Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Supplement for Undergraduate Medical and Dental Education

24 September 2009

NORTHERN IRELAND ASSEMBLY

_____

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

_____

Supplement for Undergraduate Medical and Dental Education

_____

24 September 2009

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mr John McCallister
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:
Mr Neil Cunningham)
Dr Damian Fogarty)
Dr Drew Gilliland) British Medical Association Northern Ireland
Mr Nigel Gould)
Ms Gráinne Magee)

The Chairperson (Mr Wells):

I welcome a high-powered delegation from the British Medical Association (BMA) Northern Ireland. Dr Damian Fogarty is chairman of the Northern Ireland medical academic staff committee, Mr Neil Cunningham is a member of the Northern Ireland medical students committee, Mr Nigel Gould is the Northern Ireland deputy secretary, Dr Drew Gilliland and Ms Gráinne Magee, who is the BMA Assembly and research officer. You are all very welcome. You now have the opportunity to make a presentation to the Committee, after which I will ask

members whether they wish to ask any questions.

Dr Damian Fogarty (British Medical Association Northern Ireland):
I have placed Neil at the centre of the group for a very good reason. Neil is a medical student and, as the evidence session is about undergraduate medical education, he will give members his insight in a few moments. Dr Drew Gilliland and I are clinical academics, which means that we are involved with clinical practice. Dr Gilliland is a GP, and I am a kidney specialist. However, half of our time is spent teaching and researching at Queen's University Belfast (QUB). Our evidence this afternoon is about undergraduate teaching.

Our brightest students, after taking their A levels, go to Queen's University, where they spend five years studying medicine. The first two years are largely classroom based, with about 20% to 40% patient contact. As the students move through third, fourth and fifth years, they spend more and more time on wards, in general practices or in outpatient clinics. By the time they reach their final year, all their time is spent in the Health Service sector.

The supplement for undergraduate and dental education (SUMDE) reflects the additional income that comes to the health and social care sector to support the education of medical students when they are on a ward. One must recognise that, if a group of students is on a ward, in outpatients or in general practice, doctors cannot see as many patients, and they have to set up an environment that will allow the students to be taught as well as treating the patients. The students see real patients, and they talk to them. SUMDE funds the trusts and clinical sessions that are taught by a consultant or a general practitioner. The supplement is additional to the income that the university receives for any undergraduate student; that is an important point. The university will receive funding for undergraduate students, in any case: SUMDE goes to the health and social care sector.

Medical students comprise a very different group of students compared with other students, but that is not to detract from other students. At the end of the students' final year, in June, Dr Gilliland and I assist with the final examinations, and, after a rigorous process of evaluation, we can say that they are qualified: they have become doctors. That process is regulated by the General Medical Council, which is an external agency. Two months later, at the start of August, they start to practise medicine. At that stage, they are in hospitals, well supervised and rarely do anything on their own. However, they are very different from other categories of student, be that

engineering, law or whatever. Those junior doctors will help to treat your relatives and mine: for instance, my father passed away, and he was managed very well by many first-year junior doctors. It is in all our interests to get this right: the quality of patient care is reflected in the quality of the new junior doctor.

Dr Drew Gilliland (British Medical Association Northern Ireland):

As a GP, I spend half of my time in general practice, and the other half in the medical school at Queen's University. My main role involves assessment in the medical school, and I also look after the fourth-year course, which, as Damian said, is clinically based.

There are two sides to SUMDE. A small amount of SUMDE goes into general practice. I am sure that members — and others — have had difficulty in trying to work out what SUMDE is all about. However, the general practice aspect is fairly transparent. The money comes to specific practices, at a practice level, and there is a set payment for teaching groups of students. In fourth year, students are attached individually, and there is a payment for the practice to help GPs because they spend less time on actual practice work and are not as efficient when students are present.

The money comes for specific sessions or attachments. In general, a senior GP who is a partner in a practice will do the teaching. Occasionally, it will be a locum doctor or a registrar. However, the teaching is usually supervised by one of the partners. Part of the SUMDE money allows GP training sessions during the various parts of the course. If a problem arises, or if someone is unable to teach, that money can be directed elsewhere. The advantage is that the money comes in, and the teaching has to be delivered. If a GP is ill or something happens in the practice, the teaching may not be delivered, and the situation will have to be examined. However, that rarely happens. The situation works pretty well.

