Health Education England

Post Graduate Medical Education Commissioning 2018 for 2019 Recruitment

Date	23 June 2018
Version	1.1
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History	The guidance has been through three drafts and this version incorporates comments elicited through a clear internal engagement process. The draft guidance was approved off by the HEE Executive on 29 May 2018. This version incorporates minor revisions to the document approved by the Executive.

1 Introduction

This guidance document sets out the context, approach and process for HEE's post graduate medical education (PGME) commissioning until further notice. The process culminates in the provisional sign-off of the commissioning plan by the HEE Executive and final formal sign-off when budgets are confirmed, at which point the commissioning plan for each geography is reported to the HEE Board.

The guidance has been through three iterations and incorporates comments provided from HEE staff identified in figure 8 (page 14), Regional DEQs, and HEE Executive colleagues.

Note the guidance does not cover Dentistry. The HEE Dental Programme is responsible for bringing forward annual investment plans covering Foundation, Core, and Higher Dentistry, and Dental Care Practitioners (DCPs). The workforce planning and analysis team will support where requested.

2 Consultant growth

The training system has fuelled sustained growth in consultant numbers over the long term, with the number of consultants (wte) doubling in the period 1997-2012, averaging 4.5% growth per year.

In the most recent six-year period (2012-2018):

- the medical workforce **as a whole** (excluding Foundation trainees) has grown by an average of 2.3% per year.
- the number of **consultants** employed in the NHS has grown by an average 3.6% per year.
- The number of 'non consultants –that is trainees, 'SAS' and other doctors has grown by an average 1.1% per year.

Within this overall growth there have been marked differences in the scale of change between geographies and specialties. Figures 1 and 2 exemplify this. Figure 3 demonstrates the change in 'skill mix''.

Medium term supply projections indicate that, if posts are made available, *broadly* similar rates of change, and differential change, in consultant numbers will be sustained for the next five years[1], irrespective of any interventions in respect of training posts or trainees (that is, the pipeline for most specialties is already in train).

Key considerations for HEE and the wider system are:

i. What will be the longer term pattern of change in the relative geographical and specialty distribution of consultants?
ii. Is this pattern what the system wants or needs?
iii. If not, what policies and interventions might be expected to either alter this pattern, or adapt models of care delivery to accommodate such a pattern?
iv. Of these policies and interventions, which might be implemented by which actors within the system and over what timescales?

[1] Specialty level data packs will explore this with more granularity and include a 10-year projection. See section 6 on supporting material.

Figure 1: Growth in Consultant wte by grouped specialties indexed to 2012

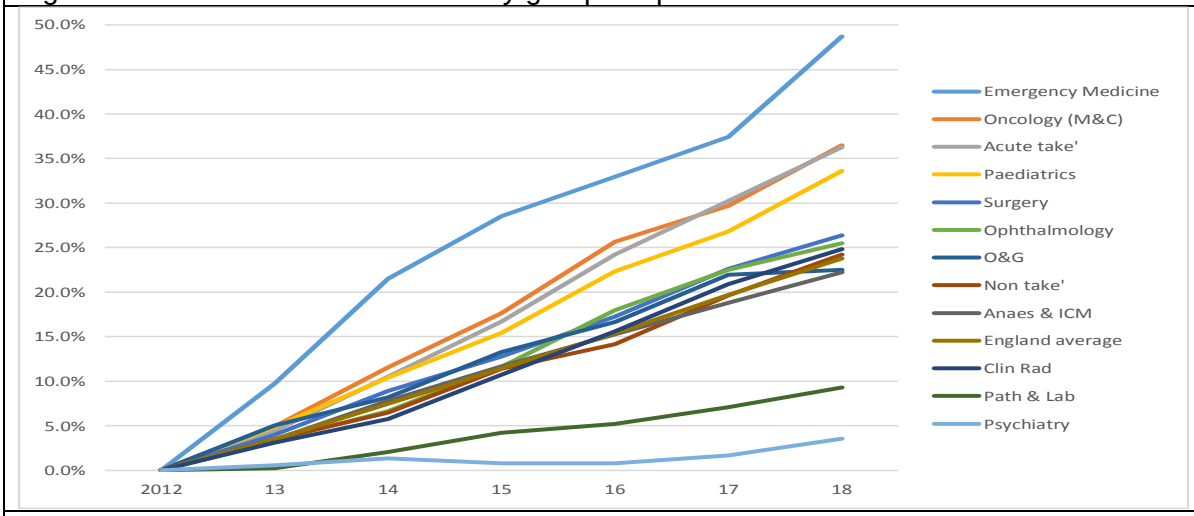


Fig 2: Growth in Consultant wte by HEE Region (2017 configuration) indexed to 2012

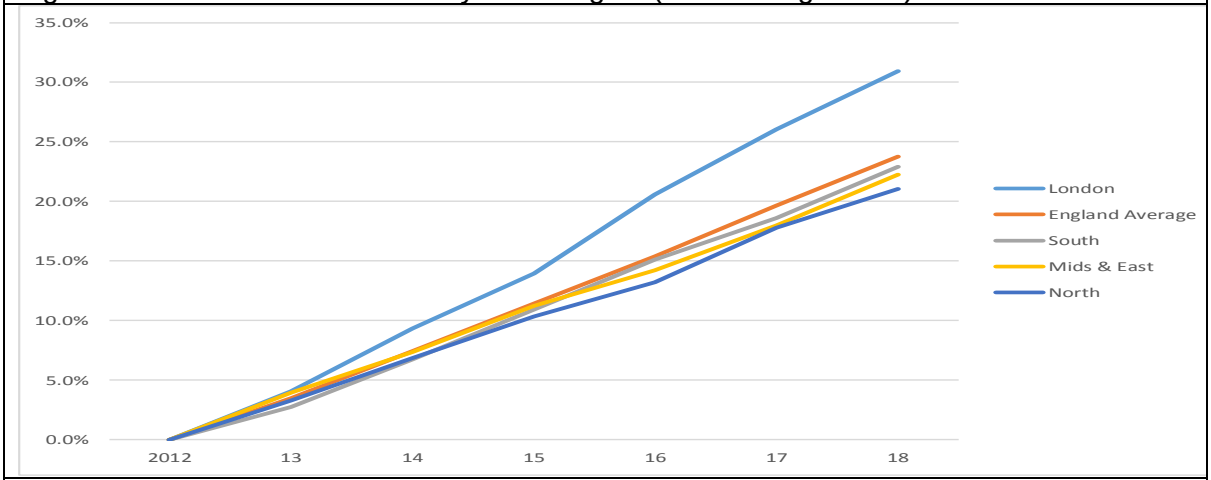
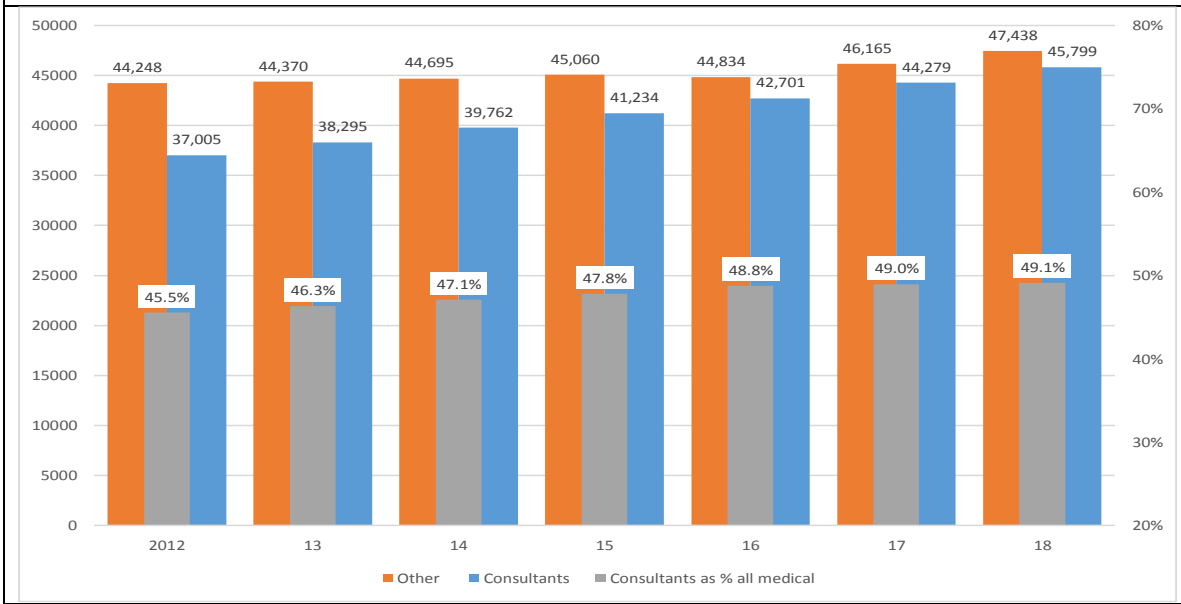


Fig 3: Numbers (wte) of Consultants and other medical staff, excluding Foundation trainees, and consultants as % total



Source: NHS Digital Monthly 'experimental' statistics.
NB: Excludes Dental and Public Health consultants

3 System scale and complexity

HEE invests £1.9bn annually in post-graduate medical education (PGME). There are in the order of 50,000 PGME trainees in the English NHS at any one time.

