of information is collected, but it lacks coherence and is incomplete. Proposals for improving the currently available information are included in this section.
6. Table 1 lists every university medical and dental school together with its main designated teaching district and main hospitals used for undergraduate teaching. It thus shows the main hospitals involved in medical and dental education. Additional lists of other hospitals where some education takes place are not readily available nationally, nor is the amount of provision in each of the hospitals listed. Table 2 shows the population by age in each Regional Health Authority. More detailed information may be required at the local level. For example, it may be more useful to give the catchment population for each speciality.
7. Tables 3-5 provide information on medical and dental school academic staff but the coverage of each table is slightly different. Table 3 shows all university clinical academic staff (those on clinical rates of pay) sub-divided by full-time/part-time status, by function of present employment (classified as teaching and research or research only) and by whether they are funded wholly, partly or not at all by university general funds. Table 4 shows for all full-time academic staff in the clinical cost centres what their source of funding is and whether they have a teaching commitment. Unlike Table 3 it includes staff on non-clinical rates of pay but excludes the small number of clinical staff in other cost centres. Table 5 shows to which cost centres the full-time staff on clinical rates of pay are allocated. Thus the tables provide staff numbers but none of these show the actual teaching commitment of the staff. Nor do they quantify the relative contributions of the various funding agencies.

8. Table 6 shows the speciality and grade of all medically qualified staff including some NHS staff holding honorary university appointments. The information is required for national manpower planning purposes. There is some overlap in the collection of these latter data and the university staff data. Within the university system there are also different interpretations of DH requirements in completing the returns. There is no equivalent table for dentally qualified staff. Further investigation is required into possible improvements or revised forms of data collection systems for medical and dental manpower.

9. Table 7 shows the numbers of students entering medical and dental schools and the total undergraduate and postgraduate student load together with data on postgraduate continuing education medical and dental courses. Thus the flow of students through the medical and dental schools is known. But the nature of student load upon individual hospitals is not available centrally. This should be made available locally.

10. Departmental expenditure in the pre-clinical cost centres is shown in Table 8. Precise information on the attribution of university central expenditure to cost centres is not available centrally; neither are data on the expenditure on pre-clinical and clinical education that takes place outside the pre-clinical and clinical cost centres. However, there is now some information on payment from universities to medical authorities for premises used.

11. It is not possible to identify the sources of income that contribute to general expenditure. Nor is the concept of a budget, against which expenditure can be monitored, well defined. Improved collection procedures for the assembly of data on the funding of medical and dental education should be introduced.

12. Tables 9 and 10 illustrate a selection of derived indicators which provide important management information. It is recognised that although there is a wide variation shown between different schools, partly reflecting organisational and definitional differences, more could be done with the information currently available to understand the various university systems in operation. A set of derived management indicators and a method for calculating them, taking into account the variations directly attributable to organisational and definitional differences, should be agreed.

Proposed information system for medical and dental schools

13. The group's basic recommendation is that certain key information be made available on a coherent and consistent basis for efficient planning of medical and dental education for each medical and dental school. Most of this will be required annually as a background to the planning cycle. But some more detailed information on aspects which would normally be expected to change only gradually, or where the information is very expensive or difficult to collect, should be obtained on a regular basis but less frequently, say on a five year cycle. The information set out below is thought to be the minimum that is required. In some cases this may involve adaptation of existing returns to meet the special needs of medical and dental education. In other cases new returns are proposed.

Annual information

14. A list of medical and dental schools, and their associated hospitals, will need to be updated along the lines of table 1 in Annex B. Information will be required not only for the university cost centres covered by these schools but also for other cost centres which contribute to medical and dental education. Student data will cover the numbers on each year of the course and obtaining qualifications, and also be expressed in terms of full-time equivalent load on each of the relevant cost centres. Details for postgraduate students and continuing education courses must not be neglected; it is recognised that the current data are unreliable as an indication of the universities' contribution and that more needs to be done to obtain consistent coverage.

15. Staff data will cover not only numbers of university clinical and non-clinical academic staff, but also the number of non-academic staff. A new return to indicate source of funding is needed, although the precise form of the data required will depend on the planning system adopted. Annex C Forms C1 and C2 illustrate what might be required. A field for source of funding of academic staff by organisation is already included on the USR Staff Return, but not in the form required by Form C1, eg the NHS is not shown as a distinct source of funding for those not wholly funded by university general funds.

16. One of the most difficult issues that the ITG has had to consider is the proportion of staff time which is devoted to undergraduate medical and dental teaching. For academic staff, their teaching load in each department, together with the teaching load provided by NHS staff and other staff, would provide information on the total resources expended on teaching and research. A new form might have to be introduced to collect these data. The UGC required similar information for all cost centres and is currently discussing a new staff load return. This return would give the total academic departmental staff effort within the clinical and pre-clinical cost centres of all staff, including that of NHS staff who do not have university contracts. Annex C Form C3 illustrates the information that might become available from the UGC return. The return would not separate out the amount of time spent on teaching and on research. However, the UGC are planning an exercise on research expenditure which will show the resources accounted for by research.

17. On the financial side, there is a need to monitor expenditure against a planned budget; and to know where the funding for such expenditure comes from. Table C4 indicates the sort of breakdown likely to be required; this is not currently available for universities' general expenditure. In the absence of detailed information, expenditure by the NHS as a direct result of medical education might be taken as the additional allocations made available under the Service Increment for Teaching (SIFT) procedures, assuming these continue. Expenditure in each school will need to be specified in terms of salaries, equipment and other appropriate headings. It may also be necessary to identify the areas of research covered under this expenditure, so that the universities and health authorities can assess the direction and balance of the research programme.