The difficulty is that there has been very little funding for facilities. The overall budget for 2009-2010 is £1·3 million, which is about 3% of the total budget. For facilities funding this year, about £5,000 has been set aside for video equipment. During fourth year, we do some video teaching, and that equipment is produced. No other money goes into the funding.

Part of the problem is that that money has worked well: the GPs are happy with it; the university is happy; the Department is happy because it can see what is happening; and the

student evaluations are very good. However, we would like some facilities, because some of our practices are restricted in the teaching that they can provide for undergraduates and postgraduates because of a lack of facilities. We would like to have an additional teaching room. When the students are out on general practice, such as in fourth year, we would like to be able to put them in a surgery on their own. If a student is sitting with someone such as Dr Deeny or me, the patient will talk to the GP, but if a student is on his or her own, I would hope that the patient would see the student as a health professional and talk to him or her.

General practice is a powerful teaching tool: the students like it, and the GPs enjoy it. To some extent, our experience has been that SUMDE funding in general practice is an exemplar of what could happen with other aspects of SUMDE funding.

Dr Fogarty:

The issue for debate is that over £30 million of SUMDE funding goes to the health and social care sector. The vast majority of that — over 80% — is set aside for facilities, and that is outwith what happens in general practice; that goes to the trusts. The current SUMDE review examines the redistribution of some of the non-facilities funding. In such a redistribution, it is suggested that some of that would go to the university to deliver the education. The BMA medical academic staff committee has no major focus on who is best able to provide that, the university or the trust. However, we want the funding to be accountable and we want to see exactly what is happening with the money from all sides.

We would say the same about the funding that comes to medical students in first year and second year that does not go near the trusts. We would like accountability in the university sector money and in the healthcare sector money.

This morning, senior management in one of the trusts told me that, if the additional money moves from the trust SUMDE to the university, it could impact on patient care. I do not have any further detail on that, but the trust is worried about it. The university is worried that it cannot deliver the teaching required with a modern-day approach, given current resources. We have come to a slight impasse, with which I hope the Committee can help us in working out the redistribution of the SUMDE funding, particularly as no additional money is being requested overall: it is a redistribution within the existing budget.

Perhaps now is a good time to hear from Neil.

Mr Neil Cunningham (British Medical Association Northern Ireland):
I am a fourth-year medical student, and it is not every day that I get the opportunity to do something like this. If I get nervous, I could go off on a tangent and talk a lot. I can be like that. However, I have collated my ideas, and I also have my peers' responses, as we conducted a survey.

During the past two years, in my third and fourth years, which, as Dr Fogarty said, are primarily clinically based, I began to observe a discrepancy in the levels of teaching received. I am a member of the BMA Northern Ireland medical students committee, and I undertook a survey of our members' attitudes and experiences about the standards of their medical education, and I will share those with the Committee.

I will give some background information and a flavour of what happens. During my first year, I was relatively shielded from the inadequacies of the funding system, because a larger portion of the teaching was the responsibility of Queen's University staff. It was mostly scientific teaching, and around 20% of the staff were clinically qualified. The majority of the patients that I saw in clinical settings were favourable, for several reasons: I was in a group of approximately eight students, the teaching was interactive, and I felt very much involved and part of the team.

My second placement in semester two of the first year was in the general practice arena, and it was absolutely excellent. The students had contact with patients who presented their problems, and that coincided with what we were learning at that time; it was directive learning. The enthusiasm of the GPs was notable, and they made sure that our clinical standards were up to scratch. That was invaluable, and, at that point, I was really happy with the career choice that I had made. I was determined to be the best doctor that I could be. That experience has remained with me through some of the darker moments, which I will mention later.

In second year, I was placed in the Royal Victoria Hospital (RVH) for my first clinical attachment. It was then that I began to feel disenfranchised, disengaged, a bit of a burden and sort of in the way. The staff seemed unsure about who was looking after us, and, quite often, they sent messages that they were sorry but they were too busy. That correlates with what my colleagues have said, and they also found a wide disparity among different hospitals, trusts and

specialty departments. In the survey, my colleagues described poor teacher attendance; competition with service delivery; and teaching time that was rarely prioritised and often cancelled without warning.