HEE's contribution is provided in the form of a tariff for salary support and placement fee as well as other local determined costs such as costs of GP Trainers and Post Graduate Centres. Tariffs for placements in secondary care are derived from Department of Health Education and Training placement tariffs guidance. A transitional formula is applied to progress funding allocations received by local offices from the baseline (pre 1 April 2014) to a full implementation of tariff rates.

The programmes in which HEE invests are of varying length (from two to eight years) and so, in practice, much of this annual spend is committed by decisions taken in previous years. HEE does not fund but does administer all PGME training posts: in 2017 15% of training posts (close to 8,000) were 'trust funded'.

The PGME system entails around 70 different curricula including Foundation training, Core and Common Stem (7) which equips trainees to apply to higher specialty training (55) and 'run-through' programmes (10) to which trainees can apply directly from Foundation training. There is more than one route to completion of training for some specialties.

The number of trainees in individual specialties ranges from fewer than 10 to more than 3,000 (paediatrics). At any one time more than 10% of trainees will be 'Out of Programme' (including some 'OOPs' which contribute to training and to programme completion[2]) or on maternity/other leave.

Training posts may be introduced or removed for considerations not directly related to future supply of consultants. Such considerations include ensuring the quality of training, maintaining rotations, and enabling access to specific training.

Thus HEE's guidance to the PGME training system needs to balance national workforce policy considerations, which seek to address current *and* future workforce concerns, with the practicalities of management and administration of the system through 11 local offices reporting to HEE's Regional Directors and ultimately to the HEE Executive.

<u>Geographical distribution</u>

HEE recognises[3] that for the majority of specialties the distribution of training posts and trainees is historical and that this does not necessarily represent equitable distribution. The HEE Executive is committed to exploring policy in this area.

[2] For example, for trainees who are out of programme on OOP-Training a year on OOPT 'counts' as an ST level.
[3] Workforce Strategy Consultation

4 The HEE approach

HEE's approach is to focus attention in any single planning round on a limited number of specialties, based on the following criteria:

- Specialties most clearly aligned with identified NHS priorities for service development;
- Specialties where numbers (and thus investment) are of sufficient scale to warrant national oversight;[4]
- Specialties and/or geographies where there is evidence of systemic issues with current or projected supply which might be addressed by specific interventions in training commissions.

Feedback

- Regions have indicated that HEE's approach needs to accommodate local supply pressures and cases where LWABs/ STPs require changes to enable delivery of strategic plans;
- English Deans have commented that the approach should explicitly further the multi-disciplinary agenda.

Therefore:

- The 'key tests' (Figure 7, page 9 below) allow for flexibility where changes are supported by clear plans;
- The supporting information (section 6) will be developed to aid consideration of local circumstances.

However, the fundamental supply constraint combined with the 'dual role' of trainees acts as a constraint on easy and rapid solutions. This is explored further (section 5) below.

[4] HEE conducted a review of a number of the smallest specialties in 2016. In 2017 HEE Executive approved recommendations for small changes to the number of posts. These changes are now being implemented and monitored through the Deans network.

5 The fundamental supply constraint

There are two key considerations HEE must take into account when determining changes to the number of posts in any geography or speciality.

Firstly, trainees provide service. This means it is not a simple matter to significantly increase or reduce commissions in any one specialty or geography in a single year. To do so may create or exacerbate 'rota gaps'.

Secondly, at the same time, there are not enough trainees to fill all available training places:

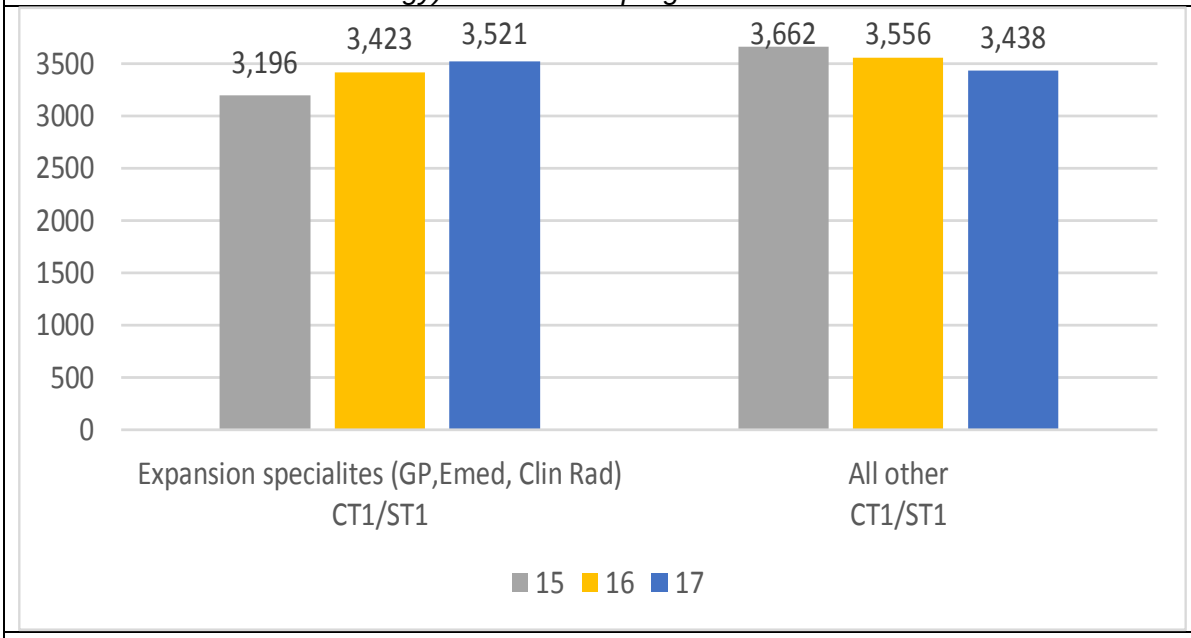
- over the three years 2015 to 2017 of approximately 7,700 posts advertised each year at CT/ST1 an average of 750 were not filled. Of those that were filled approximately 1,000 each year were filled by trainees who were not previously in the UK PGME training system at Foundation level (i.e. trainees from outside the UK);
- Over the three years 2015 to 2017 of approximately 3,100 posts advertised each year (average) at ST3 and above an average of 600 have not been filled.
-

Figure 4 Posts advertised (P) and Accepted (A) and fill rates 2015-2017 (blue lines) by HEE Region (2017 configuration)

Source : HEE Recruitment Team

While the post-Foundation PGME recruitment system is not 'closed' and the total number of applicants, including those from overseas, exceeds the total number of posts available, the number of *appointable* applicants does not. The evidence to date indicates that the explicit and successful planned expansion of *posts* in priority areas has led to unplanned contraction of *trainees* in other areas (see figure 5 and appendix A).

Figure 5: Recruitment (acceptances) to ST1 in 'expansion programmes' (GP, Emergency Medicine and Clinical Radiology) and all other programmes 2014-17