18. The process of medical and dental education requires the availability of key facilities, such as beds, cases, out-patients and GP practices. The numbers and, where relevant, the disposition of these facilities will need to be monitored regularly.

Information to be collected every five years

19. Monitoring how the medical and dental curricula are being delivered is important. Details of the student's work-programmes and the time spent on clinical studies in different hospitals, or attached to GPs, would indicate whether provision matched the required developments in medical and dental care. Information on the lines of the form shown at C5 would be necessary. Obtaining details of that type might be justified every five years.

20. It will be necessary from time to time to take a more detailed look at the way staff spend their time. In particular we will have to quantify the proportion of time spent on teaching, as opposed to undertaking research, patient care or administration. Precise information cannot be obtained, but a survey which required all those with teaching or other duties associated with the provision of medical and dental education to complete time schedules over various specified periods, would provide a basis for estimating staff costs. It should be possible to devise procedures which were not too demanding of individuals' time.

Management and control of information

21. Effective planning of medical and dental education therefore requires a rationalisation of existing data collection, together with new surveys covering sources of funding, estimation of staff load and student curricula. These will provide the minimum basis for monitoring, whatever precise system of planning is adopted. The more coherent and consistent in coverage the information, both within and between schools, the more valuable that information will be. Substantial issues on definitions needing urgent attention have been recognised. In addition the proposals for the collection of additional data will produce a number of other definitional problems. Annex D gives a number of examples of such problems. Some of these are due to the different methods of organising medical education in different universities and hospitals. Others are examples where there may be no 'correct' definition but where a consistent line is required if provision across institutions is to be compared and national statistics compiled.

22. Since a number of departments and organisations are likely to be involved, it is recommended that a formal working group of managers and statisticians be set up to review the information required, and to specify the areas to be covered and the definitions to be used. In addition the group would

- a. monitor progress in data collection and associated problems;
- b. make recommendations for presentation and publication, including appropriate performance indicators;
- c. propose adaptations and improvements required to meet developing planning and policy needs.

Statistical Profiles

23. The proposed working group may agree that the statistical information be published in the form of volumes or bulletins from time to time. However, we also recommend that the Dean of each medical and dental school should publish annually a key set of administrative, management, financial and output indicators. These statistical profiles, which would in effect be summaries of the more detailed data, would allow key objectives to be monitored from one year to another. An example of a possible profile is attached at Annex E. Not all the items are currently available, but we doubt whether future developments can be planned without taking them into account.

24. National summary statistics should be produced by Government, based on the profiles and on the more detailed data collected as part of the monitoring process. National statistics would enable developments in medical and dental education to be identified over time. Equally important, they would provide a benchmark against which developments in particular universities or health authorities could be compared.

The Role of Information within the Recommended Planning Process

25. Details of what information should be made available to whom and when can be finalised only after decisions have been reached on the appropriate planning procedure.

Summary of Recommendations

26. i. Amendments to current data collection and assembly procedures to meet the special needs of planning medical and dental education are required (paras 6 to 12 and Annex B).
- ii. New information on source of funding in total and for academic and non-academic staff, on staff load and on students' courses and deployment across hospitals should be collected (paras 14 to 20 and Annex C).
- iii. A standing working group should be set up to maintain and monitor the information and publication systems (paras 21 and 22).
- iv. Key summary statistics should be published annually for each medical/dental school in addition to national summaries (paras 23 and 24 and Annex E).

EXISTING REGULAR DATA SOURCES

1. Medical and Dental Schools and Teaching Hospitals

University medical and dental schools are identified in a number of university publications including "University Entrance: the Official Guide" produced by the Committee of Vice-Chancellors and Principals, the UCCA handbook of university undergraduate courses and University Management and Performance Indicators.

Lists of teaching hospitals and teaching districts are maintained by the health departments. In addition, the UGC maintains a list (obtained as a product of the Form 3 return) of university departments and their associated cost centres.

2. Students

The University Statistical Record (USR) maintains a record for every individual undergraduate and postgraduate student enrolled at each university, which is updated annually. It contains personal data, details of the course attended and when the student leaves details of his qualification, or if he left without qualifying, the reason for leaving.

The USR also maintains a Continuing Education Record (CER) which gives information on, for example, courses run by postgraduate medical departments, showing the length of and structure of the course, the number of students involved and the qualification to which the course will lead. A separate student load return is in force which calculates the FTE load on cost centres, the data from which can be used to calculate departmental unit costs.

3. Staff

The USR also maintains a record for each member of the academic staff holding a university contract. It provides personal details and shows the cost centre to which the member of staff is allocated. For clinical staff it does not provide details of the extent of their clinical commitment, nor of their clinical specialty. Nevertheless, the Staff Record does show the individual's academic discipline (broadly the area in which the member of staff lectures or is mainly concerned with academically) and degrees and qualifications held, by subject.

The health departments collect details annually of all medically qualified academic staff showing their grade and specialty.

4. Finance

The UGC collects an annual financial return from universities (FORM 3). This gives details of general departmental expenditure, in terms of salary and other costs, by cost centre and, separately, for these sub-divisions (as they are relevant) specific expenditure resulting from work financed by research grants and contracts and incurred on other Services rendered. FORM 3 contains information on central university expenditure (eg premises costs, academic services, administrative expenditure) though this is not attributed routinely or precisely to appropriate academic departments.

The UGC can provide information on FTE planned student numbers paying home fees, this being the basis on which the allocation of recurrent grant mainly takes place. However each university may allocate its funds as it wishes and so cost centres may or may not receive exactly the funds calculated as a result of the resource allocation process. Funds are not specifically earmarked by the UGC for the medical and dental cost centres.

The DH (through the Resource Allocation Working Party (RAWP) and the Service Increment for Teaching (SIFT) process) can provide information on planned NHS funding for medical and dental education. However it cannot identify how much money is actually spent on medical and dental education.