The more traditional lectures were based on the Royal Victoria Hospital site. The lecture theatre was unable to cope with the increasing number of students — there are 270 students in my year — despite the extra money that Queen's University received for the additional students not connected to SUMDE and directly from the Department for Employment and Learning for all university students. We were placed in two lecture theatres, one of which was video linked. The people upstairs in the video-linked lecture theatre were just about able to see the lecture notes on one screen and the lecturer on the other, which was far from ideal. It meant that we were unable to ask questions or interact. The equipment was often unreliable: the screen would not work, the sound was lost or the connection between the two lecture rooms would be cut off.

That situation became so bad that, as a group, if we could not get downstairs, we went to the library to read the lecture rather than sit in a room with the temptation to talk because the teaching method was unsatisfactory. The facilities could not cope with the number of students; that was particularly highlighted when I had to compete for a seat to attend revision lectures. It was like being at a U2 concert — we had to get there early.

At that point, I became so disillusioned that I decided to join the BMA to try to rectify the situation and find someone who would listen to what we were saying. I want to be a world-class clinician. I do not want to settle for mediocrity, but I must be equipped and learn in the right environment to allow me to do so. I decided to stay in Northern Ireland because I wanted to remain at home and be close to support networks; studying medicine carries a significant emotional burden as well as an intellectual one. It is good to have family to fall back on when times are tough, especially early on in one's clinical experience. At that point, however, I was beginning to feel that the lack of adequate facilities, which increased the amount of self-directed learning, was failing me as an individual and would not allow me to fulfil my potential.

The third, fourth and fifth years in medical school are important, as those are the formative years in which I will develop into the role of a clinician. As Dr Fogarty said, I will sit my final examinations in June 2011, and, two months after that, I will be practising as a junior house doctor. In third year, I had the best experiences of my life in the Mater Hospital, in the ear, nose

and throat (ENT) clinic in Craigavon Area Hospital and in the nephrology unit in Belfast City Hospital. I felt engaged and involved; I felt that I was a part of the team and was allowed to express myself.

On the other hand, I had poor experiences in the Royal Victoria Hospital. Quite simply, there were far too many of us on the ward. There were so many in dermatology that we had to sit in a room reading ancient dermatology books. That happened because the consultant felt that having two or more students in a consulting room was not appropriate for the patients and could make them feel uncomfortable. Imagine having all those faces staring blankly at you. It was clear that there was no communication between Queen's University and the trust. Those problems seemed to be a recurring theme throughout the year in the dermatology clinic.

Those experiences correlate with the comments that my peers made in the survey about the overemphasis on self-directed learning and on the allocation of teaching time being dependent on the attitude and interest of each consultant. The consultant said that it is ultimately the patient who takes priority, which is a fair point. We would be summoned into the room if she felt that there was anything of importance that we must see, and, in the meantime, we were told that we could research common diseases in the library. On one occasion, the consultant summoned 11 of us into the room. That stuck with me, because I heard a patient, who is now a junior doctor, remark that, when she was studying dermatology, there were only three students. She could not believe that 11 of us were standing in line to view a patient's dermatological condition. The patient did not realise that she would have to sit there for half an hour while we all viewed her and chatted with her about her condition.

The overarching message from medical students in our survey is that staff:student ratios are very poor. Too many students are on single attachments, and the quality of teaching suffers as a result. Medical students recognise the difficulties in reducing the size of attachment groups but contend that dividing students among staff would mean fewer students accompanying consultants on ward rounds, less imposition on patients and more opportunities to attend clinics and shadow doctors. It is obvious that we need more teaching staff.

I had similar experiences in ophthalmology. There were too many students, and the university attempted to address that by introducing an elaborate rotation system. However, the consultants refused to follow that format and stated their preference for the old system, in which they

established a relationship with the students on the first day and ensured that they learned all they needed for a sufficient grounding in ophthalmology for undergraduate medicine by the end of the week. In that way, they could say that the students had met the set objectives and knew what they needed to know.

Unfortunately, that meant that I had only five hours of clinical exposure in ophthalmology in my one week of clinical teaching. The teaching during those five hours was excellent. However, it was insufficient, and that is all the teaching that I will receive on ophthalmology during my undergraduate degree programme. When I raised the matter with the consultant, he said that Queen's must source other teaching centres to facilitate the increase in numbers, and that the university simply could not handle the sheer number of us who are going through the system.

Too much money seems to be placed in facilities and not enough in consultant and GP time. Funding must follow the student. I cannot understand how we can justify £19·2 million a year pouring into the Belfast Health and Social Care Trust, because there does not appear to be adequate facilities for students.