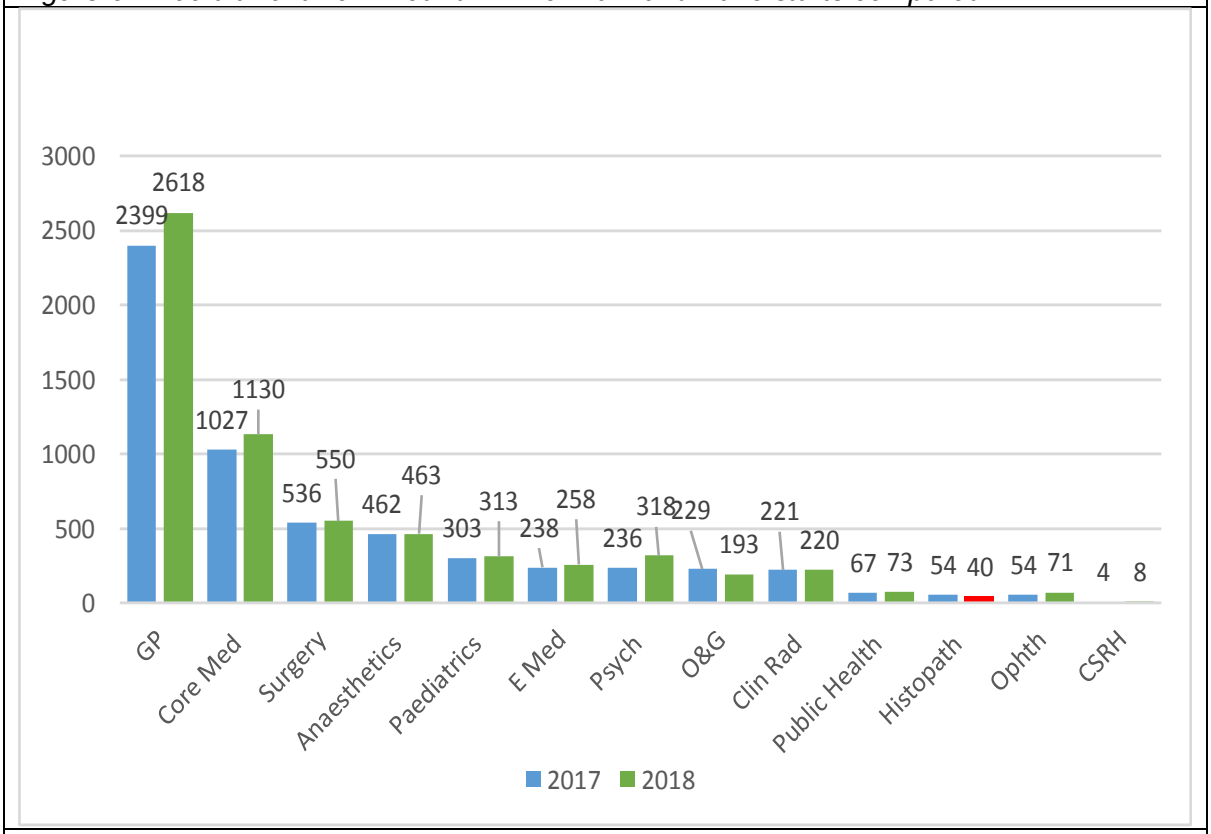


Source: HEE Recruitment Team

Initial 'Round 1' recruitment data (March 2018) indicates recruitment levels have recovered compared to the same point in 2017 (figure 6), with 425 more acceptances than at the same point last year. Further data will be available later in the planning round.

Even if the observed recovery in recruitment numbers is confirmed by the final Round 1 data, HEE never-the-less anticipates there will still be training posts unfilled in 2018 and beyond. At this stage we cannot be certain what has fuelled this recovery, or whether it can be sustained. Therefore, in the 2018 round explicit targeted plans for expansion in given specialties will need to be accompanied by explicit targeted plans for ameliorating contraction in other specialties. Options include targeted decommissioning (geography and programme), targeted interventions to 'freeze' recruitment above a given level (geography and programme), and targeted international recruitment to fill training posts.

Figure 6: Recruitment from Round '1A' for 2017and 2018 starts compared



Source: HEE Recruitment Team

In the longer term as new graduates from the expansion in medical undergraduates emerge from Foundation training (i.e. from 2025 onwards) the fundamental supply constraint will ease unless training expands markedly. Until that time local, regional and national investment plans which entail changes to the current number of posts in any specialty will need to be accompanied by responses to the key tests overleaf (figure 7).

Figure 7: the key tests

Proposals to expand the number of posts	
1	*What is the rationale for the proposed change and how has this been prompted? (National policy, HEE locally, employers / STP)*
2	*Has the system (i.e. nationally or locally) as a whole signalled an agreed level of demand for future medical specialist staff, taking into account the extent to which measures to manage and reduce demand are likely to prove successful?*
3	*Has the system as a whole signalled a strong likelihood that CCT holder posts required as a result of the demand assessment above will be funded and available?*
4	*Is there clear evidence that this level of demand will not be met through changes in supply that can be reasonably expected?*
5	*If there is clear evidence that projected supply will not meet the demand agreed across the system, is there clear evidence that approaches other than increasing the number of training posts will not lead to a sufficient increase in available supply? That is, is there more that can be done to:* • *Reduce attrition from training;* • *Increase transition from training to the workforce;* • *Improve workforce retention;* • *Incentivise increasing workforce participation in direct patient care activities;* • *Direct recruitment into specialist roles from non-UK sources;* • *Free up trainee and specialist time through multi-disciplinary approaches to care delivery.*
6	*Is there a reasonable expectation that new training posts will fill?*
7	*Is there the capacity to expand training, fulfil the curriculum without detriment to other trainees and maintain the quality of education and training?*
8	*Are there potential consequences from increasing training opportunities in the given specialty that will detract from the wider strategic agenda and if so have these consequences been accepted by the system?*
Proposals to reduce the number of posts	
1	*Has the system described a plausible supply projection?*
2	*Does the system agree that projected future new CTT holder supply is unlikely to be warranted and unlikely to be employed/effectively deployed?*
3	*Has the system considered the impact on service of removal of training posts, and described a plan to mitigate such impact?*

6 Supporting material

Supply

To support local processes, the central analytics function will develop **supply-side** data packs for the specialties most closely associated with the five main NHS priority programmes, for the two largest other specialties, and for several others. All packs will be shared nationally with *external* stakeholders[5] over the course of the planning round.

Note that for **Clinical Radiology** and **Emergency Medicine** (and also GP recruitment) policy has already been set. No changes to commissions are envisaged in 2018 in these specialties.

In **Psychiatry** the underlying issue is not the number of posts but the extent to which posts are filled. Therefore, it is not anticipated that the number of psychiatry posts will change materially, although there may be specific changes in particular geographies and individual specialties.

Demand

The Directorate of Workforce Planning and Intelligence has developed a 'prototype' tool which provides a high level 'baseline' assessment of aggregate (not specialty level) demand, were activity to change in line with population (essentially a baseline minimum level of increase which takes no account of other factors or interventions which may accelerate or reduce demand). The tool, designed to stimulate discussion, is available via Regional Associate Directors of WP&I.

This work will be developed further, in collaboration with system partners, to drill down to service/specialty level in the year ahead. However, there will not be a comprehensive suite of demand analysis available for all specialities under review ahead of the submission of 2018 plans for 2019 recruitment.

Therefore, any decisions to change commissions will be based on Regional assessments taking into account supply-side projections, LWAB input and the key tests.

[5] NHSI, NHSE, Public Health England, Health Education Wales, NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency, Royal Colleges, Specialty Advisory Committees, the Academy of Medical Royal Colleges, COPMED, the GMC, and the BMA.

Figure 8: Specialties for review in 2018

Specialties aligned to the 'Big 5' NHS priority programmes.

	Link to programme
Histopathology	Cancer
Palliative Medicine	Cancer
Gastroenterology	Cancer
Haematology	Cancer
Obstetrics & Gynaecology	Maternity
Clinical & Medical Oncology[6]	Cancer
Psychiatry	Mental Health
Emergency medicine[7]	UEC
Clinical Radiology	Cancer

Other specialities to be reviewed

Anaesthetics
Neurosurgery
Cardiothoracic surgery
Paediatrics[8]

Initial packs have been distributed for some of the above. These will all be refreshed and distributed in July.

[6] Medical oncology CCT holders are frequently coded to clinical oncology services in ESR and vice versa. Hence the supply analyses bring the two together.

[7] Due to a range of coding, definitional and data issues within the INTREPID data set HEE is as yet unable to quantify the proportion who 'ran through' from ST3to ST4. Until we have reliable estimates the CCT holder supply projections are very broad and have limited credibility. John Thompson from the TIS team is exploring further.]

[8] Paediatrics is a special case in Paediatric CCT holders re frequently coded to other specialist area in ESR (such as Emergency Medicine) hence the process for developing projections is 'non-standard' and requires additional analysis.

7 Resourcing, process and timetable

The medical planning round will be supported centrally by a very small team:

Kate Roberts	Planning Function PMO (0.2 wte full year)
John Stock	Head of Medical Workforce Planning and Workforce Analysis (0.4 wte full year)
Tom Clayton	Central team workforce planner (0.4 wte full year)
Gabriel Harry	Central team workforce analyst (0.6 wte full year)

Central team Deputy Heads (National Programme Planning leads for the five NHS priority programmes) will lead national stakeholder engagement for specialties aligned with priority programmes.

<u>The central team will</u>

- Prepare standard data packs
- Coordinate the overall process
- Coordinate engagement with national external stakeholders
- Manage the on-line submission from local teams of investment plan data

<u>Regions will:</u>

- Nominate a single point of contact in each Region (or local team) to act as an Investment Plan (IP) Lead to liaise with the central team on process issues. In the past we have found this system works well when the IP leads have a sound understanding of both medical workforce issues and planning processes. Fortnightly calls will be established from early June onwards and cancelled if not required;
- Manage local engagement processes;
- Submit investment plans for each constituent office, signed off by the Regional Director, incorporating narrative in respect of the key tests where changes are proposed.

Finance and Planning data collections

The Directorates of WP&I and Finance have discussed the requirements for the data collection for the PGME medical planning round and those for the maintenance of the medium to long term financial model.

The requirements for the latter are more granular in some respects (the model needs data on grade) and less granular in others (the model does not distinguish between specialties to the same extent). Therefore, merging the two collections into a single collection would ultimately prove less efficient and less effective than maintaining the two separately, particularly as in principle TIS will, in time, deliver the requirements of the Finance team, while the Planning function will need to collect prospective planning data for as long as HEE has a role in workforce planning and commissioning.