The first of these is the fact that the Commission has not yet received any information from the Government of the United Kingdom regarding the proposed changes in the law relating to the treatment of the mentally ill. It is therefore not possible to say whether or not the proposed changes will be in line with the Commission's recommendations.

The second of the main points raised in the Commission's report is the need for a more comprehensive system of care for the mentally ill. This system should be based on the principle of the least restrictive environment, and should be designed to meet the needs of the individual patient. The Commission has recommended that the system should be based on the following principles:

(1) The system should be based on the principle of the least restrictive environment. This means that the patient should be treated in the least restrictive environment possible, and that the treatment should be designed to meet the needs of the individual patient.

(2) The system should be based on the principle of the least restrictive environment. This means that the patient should be treated in the least restrictive environment possible, and that the treatment should be designed to meet the needs of the individual patient.

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CURRENTLY AVAILABLE INFORMATION

Table 1: University and other main teaching hospitals in the teaching district for each medical and dental school (University hospitals are marked*)

University Medical School	Designated Teaching District(s)	Hospitals in Teaching District used for undergraduate teaching	
		General	Specialist
ENGLAND			
Newcastle	Newcastle	*Royal Victoria Infirmary Newcastle General Freeman Hospital	
Leeds	Leeds Western	*Leeds General Infirmary	
	Leeds Eastern	*St James University Hospital Seacroft Chapel Allerton	
Leicester	Leicester	*Leicester Royal Infirmary Leicester General	
Nottingham	Nottingham	*University Hospital Nottingham City General Hospital	
Sheffield	Sheffield	*The Royal Hallamshire Northern General Children's Hospital Jessop Lodge Moor	
Cambridge	Cambridge	*Addenbrookes	
Southampton	Southampton & SW Hants	*General Royal South Hants	
Oxford	Oxfordshire	*John Radcliffe The Churchill The Radcliffe	
Bristol	Bristol & Western	*Bristol Royal	
Birmingham	Central Birmingham	*Birmingham General *Queen Elizabeth Children's	
Liverpool	Liverpool	*Royal Liverpool Broadgreen Alder Hey Children's	
	South Sefton	*Walton Fazakerley	
Manchester	Central Manchester	*Manchester Royal St Mary's	
	South Manchester	*Withington Wythenshawe	
	Salford	*Hope	

London	City & Hackney	*St Bartholomew's Hackney
	Tower Hamlets	*London Whitechapel Mile End
	West Lambeth	*St Thomas's
	Camberwell	*King's College Dulwich
	Lewisham & North Southwark	*Guy's Lewisham
	Wandsworth	*St George's St James
	Parkside	*St Mary's W2 St Mary's W9 St Charles Central Middlesex
	Riverside	*Charing Cross *Westminster St Stephen's
	Hampstead	*Royal Free
	Bloomsbury	*University College Hospital *Middlesex
WALES		
University of Wales College of Medicine	South Glamorgan	*University Hospital of Wales Cardiff Royal Infirmary Llandough Whitchurch
SCOTLAND		
Aberdeen	Grampian	*Aberdeen Royal Infirmary Woodend General
Dundee	Tayside	*Dundee Royal Infirmary *Ninewells
Edinburgh	Lothian	*Edinburgh Royal Infirmary *Western General, Edinburgh Edinburgh City Eastern General, Edinburgh Bangour General
Glasgow	Greater Glasgow	*Glasgow Royal Infirmary *Western Infirmary, Glasgow Southern General Gartnavel General Stobhill Victoria Infirmary

University
Dental School

Designated
Teaching District(s)

Hospitals in Teaching District used
for undergraduate teaching

General

Specialist

Newcastle

Leeds

Sheffield

Bristol

Birmingham

Liverpool

Manchester

London

University of
Wales

Dundee

Edinburgh

Glasgow

Table 2

MID-1986 POPULATION ESTIMATES
BY REGIONAL HEALTH AUTHORITIES AND AGE BANDS

		0-4	5-14	15-44	Age bands 45-64	65+	Total
England RHA							
Northern	(000's)	196.1	390.4	1335.2	694.7	464.0	3080.2
	(%)	6.4	12.7	43.3	22.6	15.1	100.0
Yorkshire	(000's)	232.2	461.2	1573.6	778.9	555.5	3601.4
	(%)	6.4	12.8	43.7	21.6	15.4	100.0
Trent	(000's)	288.5	583.7	2048.3	1016.2	697.0	4633.9
	(%)	6.2	12.6	44.2	21.9	15.0	100.0
E Anglia	(000's)	127.1	252.4	869.1	420.4	322.7	1991.6
	(%)	6.4	12.7	43.6	21.4	16.2	100.0
NW Thames	(000's)	227.0	417.3	1607.9	745.7	490.1	3488.1
	(%)	6.5	12.0	46.1	21.4	14.1	100.0
NE Thames	(000's)	247.2	452.6	1687.2	803.3	570.5	3760.8
	(%)	6.6	12.0	44.9	21.4	15.2	100.0
SE Thames	(000's)	223.4	426.7	1569.8	776.7	622.0	3618.6
	(%)	6.2	11.8	43.4	21.5	17.2	100.0
SW Thames	(000's)	177.4	344.3	1296.2	651.2	495.4	2964.5
	(%)	6.0	11.6	43.7	22.0	16.7	100.0
Wessex	(000's)	173.6	347.9	1255.5	613.9	485.5	2876.4
	(%)	6.0	12.1	43.6	21.3	16.9	100.0
Oxford	(000's)	166.9	326.2	1166.8	502.1	314.3	2476.3
	(%)	6.7	13.2	47.1	20.3	12.7	100.0
S Western	(000's)	186.5	379.8	1349.0	697.2	565.1	3177.5
	(%)	5.9	12.0	42.5	21.9	17.8	100.0
W Midlands	(000's)	337.0	672.0	2286.4	1145.5	740.4	5181.2
	(%)	6.5	13.0	44.1	22.1	14.3	100.0
Mersey	(000's)	157.0	312.9	1053.9	533.9	356.5	2414.1
	(%)	6.5	13.0	43.7	22.1	14.8	100.0
N Western	(000's)	264.3	512.5	1740.9	856.1	616.0	3989.8
	(%)	6.6	12.8	43.6	21.5	15.4	100.0
England	(000's)	3004.2	5879.7	20839.7	10236.0	7295.1	47254.6
	(%)	6.4	12.4	44.1	21.7	15.4	100.0
Wales	(000's)	178.9	358.5	1202.7	624.3	456.8	2821.0
	(%)	6.3	12.7	42.6	22.1	16.2	100.0
Scotland	(000's)	323.0	657.0	2278.2	1120.3	742.6	5121.0
	(%)	6.3	12.8	44.5	21.9	14.5	100.0