I also had only two clinics in three weeks in Altnalgelvin Area Hospital. That was partly because my consultant was on holiday. However, that highlights the issue of planning. Altnagelvin Area Hospital had good computer facilities, so I was able to self-direct my learning much better than had I been on attachment elsewhere.

You are probably thinking that all those experiences have left me disillusioned, and they have; I am concerned because, if you consider the bigger picture and factor in the poor teaching methods, the inadequate clinical exposure and the facilities, the Northern Ireland Health Service will definitely suffer. Despite all that, centres such as Craigavon Area Hospital and the Mater Hospital have spent their money wisely. I had excellent teaching at those centres, was busy from nine to five, and I relished the opportunity. I felt privileged to have been placed in those centres and to have been exposed to such quality teaching, which still keeps me motoring.

In general, our survey found that the peripheral hospitals provide a better standard of teaching in hospitals located within the Belfast Trust, because of increased contact with consultants. Students felt strongly that teaching should be protected. My best experiences were when I felt that I was involved and when consultants spent time with me.

I genuinely want to be the best young doctor that I can be, and, one day, I hope to emerge as a world-class clinician. However, I need the teachers and the learning environment to succeed and, ultimately, to deliver the best service for the people of Northern Ireland. Thank you for your time, for allowing me to present my perspective on my experience of medical education and to present the feelings of my peers.

Dr Fogarty:

The SUMDE review largely concerned the supplement. However, there was an annexe that focused on joint appointment consultants, the 60 of us who spend half of our time working for the university and the remainder for the Belfast Trust. The review contained a proposal that we should work full-time for the university. I have received many telephone calls and messages saying that many of my colleagues would not agree to such a system because it would take them away from the ward environment, where they can help to co-ordinate courses and make the exposure for students better.

There is, however, an important message in that proposal: Northern Ireland is underserved compared with other devolved nations. I have a graph that illustrates that the number of clinical academics in Northern Ireland who co-ordinate courses, direct people and help to get other consultants on board is far less in relation to student numbers compared with Scotland and Wales. Northern Ireland is at the lowest end of the spectrum of all the established medical schools. We clearly need the resources to go to consultants and people with appropriate educational backgrounds, and to move closer in delivering to students in order to help them to improve their learning and get a better-qualified and better-trained junior doctor.

The Chairperson:

Thank you, Dr Fogarty. Quite a few members have indicated an interest in this subject. I have a couple of brief questions.

SUMDE funding seems to have just evolved; there seems to be no logic as to how it was introduced. There does not seem to be a good paper trail about needs and how it is funded**.** Why does 85% of the funding go to the Belfast Trust, which provides only over half of the training? Committee members from rural constituencies would like to know why the training of a doctor at, for example, Daisy Hill Hospital seems to receive far less SUMDE funding than a doctor at the

RVH or the Mater Hospital.

Dr Fogarty:

I do not know the details, but that has evolved over 30 years of training. When I was training in the 1980s, a large part of our training was based around the Belfast hospitals. Appropriately, therefore, many of the facilities were set up at that time.

Rural attachments were less obvious, but they have become more important and relevant. It is harder to get the capacity in the Belfast Trust. The turnover of patients in the Belfast Trust is substantially different from when I was a medical student. Now, patients are rarely there long enough to be dealt with adequately. There is a turnover issue. There are also issues around gaining exposure to general practice, which means that more students will go to general practices in the peripheries than previously. However, I do not know the exact reasons.

Dr Gilliland:

Some of the "old SUMDE" money seemed to be written on tablets of stone. After the new expansion was introduced, I was at a meeting where the director of a health and social care trust at that time said that the old SUMDE money could not change and that we should be prepared to negotiate on the "new SUMDE" money. The majority of the teaching is probably still done in the Belfast hospitals. However, there is a complicated way of working out teaching time. The money has followed some of the teaching peripherally. The majority of individual placements for our fourth-year students are outwith Belfast.

We are strongly supported in general practice from the west of the Province. We have around 120 practices with about 150 GP tutors who help with the fourth-year course. We are due to have our annual meeting at the end of October, and, last year, 120 GPs attended that annual meeting, many of whom came from as far away as Lisnaskea, Derry and west of the Bann. In general practice, much of the little SUMDE money that we have has gone to other parts of Northern Ireland.