It has been agreed that, in so far as possible, 'temporal' separation of the two collections will be used to relieve some of the burden on local teams. The Commissioning Plan data collection (via an on-line pro-forma) will go live in July and 'cuts' will be taken Friday 28 September and Wednesday 31 October, at which point the process will close.

The finance team will be sensitive to this timescale but may still need to make contact with PG colleagues in the time period Sept to Oct.

6 Investment Plan Leads Group

The main forum for internal HEE communication throughout the process will be a monthly PGME Investment Plan Leads meeting (via Skype) to:

- Share updates on key national issues arising;
- Share updates on key local issues arising;
- Escalate issues and questions;
- Agree an update communication to the HEE Director of Workforce Planning and Intelligence.

The group membership is set out in figure 9.

This represents a considerable commitment of senior resource and there is some potential duplication.

Regional Offices and Deans may wish to consolidate and rationalise their representation.

Figure 9 : Investment Plan Leads Group

david.wilkinson@hee.nhs.uk;	Dean	EMed, Clin & Med Onc. Histopath,
Graeme.Dewhurst@hee.nhs.uk;	Dean	Palliative Medicine
Helen.Barrett@hee.nhs.uk;	Dean	Communications team
Jane.Mamelok@hee.nhs.uk;	Dean	Psychiatry
Julia.Whiteman@hee.nhs.uk;	Dean	Clinical Radiology and Gastroenterology
Martin.Beaman@hee.nhs.uk;	Dean	Haematology
Peter.Hockey@hee.nhs.uk;	Dean	CT Surgery
sanjiv.ahluwalia@hee.nhs.uk;	Dean	Paediatrics
Ian.Wheeler@hee.nhs.uk;	Deputy Head of Workforce Planning	Cancer and Primary Care Programmes
Maryna.Popova@hee.nhs.uk;	Deputy Head of Workforce Planning	Mental Health and UEC programmes
Thomas.Speller@hee.nhs.uk;	Deputy Head of Workforce Planning	Maternity programme
Sheona.MacLeod@hee.nhs.uk;	Deputy Medical Director for Education Reform	DEQ SLT
Helen.Friedrichsen@hee.nhs.uk;	Finance Manager	Finance Directorate
Sam.Illingworth@hee.nhs.uk;	Head of Commissioning for Quality and Safety	Quality
jonathan.howes@hee.nhs.uk;	Head of Medical Recruitment	Recruitment team
john.stock@hee.nhs.uk;	Head of Workforce Analysis	P&I
andrew.milner@hee.nhs.uk;	Medical Education Reform Programme Lead	MERP Programme
tom.clayton@hee.nhs.uk;	National Workforce Planner	P&I
Kate.Roberts@hee.nhs.uk;	PMO	P&I
Andrew.Matthewman@hee.nhs.uk;	Policy Lead	DEQ Policy Team
Chris.Kent@hee.nhs.uk;	Regional Associate Director P&I	M&E
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Derek.Marshall@hee.nhs.uk;	Regional Associate Director P&I	North
Nigel.Burgess@hee.nhs.uk;	Regional Associate Director P&I	London
andy.gill@hee.nhs.uk;	Strategy Lead	Strategy team

7 Schedule

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Fortnightly IP group Skype (Kate to set up)											
Establish IP group											
Identify Regional IP leads (x4)											
Exec sign off guidance											
Final data packs issued											
IP template on line											
National engagement (led by central teams)											
Regional engagement (Led by Regional teams)											
First submission deadline											
Progress paper to Exec Leads (Rob Smith, Wendy Reid)											
Final deadline											
Investment Plan sign off at Exec											
'Publish' Investment Plan											

APPENDICES

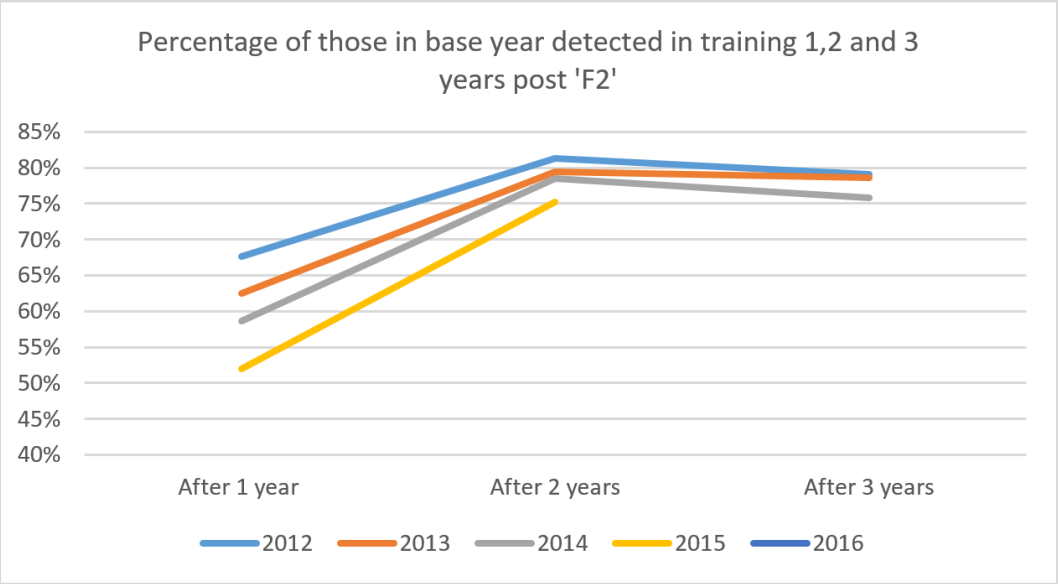
The fundamental supply constraint and its implications

Analysis of trainee flow from Foundation to further training

Base year	At F2 in base year	Detected in training in subsequent years		
		After 1 year	After 2 years	After 3 years
2012	6280	4244	5102	4965
2013	6257	3909	4967	4920
2014	6229	3654	4892	4718
2015	6406	3328	4815	
2016	6331	2988		

Cohort	After 1 year	After 2 years	After 3 years
2012	68%	81%	79%
2013	62%	79%	79%
2014	59%	79%	76%
2015	52%	75%	
2016	47%		

These are ENGLAND data



The analysis confirms the continuation of the established trend for trainees to delay transition to further PGME training (ie core, common stem and run-through). Of the 2012 cohort 67% of those at F2 were detected in training in the subsequent year (2013). Of the 2016 cohort the corresponding figure (detected in 2017) was 47%.
For all cohorts the rate of flow has recovered substantially by the second year, but there has been a decline in the rate of this recovery from 81% (2012 cohort) to 75% (2016 cohort). Rates in the third year post Foundation are slightly lower than those in the second year.
By the fourth year (not shown) the detection rate decreases as, by this stage, a proportion of those in core training will have completed and may be taking breaks, and some of those in GP training will have completed and moved out of training.
HEE is undertaking a comprehensive review of movement between training levels at the level of specialty in coming year.

CT/ST1 posts advertised and filled 2015, 2016, 2017

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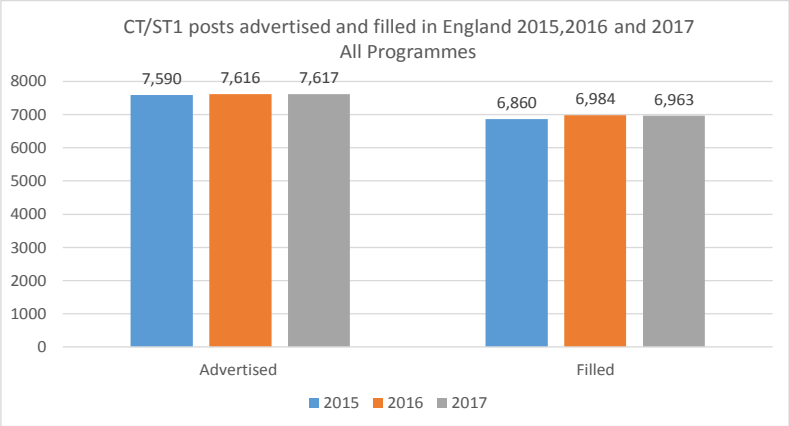
	Avertised				Filled				Fill tate		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
BBT	83	0	0		67	0	0		81%		
Core Psych	419	558	482		362	406	327		86%	73%	68%
Core Ana	581	551	551		568	534	532		98%	97%	97%
Core Med	1,368	1,375	1,423		1,339	1,305	1,281		98%	95%	90%
Core Surgery	508	507	501		498	505	500		98%	100%	100%
GP	3,120	3,310	3,568		*2,659*	2,895	3,016		85%	87%	85%
EMED	327	321	308		*325*	316	279		99%	98%	91%
HISTO	74	79	85		76	78	60		103%	99%	71%
CT Surg	6	5	8		6	5	6		100%	100%	75%
OMFS	5	3	7		5	3	7		100%	100%	100%
NSURG	25	23	27		25	23	27		100%	100%	100%
O&G	205	230	238		205	228	237		100%	99%	100%
Clin Rad	212	212	226		212	212	226		100%	100%	100%
Paeds	373	379	381		359	351	336		96%	93%	88%
Ophth	74	61	56		74	61	56		100%	100%	100%
Pub Hlth	78	57	70		78	57	69		100%	100%	99%
CSRH	2	5	4		2	5	4		100%	100%	100%
	7,460	7,676	7,935		6,860	6,984	6,963		92%	91%	88%