Table 3

CLINICAL STAFF IN GB UNIVERSITIES

	1980	1981	Academic Year starting in			1985	1986
			1982	1983	1984		
Full-time							
Teaching/Teaching & research							
Category A	2636	2492	2293	2245	2174	2158	2088
Category B	165	223	241	249	314	364	384
Category C	279	341	452	529	672	746	831
Total	3080	3056	2986	3023	3160	3268	3303
Research only							
Category A	19	20	18	16	19	18	16
Category B	3	3	1	3	3	2	5
Category C	302	303	350	385	451	556	635
Total	324	326	369	404	473	576	656
Part-time							
Teaching/Teaching & research							
Category A	401	399	417	422	435	448	437
Category B	12	19	45	46	22	28	34
Category C	64	73	87	111	100	125	139
Total	477	491	549	579	557	601	610
Research only							
Category A	3	3	3	3	9	4	2
Category B	0	1	3	3	4	3	4
Category C	44	41	48	48	61	72	84
Total	47	45	54	54	74	79	90

Category A - wholly university funded

Category B - partly university funded

Category C - not university funded

Clinical staff are those on clinical rates of pay.

Source : USR

Table 4

FULL-TIME ACADEMIC STAFF (CLINICAL & NON-CLINICAL) BY COST CENTRE
GB UNIVERSITIES

	1980-81	1986-87	% change
Clinical medicine cost centre			
Teaching/Teaching & research			
Category A	2809	2241	-20.2
Category B	188	446	137.2
Category C	462	1012	119.0
Total	3459	3699	6.9
Research only			
Category A	137	147	7.3
Category B	5	17	240.0
Category C	1399	2393	71.1
Total	1541	2557	65.9
Total	5000	6256	25.1
Clinical dentistry cost centre			
Teaching/Teaching & research			
Category A	535	543	1.5
Category B	4	24	500.0
Category C	13	26	100.0
Total	552	593	7.4
Research only			
Category A	5	6	20.0
Category B	0	0	0.0
Category C	27	43	59.3
Total	32	49	53.1
Total	584	642	9.9

Category A - wholly university funded

Category B - partly university funded

Category C - not university funded

Source: USR

TABLE 5

FULL-TIME ACADEMIC STAFF ON CLINICAL RATES OF PAY IN GREAT BRITAIN
UNIVERSITIES 1986-87

Departmental Cost Centre	Wholly University Financed	Partly University Financed	Not University Financed	Total
Clinical Medicine	1652	370	1388	3410
Clinical Dentistry	418	18	39	475
Pre-clinical studies	14	1	14	29
Anatomy and physiology	3	-	5	8
Pharmacology	9	-	4	13
Other studies allied to medicine	4	-	3	7
Biochemistry	-	-	3	3
Psychology	-	-	1	1
Other biological sciences	2	-	3	5
Veterinary science	-	-	2	2
Engineering cost centres	-	-	3	3
Education	1	-	1	2
TOTAL DEPARTMENTAL COST CENTRE	2103	389	1466	3958
Other	1	-	-	1
TOTAL ALL COST CENTRES	2104	389	1466	3959

Source: USR

UNIVERSITIES, MEDICAL SCHOOLS, INSTITUTES ETC MEDICAL STAFF
ANALYSIS BY UNIVERSITY SUBJECT, UNIVERSITY NATURE OF APPOINTMENT
AND UNIVERSITY GRADE OR TITLE
30 SEPTEMBER 1986
ENGLAND AND WALES