The Chairperson:

Is there not an irony in what Mr Cunningham said about getting excellent training in Altnagelvin and Craigavon, when the figures clearly show that they receive a tiny fraction of the SUMDE money, and the fact that he was let down in the teaching hospitals in Belfast, which receive 85%

of the £34 million? It strikes me that the money is not being well targeted. Am I right in thinking that the Belfast Trust simply regards SUMDE as money that is built into its budget and that it spends it on necessary areas, and, if the trust organises a bit of training, that is fine? Is there a clear path to show where the money has been spent in the Belfast Trust?

Dr Fogarty:

There are moves to have clear paths. That is certainly is a major initiative in the Belfast Trust. It is an important question to ask the trust.

Dr Gilliland:

That has hit the nail on the head.

Mrs O'Neill:

Before the present Chairperson's time, the Committee took an interest in this subject, and members went to Queen's University at the invitation of Professor Paddy Johnston. The issues that he highlighted included the fact that there is no mechanism to trace the funding allocation and that there is great funding disparity between hospitals in the west and the city hospitals, which is why the Committee took that keen interest. The thinking behind SUMDE is to redistribute that money and to make it traceable and accountable. That is what everyone is keen to see.

Damian spoke about how a senior person in the trust said that they would not favour the money being centralised or going to the universities.

Dr Fogarty:

The statement was that the person would be worried if the funding left the Belfast Trust to go to the university, because that might impact on patient services.

Mrs O'Neill:

Equally, there is a flip side to that argument. Do you not agree that, if the money is not following the students and allowing them to have the best facilities to be able to train properly, that would impact on their ability to provide care?

Dr Fogarty:

That is a good point. It could be argued by the trust that some front-line services are affected in the short term. Our argument is based on the longer term and the impact of better training in general. That is important for the long term. An investment is required, and I want to move away from the urban versus the rural argument. Essentially, the trusts want the best doctors to come to work for them, regardless of whether they were trained in urban India, rural India, urban Belfast or rural Northern Ireland. We all want the best person, and that is an important concept to keep in the back of our minds.

Mrs O'Neill:

The funding must follow students to give them the best opportunity to succeed and, as Neil said, be the best that they can be. SUMDE does not address the problem of the insufficient number of clinical academics to train the number of students.

Dr Fogarty:

No, it is not addressed. A large part of the review reflects the redistribution of the teaching SUMDE, not as salary support for the clinical academics or support for more of us to be involved.

Mrs O'Neill:

There have been eight responses to the consultation, including the BMA. Are you in talks with the Department about the matter? Do you sit on the group that was established?

Dr Fogarty:

I asked to sit on the group, but my offer was politely rejected. Ironically, we have a balanced view because we work for trusts and for the university. We work in patients' interests and in students' interests. We have more insight, which would be useful to both the trusts and the university than the majority of the current panel.

Mrs O'Neill:

The Committee could raise that matter with the Department. It is a massive oversight to omit the BMA from that group.

Dr Gilliland:

As a GP academic, I am a member of the subgroup that considers joint appointments. It has met

twice.

Mr Easton:

I may have picked this up wrong: did you say that some of the £34 million of SUMDE money will be used for purposes other than to train teachers?

The Chairperson:

Doctors.

Mr Easton:

Sorry, doctors. I do not know how long SUMDE has existed.

Dr Fogarty:

Mr Easton is asking whether we know if the money will be used for purposes other than to train doctors. We do not know the answer because there has been no accountability. I met a gynaecologist today who said that a student accompanied him in the theatre yesterday during an operation. It is difficult for a trust to account for and measure such teaching. It is difficult to total up each session of apprenticeship learning. Human resources departments in the trusts could tell us which senior staff hold teaching sessions. That would be a good start and would enable us to find out exactly who is involved with undergraduate teaching. It would provide broad figures. Senior medical staff could calculate individual sums and relay that to the Committee via human resource departments in the trusts.

Mr Easton:

I may have picked this up wrong: did you say that a senior medical person said that treatment would suffer if —

Dr Fogarty:

Given the Belfast Trust's financial crisis, it would contest that any loss of income stream will impact on front-line services to patients.

Dr Gilliland:

The medical service increment for teaching (SIFT) money is the English equivalent of the £34 million. I remember a meeting at which a senior dean said that a major teaching hospital with

students present was almost 20% less efficient. Part of that funding is to protect that type of issue. Much of the money must go towards the running of the hospital as opposed to being allocated to students. We want more money to be spent on facilities as well as on consultant teaching time. One major difficulty with the new consultant contract is that it contains less protected time that is specifically for undergraduate teaching. The consultants have to undertake extra postgraduate and undergraduate teaching, and the latter often tends to be squeezed. We want the trusts to put more money — not all of it — into that type of area.