The successful focus on GPs has reduced the numbers entering other programmes

NHS
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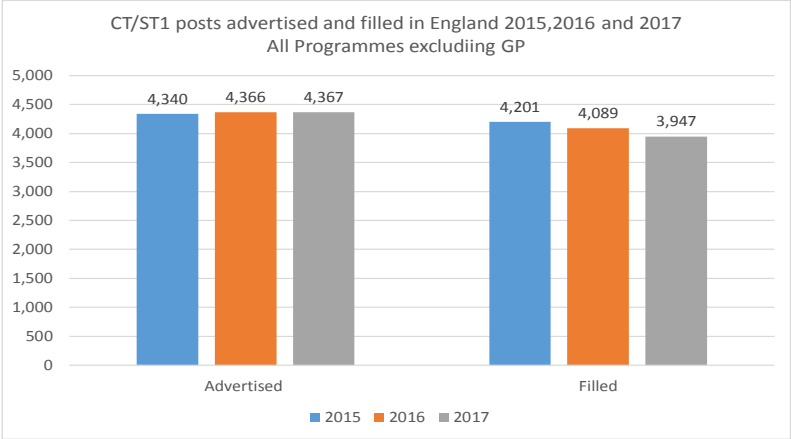
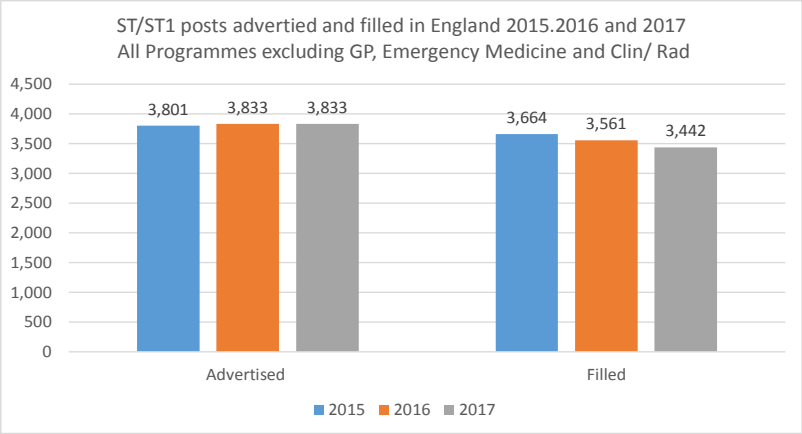
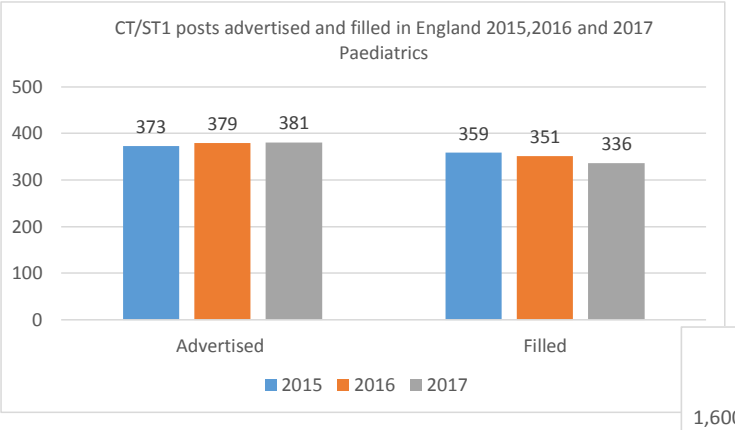
The number of doctors entering 'specialist training' has wavered only slightly.





The further focus on Emergency Medicine and the highly popular Clinical Radiology has similarly reduced the numbers entering other programmes (although Emergency Medicine CT/ST1 did not itself fill in 2017)



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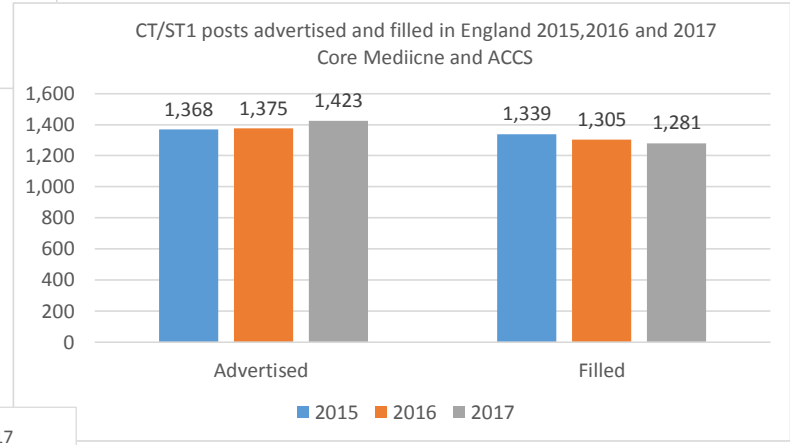
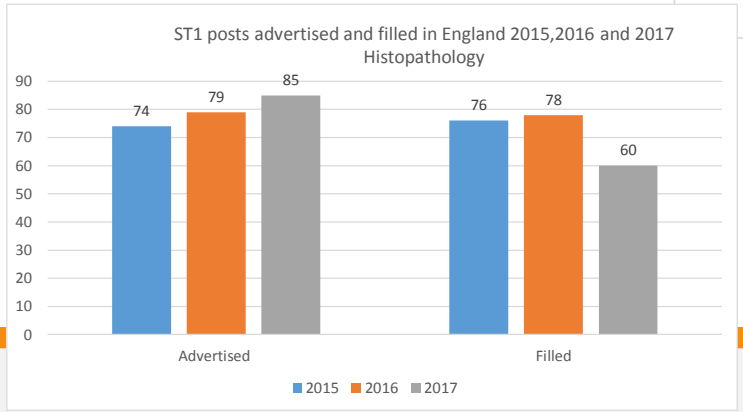
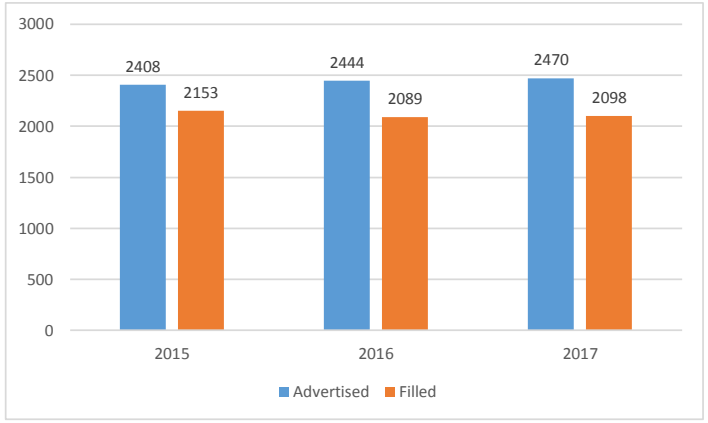
The charts show the areas of recruitment that have been most impacted by expansion in the context of the fundamental supply constraint



Lower recruitment to Core and ACCS Acute can be expected to impact on recruitment to higher specialties in the future

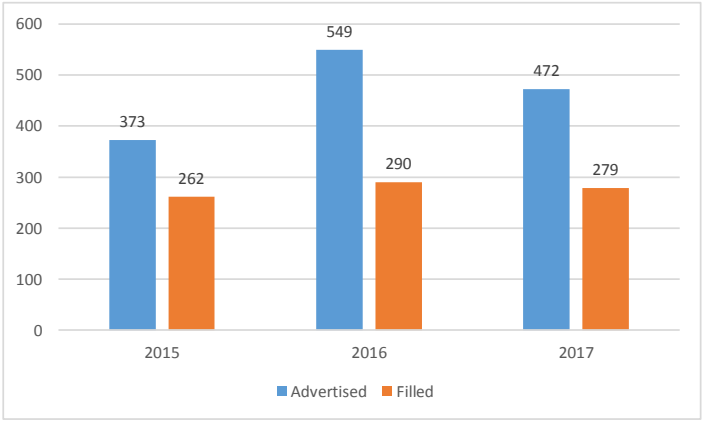


Histopathology is a particular concern in the context of the prioritisation of cancer services.