Number

Subject and Nature of Appointment	All Staff	Professor	Reader	Senior Lecturer	Lecturer	Demonstrator or Assistant Demonstrator	Research Assistant	Independent Research Worker	Tutor	Other Research Staff	Ungraded
All subjects	Total 6329	681	185	1532	1745	82	419	514	430	282	459
	Whole-time 3216	595	167	778	1016	67	283	5	72	183	50
	Part-time 603	40	12	256	143	9	36	-	19	19	69
General Medicine	Honorary 2510	46	6	498	586	6	100	509	339	80	340
	Total 560	58	20	118	146	5	59	41	54	46	13
	Whole-time 300	53	17	61	83	3	36	-	17	29	1
	Part-time 41	3	3	26	3	1	2	-	1	2	-
	Honorary 219	2	-	31	60	1	21	41	36	15	12
Clinical Physiology	Total 22	1	2	3	6	3	-	3	-	4	-
	Whole-time 15	1	2	-	5	2	-	1	-	4	-
	Part-time 2	-	-	1	-	1	-	-	-	-	-
	Honorary 5	-	-	2	-	-	-	2	-	-	-
Nuclear Medicine	Total 8	3	-	3	1	-	-	-	-	-	-
	Whole-time 4	2	-	1	-	-	-	-	-	-	-
	Part-time 1	1	-	-	-	-	-	-	-	-	-
	Honorary 3	-	-	2	-	-	-	-	-	-	-
Rheumatology and Rehabilitation	Total 63	6	3	15	12	-	12	6	6	2	1
	Whole-time 33	5	3	8	6	-	6	-	4	1	-
	Part-time 2	1	-	1	-	-	-	-	-	-	-
	Honorary 28	-	-	6	6	-	6	6	2	1	1
Infectious Diseases	Total 41	7	1	12	11	-	5	-	4	1	-
	Whole-time 27	5	1	9	6	-	4	-	1	1	-
	Part-time 6	1	-	1	2	-	1	-	1	-	-
	Honorary 8	1	-	2	3	-	-	-	2	-	-
Thoracic Medicine	Total 70	5	2	28	16	-	10	7	-	1	1
	Whole-time 32	3	1	7	11	-	9	-	-	1	-
	Part-time 6	-	1	4	5	-	1	7	-	-	-
	Honorary 32	2	-	17	7	-	-	7	-	-	1
Dermatology	Total 60	4	4	20	7	-	6	7	5	4	3
	Whole-time 23	3	2	6	4	-	6	-	-	2	-
	Part-time 9	-	2	6	1	-	-	-	-	-	-
	Honorary 28	1	-	8	2	-	-	7	5	2	3

Continuing with a further 53 specialties

Source: Statistics and Research Division
Department of Health
Manpower Planning Return

Table 7

MEDICAL AND DENTAL STUDENT NUMBERS

GB universities

	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88
Entrants to Pre-clinical Medicine	3963	3979	4183	4140	4031	4027	4054	3912
Entrants to Pre-clinical Dentistry	962	947	956	925	894	852	861	847
Undergraduate FTE student load by cost centre								
Pre-clinical Medicine ¹	10339	10574	10496	10576	3435	3421	3483	..
Clinical Medicine	12186	12258	12403	12347	12585	12744	12681	..
Clinical Dentistry	3015	3006	3025	3002	2964	2959	2852	..
Postgraduate FTE student load by cost centre								
Pre-clinical Medicine ¹	1278	1271	1208	1192	444	438	416	..
Clinical Medicine	4288	4331	4233	4223	4205	4059	4030	..
Clinical Dentistry	262	306	302	326	314	380	354	..
Continuing education postgraduate courses								
Courses	3359	3496	3060	3280	3545	3735	3935	..
student numbers	74716	84778	76358	83524	87004	88995	96413	..
Student hours (thousands)	1745	2394	1898	1921	1733	1706	1930	..

¹. Department/cost centre classification changed in 1984-85

Source: USR

Table 8

GB UNIVERSITY MEDICAL AND DENTAL SCHOOL EXPENDITURE

	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87
PRE-CLINICAL STUDIES¹							
Salaries of academic & academic related staff	22907	23851	24354	25303	9487	9811	10615
Other departmental salaries and wages	13730	14469	14715	15146	5287	5221	5502
Other departmental expenditure	3934	3854	4464	4865	1560	1557	1647
Total Recurrent Expenditure from General Income	40570	42174	43533	45313	16334	16589	17764
Research grants and contracts	..	14171	16189	19635	7606	9178	10826
Other specific expenditure	..	1262	955	1027	906	1237	1061
Total Specific Expenditure	14230	15433	17144	20662	8512	10415	11887
Departmental equipment expenditure	4345	3944	4974	5037	1719	1949	1863
CLINICAL MEDICINE							
Salaries of academic & academic related staff	53163	55887	56911	61804	65221	73067	80593
Other departmental salaries and wages	21874	22506	23384	24914	27080	28443	29825
Other departmental expenditure	5766	5736	6901	7837	9063	9766	10235
Total Recurrent Expenditure from General Income	80803	84130	87195	94555	101364	111277	120652
Research grants and contracts	..	52491	60761	72207	85414	97905	115903
Other specific expenditure	..	23208	27507	30488	36655	42639	48937
Total Specific Expenditure	68038	75699	88268	102695	122069	140544	164840
Departmental equipment expenditure	6879	8122	8944	9194	9838	9287	9693
CLINICAL DENTISTRY							
Salaries of academic & academic related staff	11565	12600	13220	14403	15531	17077	18581
Other departmental salaries and wages	2856	2711	2573	2811	2854	2850	2971
Other departmental expenditure	567	539	661	726	800	926	1022
Total Recurrent Expenditure from General Income	14988	15851	16454	17940	19185	20583	22514
Research grants and contracts	..	1015	1124	1402	1635	2123	2237
Other specific expenditure	..	1003	1179	1513	1840	1973	2388
Total Specific Expenditure	1741	2018	2303	2915	3475	4096	4625
Departmental equipment expenditure	732	613	1203	1057	1127	837	939

.. not available

1. Departmental/cost centre classification changed in 1984-85

Source: UGC

Table 9

DERIVED INDICATORS FOR EACH SCHOOL 1986-87

University	Pre-clinical studies		Clinical Medicine		Clinical Dentistry		Percentage successful leavers ²
	FTE students	Unit ¹ Cost	FTE students	Unit ¹ Cost	FTE students	Unit ¹ Costs	
Birmingham	-	-	610	6160	240	7630	89
Bristol	-	-	610	7030	161	5960	90
Cambridge	274	4010	267	9670	-	-	93
Leeds	-	-	746	7820	183	8180	92
Leicester	250	4130	332	7470	-	-	91
Liverpool	-	-	757	4700	235	5990	93
London	2519	4730	6321	7310	1091	7150	91
Manchester	-	-	1055	6300	221	7920	94
Newcastle	348	4170	662	7340	255	5170	94
Nottingham	439	4000	413	7490	-	-	98
Oxford	-	-	419	12350	-	-	97
Sheffield	-	-	617	6670	165	6230	95
Southampton	64	5020	480	7910	-	-	91
Univ Wales Col Med	-	-	540	7370	158	7990	97
Aberdeen	-	-	452	7310	-	-	97
Dundee	-	-	463	6280	153	6370	89
Edinburgh	5	33010	863	7470	120	9700	92
Glasgow	-	-	1104	6850	224	6960	92

¹ Unit cost = Total recurrent expenditure from general income
Total FTE student load

² Successful leavers in 1985 to 1987 as a percentage of all leavers from medical and dental courses in 1985 to 1987.