Mr Easton:

Training doctors is at the core of the Health Service. It is a serious matter if doctors are not receiving the amount of teaching and training that they should be receiving. I would be shocked if money that had been set aside for training was going elsewhere. There is a question mark about that, and, if that is happening, we need to find out why. Doctor training should not affect the amount of money that is spent on front-line services. Those doctors are training and will not actually be doing anything until they are qualified. We need clarification on where all the money is going, and, if extra funding is required, we must consider what can be done in that regard.

Has there been a breakdown in communication between universities and trusts on how progress should be made? Is that an area that needs to be improved?

Dr Fogarty:

Yes.

Mr Gardiner:

I welcome Neil and congratulate him on his presentation. I am very glad that he is based in my constituency.

The Chairperson:

I was going to say that. I thought that he lived in Upper Bann.

Mr Gardiner:

Neil is brilliant, and he is welcome in my constituency. *[Laughter.]*

The Committee needs to pursue some of the concerning points that Neil raised. A director

from the Department should come to the Committee and give us an account of where the money is going and why it is not being spent in the area to which it was allocated. I have strong views that the matter must be sorted out as soon as possible.

The Chairperson:

We will decide the way forward when the witnesses have left the room. You can make a proposal then by all means.

Mr Gardiner:

I will make a proposal then.

Dr Fogarty:

For there to be good communication, both sides must be represented; they must know what each side is saying; and there must be clarity about their purposes. The ultimate aim of the investment is to keep the best people in Northern Ireland and train them well. If that happens, those people will be good researchers as well as good junior doctors. That has a knock-on effect and ties in with the desires of universities. Therefore, better communication could lead to a win-win situation.

Mr McCallister:

How seriously do trusts engage with the role of training our future doctors and nurses? We have heard that Neil, for example, was not provided with great facilities by the Belfast Trust.

Dr Gilliland:

It is patchy. Some trusts are better than others, and parts of trusts are better than others. Neil was very honest in talking about certain issues. However, I must say that students at Queen's University do not hold back. I look after the fourth year course at Queen's, and I receive e-mails at midnight when things are not happening. Those students expect a quick response, so we try to troubleshoot and work out their difficulties. I am sorry that Neil experienced the difficulties last year that he outlined, but a large proportion of the Province's trusts, consultants and GPs are very committed to teaching. A lack of resources is coming into play in training, and it is often reliant on goodwill. That is not a good way in which to deal with extra student numbers.

Mr McCallister:

We need to find a way of removing that patchiness. Does it come down to the fact that some individuals do not like teaching or training, and others do? How do we level out that situation?

Dr Gilliland:

It can be done. Among a group of surgeons in a unit, one surgeon may be really committed to teaching. The group may decide that that person will do the majority of whatever teaching has to be done. Alternatively, a group of surgeons may all be interested and share the training. Each trust must recognise that teaching takes up time, but the problem is that they are expected to squeeze it in.

Mr McCallister:

We have to wonder whether that affects efficiency. You mentioned a figure of 20% earlier. Notwithstanding that, I wish Neil well in his career.

Dr Deeny:

I welcome you all, especially Drew, whom I have not seen for years. It is nice to see you again.

This is a serious situation. I had some idea, but I am shocked by the fact that there has been no increase in the number of medically qualified academic staff while there has been a 40% increase in the number of students. Neil has more or less answered the question, but is that having a detrimental effect?

Mr Cunningham:

Yes, it has, which is why I had so much to say and was quite emotional about everything that has happened over the past four years.

Dr Deeny:

It is important to hear that. Allowing trusts to have money in their hands at the moment creates a dangerous scenario. We are being told about the need to make "efficiency savings", which are cuts, and here we have trusts that are holding money that is supposed to be used to train our young doctors.

Damian talked about redistribution of money. That issue must be examined seriously. The

three words that came to mind after I read your briefing note are accountability, transparency and equity. Surely to God, if so much money has been put aside for the training of future doctors, we must have transparency and accountability.

In your briefing note, you quite rightly state:

"The Health and Social Care (HSC) sector has a greater vested interest in delivering well qualified, safe and communicative doctors than the University sector."