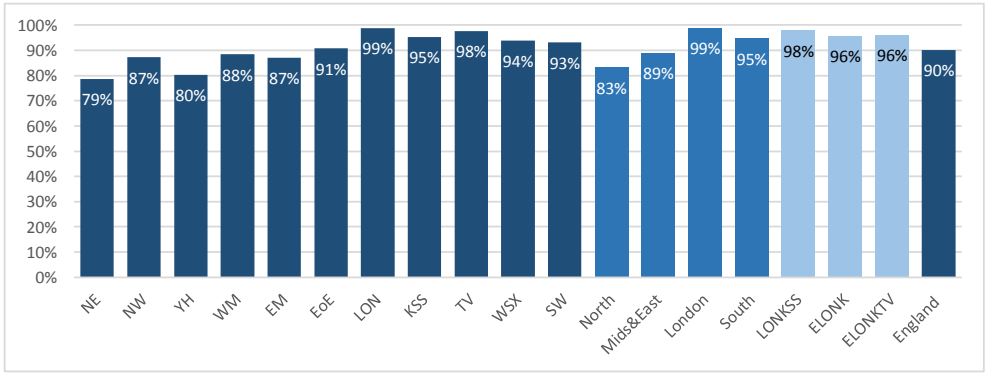


All ST3

ST4 Psychiatry



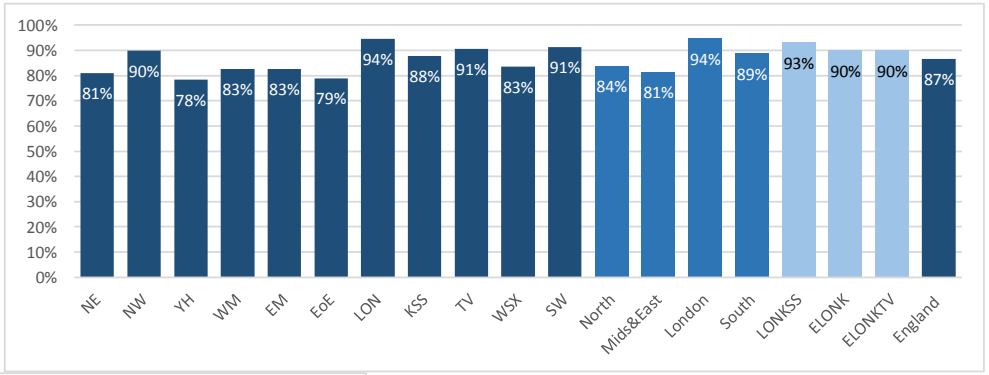
Average fill rates 2015-2017

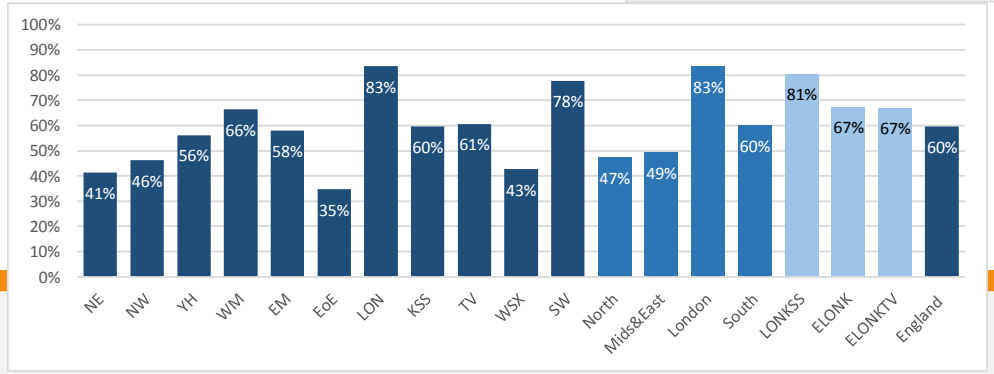


Health Education England

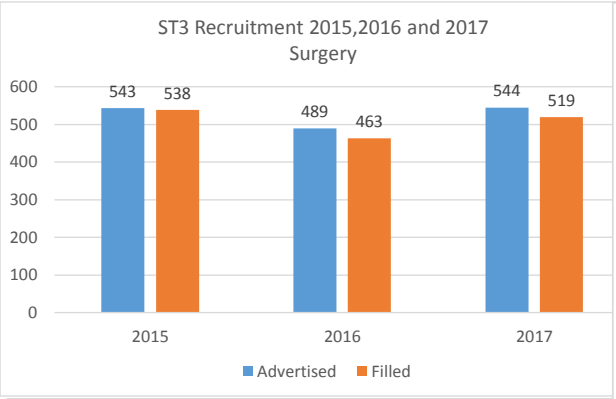
All CT/ST1
Average 750 unfilled each year

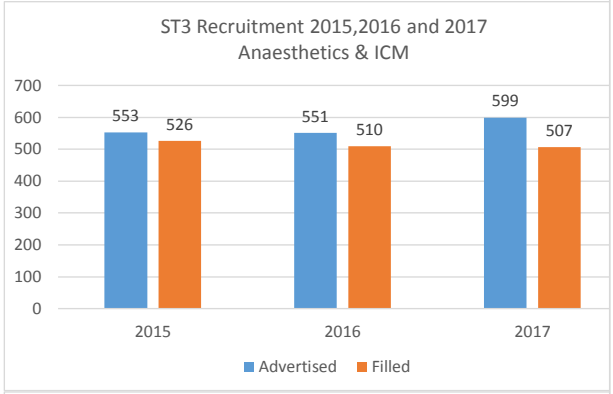
All ST3
Ave. 330 unfilled each year

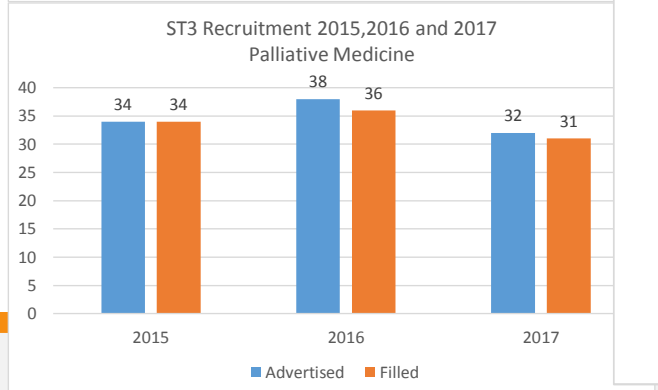


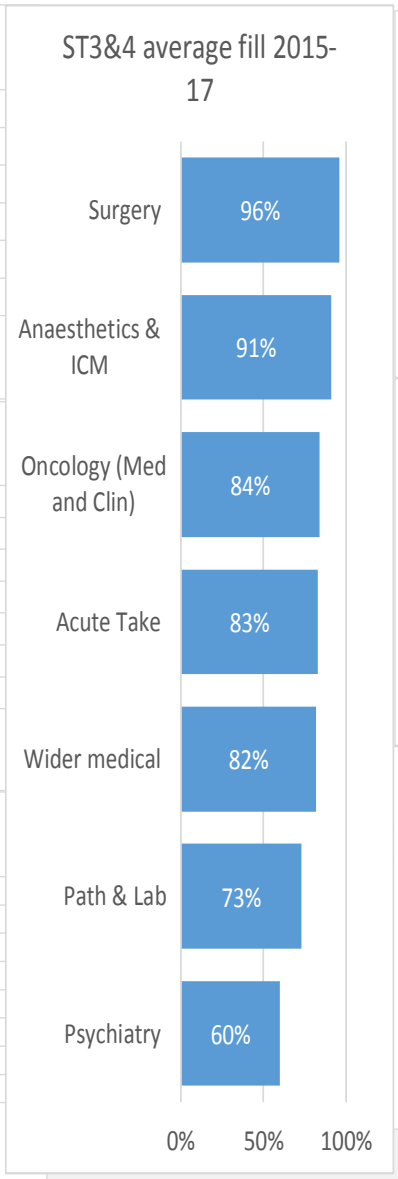


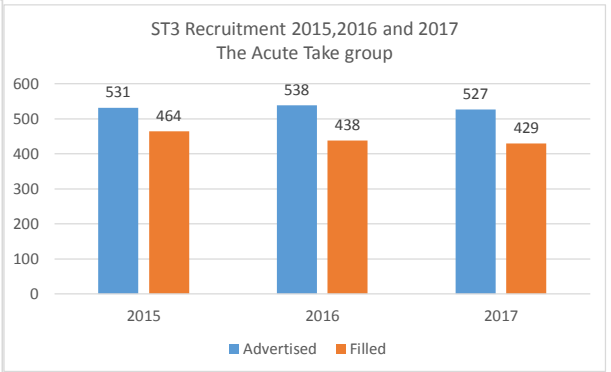
Psychiatry ST4
Ave 190 unfilled each year