Source: CVCP/UGC: University Management Statistics and Performance Indicators in the UK.

Table 10

DERIVED INDICATORS BY COST CENTRE

GB universities

	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87
Unit costs (£'000s)							
Pre-clinical	3.5	3.6	3.7	3.9	4.2	4.3	4.6
Clinical medicine	4.9	5.1	5.2	5.7	6.0	6.6	7.2
Clinical dentistry	4.6	4.8	4.9	5.4	5.9	6.2	7.0
Student/staff ratios							
Pre-clinical	-	-	-	-	8.8	8.6	8.7
Clinical medicine	-	-	-	-	4.9	4.7	4.6
Clinical dentistry	-	-	-	-	5.0	5.0	5.0
First Degree Graduates (UK)							
Clinical medicine	3227	3200	3577	3560	3592	3062	3487
Clinical dentistry	787	849	667	862	856	622	731

Notes:

1. Unit costs = $\frac{\text{Total recurrent expenditure from general income for each cost centre}}{\text{Total FTE student load}}$
2. Student/staff ratio = $\frac{\text{Total FTE students for each cost centre}}{\text{Total FTE staff (teaching)}}$

Source: USR

SPECIAL SURVEY OF FUNDING FOR STAFF HOLDING UNIVERSITY CONTRACTS
IN CLINICAL MEDICINE AND DENTISTRY

To be completed by each university medical or dental cost centre

Category A staff (staff paid wholly from general funds)

(Percentage of
funding)

Proportion funded by UGC

Proportion funded from private sources
(eg endowment)

Proportion funded from other sources
(please state)

100

Category B staff (salaries paid partly from general funds, partly from other sources)

%

Proportion funded by UGC grant

Proportion funded from private sources
(eg endowments)

Proportion funded by NHS

Proportion funded from other sources
(please state)

100

Category C staff (staff wholly funded other than from general funds)

%

Proportion funded by the NHS

Proportion funded from private sources
(eg endowments)

Proportion funded from other sources
(please state)

100

SPECIAL SURVEY OF NURSING FOR STAFF WITH PHYSICIAN ASSISTANTS IN CLINICAL MEDICAL AND DENTAL

Page 100

To be completed by staff who have been assigned to the clinical medical and dental units
Category A staff (staff who have been assigned to the clinical medical and dental units)

Category A	Category B	Category C	Category D	Category E
1.00	1.00	1.00	1.00	1.00
2.00	2.00	2.00	2.00	2.00
3.00	3.00	3.00	3.00	3.00
4.00	4.00	4.00	4.00	4.00
5.00	5.00	5.00	5.00	5.00
6.00	6.00	6.00	6.00	6.00
7.00	7.00	7.00	7.00	7.00
8.00	8.00	8.00	8.00	8.00
9.00	9.00	9.00	9.00	9.00
10.00	10.00	10.00	10.00	10.00

Category B staff (staff who have been assigned to the clinical medical and dental units)

Category B	Category C	Category D	Category E
1.00	1.00	1.00	1.00
2.00	2.00	2.00	2.00
3.00	3.00	3.00	3.00
4.00	4.00	4.00	4.00
5.00	5.00	5.00	5.00
6.00	6.00	6.00	6.00
7.00	7.00	7.00	7.00
8.00	8.00	8.00	8.00
9.00	9.00	9.00	9.00
10.00	10.00	10.00	10.00

Category C staff (staff who have been assigned to the clinical medical and dental units)

Category C	Category D	Category E
1.00	1.00	1.00
2.00	2.00	2.00
3.00	3.00	3.00
4.00	4.00	4.00
5.00	5.00	5.00
6.00	6.00	6.00
7.00	7.00	7.00
8.00	8.00	8.00
9.00	9.00	9.00
10.00	10.00	10.00

(i) Non-academic staff in each medical and dental school

Type of staff	Full-time	Part-time	Full-time equivalent
Technicians			
Dental Instructors			
Clerical			
Other			
Total			

(ii) Source of funding for non-academic staff

Percentage of funding provided by				
UGC	NHS	Other Government	Other	Total

100

*A similar return for all cost centres has been prepared by the UGC.

(1) Staff multiplied by percentage academic effort

(2) Include transfers to and from other cost centres

(3) To allow for circumstances which could not be shown on the staff return eg staff leaving during the year.

STAFF LOAD RETURN*

University Medical or Dental School: name.....

	Cost Centre		
	Pre-clinical	Clinical Medicine	Clinical Dentistry
Staff as shown on the USR staff record			
Full-time number			
Full-time equivalent ¹			
Part-time number			
Full-time equivalent			
Total full-time equivalent			
Corrections between centres ²			
Transfers in (FTE)			
Transfers out (FTE)			
Extra teaching effort (fee or hourly paid staff) FTE			
Adjustments for NHS appointments			
In			
Out			
Adjustments for extra effort ³			
Additions			
Subtractions			
Resulting total FTE			

*A similar return for all cost centres has been proposed by the UGC and USR

(1) Staff multiplied by percentage academic effort

(2) Include transfers to and from other cost centres

(3) To allow for circumstances which could not be shown on the staff return eg staff leaving during the year.