I could not agree more. As a well-qualified group of professionals, who do you think should be responsible for ensuring that we have accountability, transparency and equity in future? How should this Committee deal with those matters? We could pursue the matter when we see the Minister and his officials in two or three weeks' time. We can say to him that it is totally unacceptable that we do not know where the money that has been put aside for training doctors has gone. We can ask whether it is being used to pay for administrative staff, as was mentioned this morning on the radio, when it should be used for training the young doctors of the future. That would be unacceptable. What is the Committee's role, in your opinion? From what I hear today, you would have the Committee on your side.

Dr Gilliland:

I do not have any set views on who should control the money. If there is transparency, it would not matter who was looking after it, because it would be plain to everyone what was happening. The first thing is to have transparency. I do not think that the trusts or the Department understand that.

Dr Deeny:

How can we bring that transparency about? How can we help that process to ensure that there is transparency and accountability from now on?

Dr Gilliland:

I assume that a steering group with some clout could look at that. I am not sure that it would be solely the responsibility of the university. It might comprise a combination of people from the Health Service, the university and the Department who would oversee the process. I agree with you; in the current situation, the trusts are under enormous pressure. It is often said that, by

upsetting the apple cart, we will affect patient care. That is the card that is always being held up to us, and I worry that that puts us on the defence. However, teaching medical students is an investment in health for the future for all of us.

Mrs I Robinson:

I share Dr Deeny's concerns, but I want some clarification, and I want to hear it from the horse's mouth, as it were. Is there an implication that our student doctors are, by and large, not suitably competent when they become junior doctors?

Dr Fogarty:

No, they are very competent. They will have gone through a most rigorous undergraduate assessment process that is inspected by the General Medical Council every few years and is overseen by a significant investment by the university. We take that matter very seriously. There is no doubt that those doctors are competent.

Mrs I Robinson:

I sought clarification because I am concerned that you have made such an implication today.

Dr Fogarty:

Competence is talking about the borderline. We shift all our students upwards to improve the overall quality. Once in a blue moon, one or two individuals may be incompetent. However, we want to improve the quality of teaching so that, when students graduate, they are better qualified.

Mrs I Robinson:

I am trying to get the point across that the moneys that are set aside to train would-be doctors should be ring-fenced and targeted appropriately. An article on the BBC website states:

"An Imperial College team looked at 300,000 emergency patients admitted to English hospitals between 2000 to 2008. They compared death rates between the first week of August, when new doctors arrive, and the previous week in July."

Although the study showed that patients are 6% more likely to die when a junior doctor arrives in a hospital, the article continues:

"Our study does not mean that people should avoid going into hospital that week."

Given the rise in litigation and the cost of fixing operations that have gone wrong, it is imperative that the Committee sends a strong message that the money should be used to train doctors.

Dr Gilliland:

I will make some comments wearing my assessment-lead hat. The professionalisation of assessment in all years has been a major change in the medical school. We are more careful to identify weak students at an early stage and provide remedial teaching. However, we are very careful at the end of their final year. That has put pressure on SUMDE funding, because assessment has become more important. It must be much more reliable now, and it must be standardised.

We need to be absolutely sure that students are ready for work when they finish their studies. Even with the expansion, I am confident that we have trained students to a high level. However, it has stretched us, and the largest group has not yet come through. The largest group of 270 students is now in fourth year. A few years ago, the largest group was 180. Fourth and fifth year will provide a challenge. Mrs Robinson is right; now is the key time for us to sort it out.

Mrs I Robinson:

It is wonderful that so many young people are interested in undertaking a lengthy period of study to become doctors. It is imperative that we see the money at the other end.

Mr Cunningham:

I know that I have sounded negative today. However, excellent A-level students enter medical training, and they should become excellent clinicians. We are not necessarily achieving value for the investment. If we ensure the correct funding, we could create world-class medical facilities and world-class trained doctors.

The Chairperson:

You are saying that, in certain hospitals, junior doctors are succeeding despite the SUMDE programme rather than because of it.

All members have asked their questions. Thank you for giving evidence. Neil, you did well on your first attempt. Unfortunately, you do not live in south Down so I will not say anything else nice about you. *[Laughter.]* However, you are welcome to move to Kilkeel at any time. All

witnesses are welcome to stay in the Public Gallery while we discuss how to address the problem.

Mr Gardiner:

I want to record my appreciation for the doctors and, in particular, for Neil for coming along and making a clear statement on the situation.