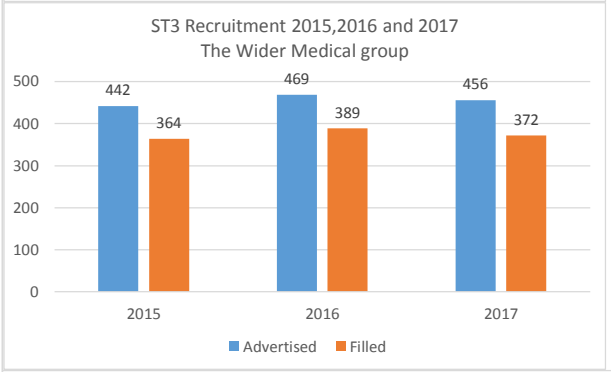

ST3 Recruitment 2015,2016 and 2017
Surgery
600
500
400
300
200
100
0
543
538
489
463
544
519
2015
2016
2017
Advertised
Filled

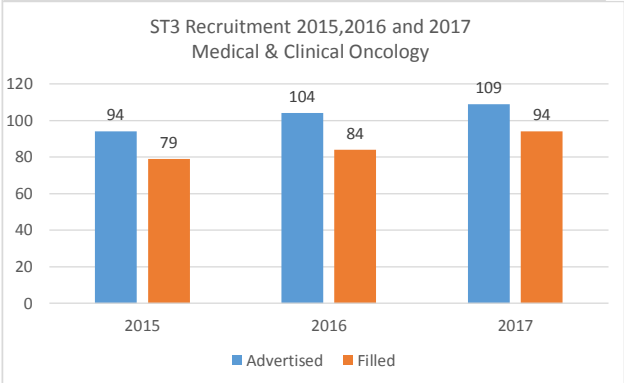

ST3 Recruitment 2015,2016 and 2017
Anaesthetics & ICM
700
600
500
400
300
200
100
0
553
526
551
510
599
507
2015
2016
2017
Advertised
Filled


ST3 Recruitment 2015,2016 and 2017
Palliative Medicine
40
35
30
25
20
15
10
5
0
34
34
38
36
32
31
2015
2016
2017
Advertised
Filled

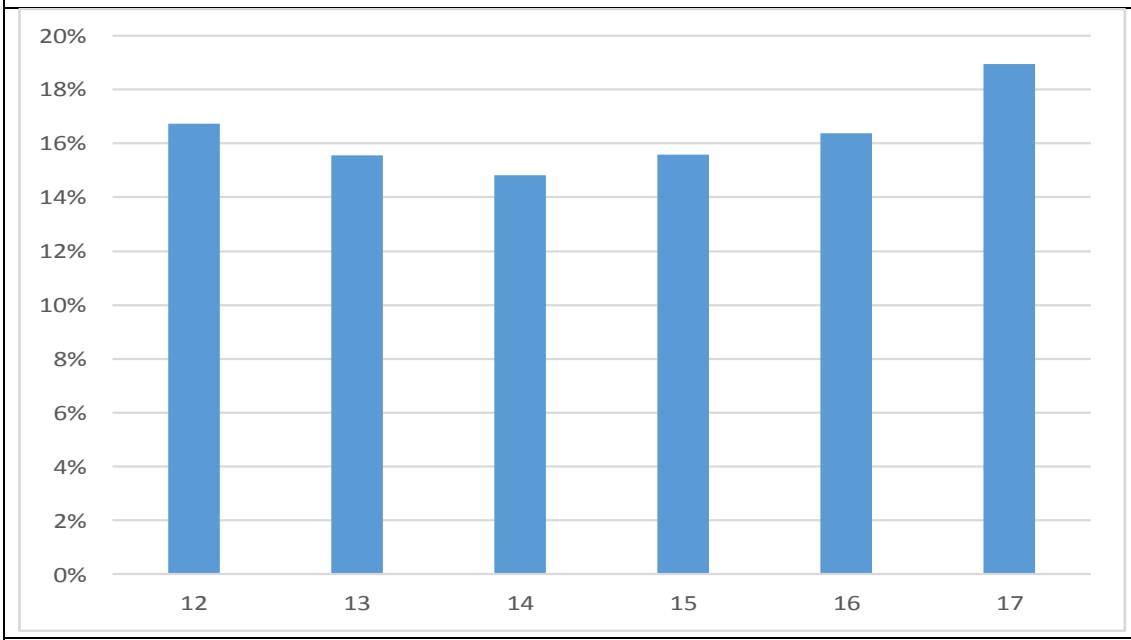

ST3&4 average fill 2015-17
Surgery
96%
Anaesthetics & ICM
91%
Oncology (Med and Clin)
84%
Acute Take
83%
Wider medical
82%
Path & Lab
73%
Psychiatry
60%
0%
50%
100%


ST3 Recruitment 2015,2016 and 2017
The Acute Take group
600
500
400
300
200
100
0
531
464
538
438
527
429
2015
2016
2017
Advertised
Filled

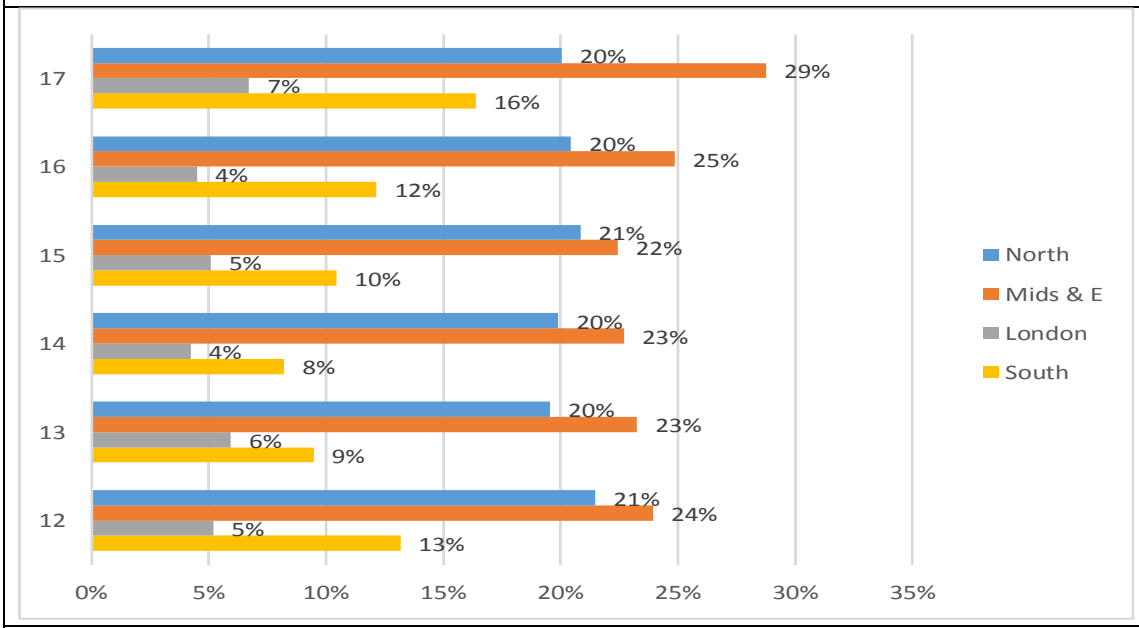

ST3 Recruitment 2015,2016 and 2017
The Wider Medical group
500
400
300
200
100
0
442
364
469
389
456
372
2015
2016
2017
Advertised
Filled


ST3 Recruitment 2015,2016 and 2017
Medical & Clinical Oncology
120
100
80
60
40
20
0
94
79
104
84
109
94
2015
2016
2017
Advertised
Filled

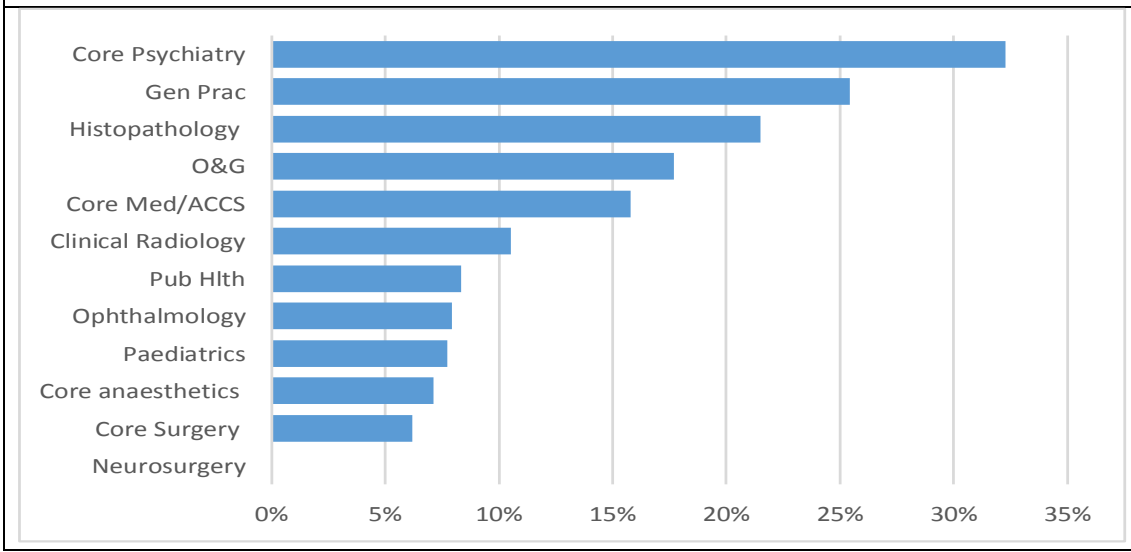
Proportion of trainees at CT/ST1 with non-UK PMQ each year 2012-17