Funding for each medical and dental school

	Source of funding (£000's)					Total
	UGC	NHS	Other Government	Endowments Donations etc	Other	
<u>Recurrent income</u>						
General funds						
Specific income						
Total income						

- (1) The number of student weeks (ie full-time equivalents) spent in each hospital for each course should be entered. The names of the hospitals should also be shown.
- (2) All salaries included in the curriculum should be listed.
- (3) It should include any teaching done outside the hospital system eg in GP practices.

Funding for each medical and dental school

Source of funding (1987-8)	1987-8			
	Other	Other Government	Other	Total
General funds				
Specific income				
Total income				

CLINICAL STUDENTS' CURRICULUM AND TIME SPENT IN DIFFERENT HOSPITALS

University Medical or Dental School: name.....

Course ²	Length (weeks)	Full/Part time	Hospitals				Total	Other ³
			1	2	3...n	Other or not Known		
Introductory								
Junior Medicine								
Junior Surgery								
Obstetrics and Gynae								
Paediatrics								
Orthopaedics								
General practice								
Total								

- (1) The number of student weeks (in full-time equivalents) spent in each hospital for each course should be entered. The names of the hospitals should also be shown.
- (2) All courses included in the curriculum should be listed.
- (3) This should include any teaching done outside the hospital system eg in GP practices

CLINICAL STUDENTS' CURRICULUM AND TIME SPENT IN DIFFERENT HOSPITALS

University / Medical or Dental School name: _____

Course	Length (months)	Full Part time	Hospitals				Other or not known	Total	Other
			1	2	3	4			
Medicine									
Surgery									
Obstetrics and Gynaecology									
Paediatrics									
Community Practice									

The number of student weeks (or full-time - months) spent in each hospital for each course should be entered. The names of the hospitals should also be shown.

All courses included in the curriculum should be listed.

This should include any teaching done outside the hospital system or in GP practices.

DEFINITIONAL ISSUES

1. In some universities pre-clinical medical and dental students are mainly taught in the medical or dental school (the pre-clinical cost centre). In other universities there is no pre-clinical cost centre and they are mainly taught in other departments, for example the anatomy department. In planning medical education the information concerning pre-clinical courses must be comparable between institutions whatever the organisation of their departments.
2. Staff who teach clinical students will frequently be carrying out teaching and patient care duties simultaneously, for example when carrying out ward rounds or out-patient clinics with students present. In assessing the contribution of these staff to medical and dental education agreement must be reached on how to allocate their time.
3. A similar problem to that at (2) above occurs in assessing staff time spent on research and whether this is educational or clinical. This question arises regardless of whether the research involves the supervision of post graduate students or not.
4. Medical and dental schools and their associated hospitals frequently share accommodation, especially laboratories and equipment. Agreement on how the costs of such joint resources should be allocated between medical and dental schools and the NHS is required.
5. The contribution of NHS staff to medical and dental clinical teaching is difficult to define and quantify. Agreement on how the NHS contribution is assessed must be reached.
6. The scope of each medical and dental school needs to be defined, in terms of the hospitals and the specialties involved. Appropriate 'catchment areas' may have to be defined by the health authorities, so that provision of medical and dental education can be related to demographic information.

DEPARTMENT OF MEDICINE

1. In some of the pre-war medical and dental schools and in the medical schools of the post-war period, it was common to have a pre-clinical department and a clinical department. The pre-clinical department was responsible for the first two years of the course and the clinical department for the last two years. In the post-war period, the pre-clinical department has been abolished and the clinical department has been expanded to cover the entire course. This has resulted in a more integrated approach to the teaching of medicine and dentistry.
2. The pre-war medical and dental schools were characterized by a rigid curriculum and a lack of flexibility. The post-war medical and dental schools have adopted a more flexible curriculum and have introduced a variety of elective courses. This has allowed students to tailor their education to their own interests and career goals.
3. A similar problem to that of the pre-war medical and dental schools was the lack of research facilities. The post-war medical and dental schools have invested heavily in research facilities and have established research departments. This has led to a significant increase in research output and has improved the quality of medical and dental education.
4. Medical and dental schools in the post-war period have been characterized by a more integrated approach to the teaching of medicine and dentistry. This has been achieved through the establishment of joint medical and dental schools and through the introduction of joint degree programs. This has resulted in a more holistic approach to the training of medical and dental professionals.
5. The post-war medical and dental schools have also been characterized by a more emphasis on research. This has been achieved through the establishment of research departments and through the introduction of research fellowships. This has led to a significant increase in research output and has improved the quality of medical and dental education.
6. The post-war medical and dental schools have also been characterized by a more emphasis on clinical training. This has been achieved through the establishment of clinical departments and through the introduction of clinical rotations. This has resulted in a more practical approach to the training of medical and dental professionals.

SCHOOL PROFILE

Name of School

Teaching District in which situated

Main teaching hospitals

Main supporting hospitals within district

Regional Health Authority in which situated

Name

Characteristics of the region

Size of population

Percentage under age 5

Percentage aged 65 and over

Students

Enrolments

Load on university cost centre

Ug Pg Total

Pre-clinical
Intercalating
Clinical (all years)Pre-clinical¹
Clinical
Other

Postgraduate & research

All

Percentage of student hospital teaching load² undertaken outside the main teaching hospitals.Percentage of student hospital teaching load² undertaken outside the teaching district.

Student hours of postgraduate continuing education

Formal courses

Other forms of training

1. Where applicable

2. Weighted hospital teaching time allowing for more intensive teaching in certain bedside/chairside/laboratory/lecture programme

Recurrent finance for 198 - 8

Budget¹

Source of income (£000's)

For specific medical or dental purposes

From general funds

Exchequer grants

fees

Other

Total

Actual expenditure

Pre-clinical

Clinical

Other

From specific income

Salaries

Academic

Non-academic

Other

Total

From general income

Salaries

Academic

Non-academic

Other

Total

All

Management information

Graduates

Postgraduates

First degree: pre-clinical

First degree: intercalating

First degree: clinical

Higher Degrees

Diplomas

Student:staff ratios

Pre-clinical

Clinical

Undergraduates leaving course without a degree during or at the end of the pre-clinical course

Undergraduates leaving course without a degree during or at the end of the clinical course

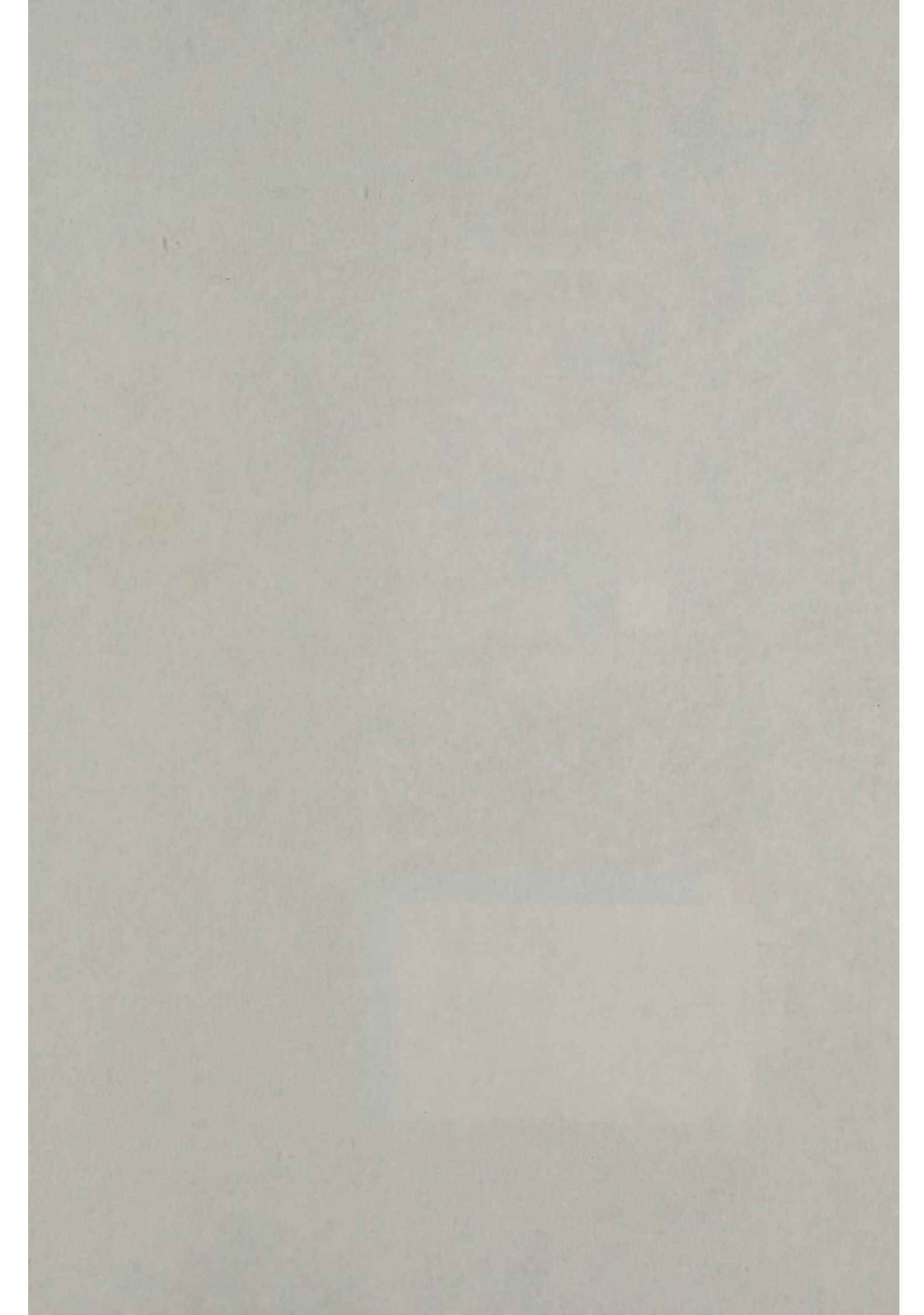
Unit costs² adjusted for continuing education load

Pre-clinical

Clinical

1. Planned expenditure

2. Total recurrent expenditure divided by full-time equivalent student load



Expenditure Summary - 1985-86

Notes:

Source of Finance 1985/86

The specific medical and dental purposes
from general funds

Expenditure groups

Net

Other

Total

Actual expenditure

Pre-clinical

Clinical

Other

From specific income

Salaries

Academic

Non-academic

Other

Total

From general income

Salaries

Academic

Non-academic

Other

Total

All

Management information

Graduates

Postgraduate

First degree: biomedical

Higher Degrees

First degree: interdisciplin

Diplomas

First degree: clinical

Undergraduate studies

Pre-clinical

Clinical

Undergraduate leaving course without a degree during or at the end of the pre-clinical course

Undergraduate leaving course without a degree during or at the end of the clinical course

Undergraduate adjusted for continuing education for 2

Pre-clinical

Clinical

1. Planned expenditure

2. Total recurrent expenditure divided by full-time equivalent student load