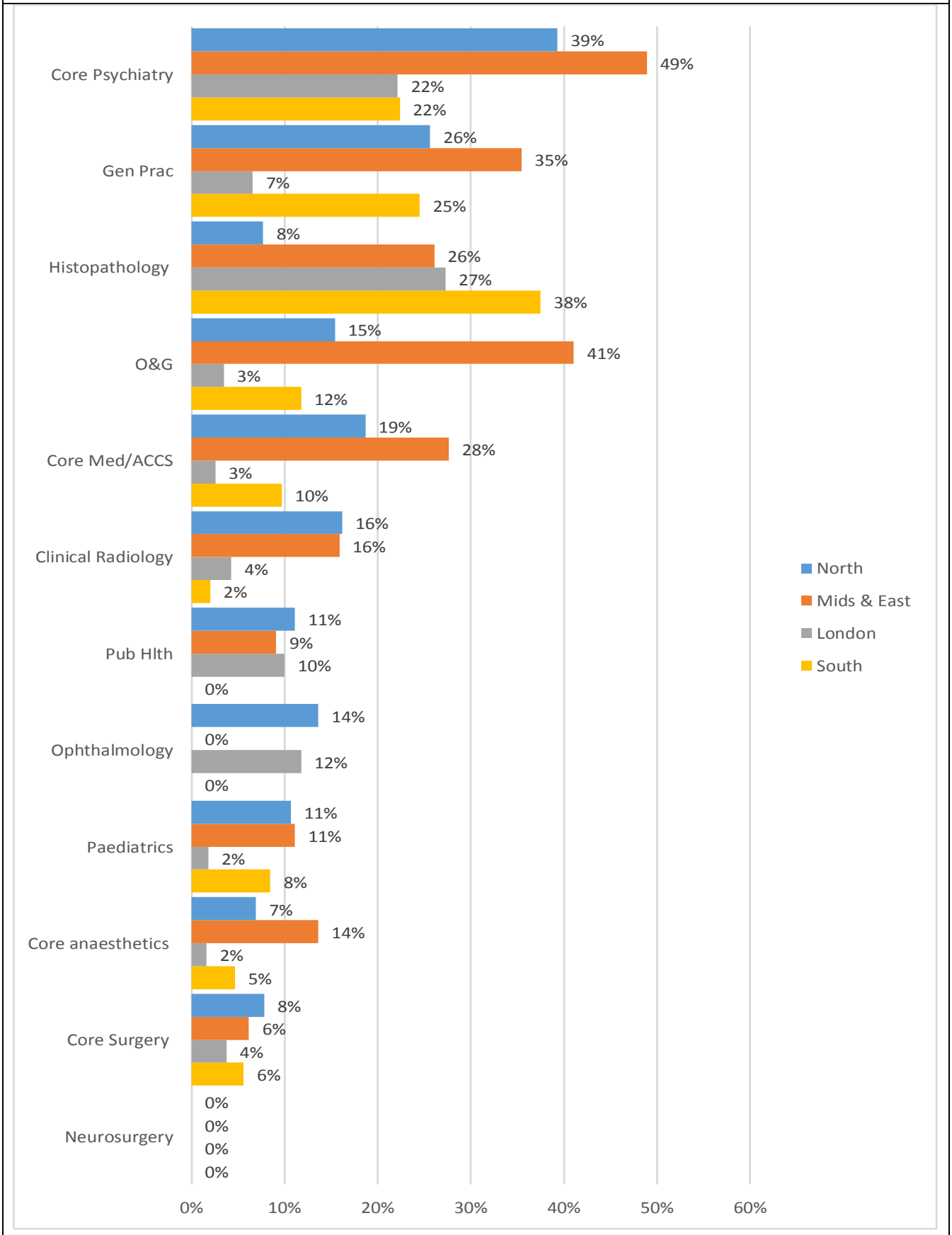
Proportion of trainees at CT/ST1 with non-UK PMQ by Region 2012-17



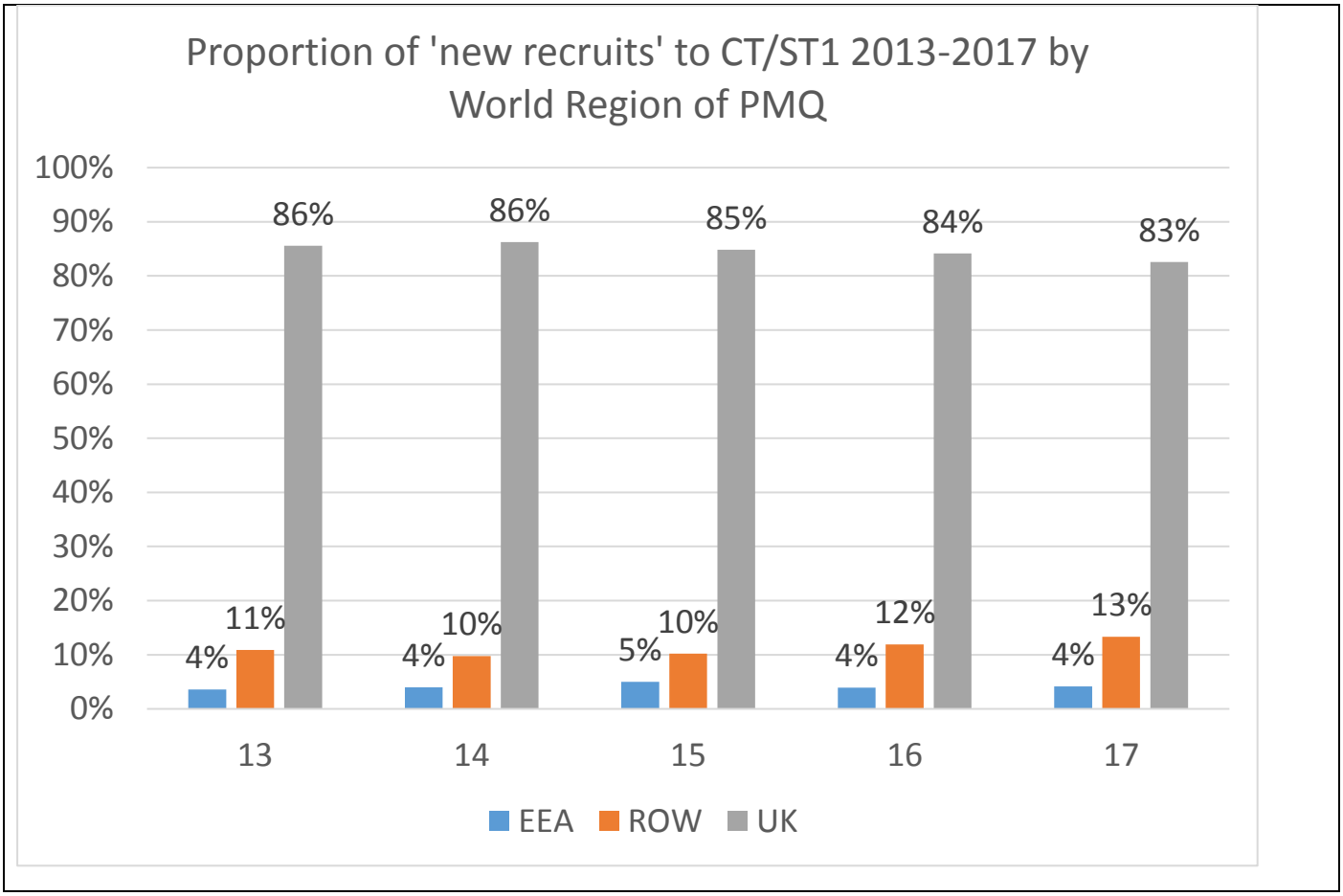
Proportion of trainees at CT/ST1 with non-UK PMQ in 2017 by programme/group



Proportion of trainees at CT/ST1 with non-UK PMQ in 2017 by programme/group by Region



Proportion of recruits to CT1/ST1 by PMQ



The chart is based on NTS data from 2012 to 2017.

The selection is all trainees in English Deaneries in given year at CT1 or ST1 who were either at F2 or not in the NTS in the previous year. This is thus an estimate of 'new recruits' to entry levels for core and run-through training.

The NTS 'census' data relates to March/April each year and this reflects recruitment to the programmes starting in the previous academic year. For example, the 2017 figure reflects recruitment for September 2016, which would be undertaken in the period to June 2016.

The data indicate there has been some marginal change in the proportion from outside the UK over the period.

The next set of data will be available for analysis in June/July 2018.