

Proposed changes to currencies for education and training placements:

Invitation for feedback from stakeholders

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1. Introduction to currency design

1.1. Purpose and objectives

Health Education England (HEE) exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.

One of the key levers to achieve this is via funding training placements with healthcare providers. This document informs stakeholders of the proposals HEE has developed for new funding currencies for education and training placement activities to better meet our objective.

HEE commissions and pays for education and training placements based on a mix of an interim transitional tariff that was introduced by the Department for Health and Social Care (DHSC) in April 2013 and local arrangements for areas that are outside the scope of the transitional tariff for that period.

The tariff-based approach was set out in *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*¹. The latest tariffs can be found on the internet².

Two key terms are used throughout this document and these are defined below to ensure clarity when reading this document.

Currency – the unit of activity for which a payment is made. For NHS acute services the unit of currency is the Healthcare Resource Group or HRG. It is proposed that each student or trainee placement is an activity and these activities are allocated to an '*education resource group*' (ERG). Each grouping of educationally similar training or education activity which consumes a similar level of resource will be known as an ERG.

Tariff – the set price paid for each currency. This may be a price that is amended by a '*market forces factor*' to reflect local differences in the cost of delivering activity.

Currently, transitional tariffs cover a subset of placements, but the intention is to create currencies that apply to all placements irrespective of whether they are in or out of the scope of transitional tariff.

Alongside the roll-out of new currencies the DHSC are working to determine a more permanent set of tariffs which will replace current transitional arrangements. The intention is for these tariffs to better reflect the cost of education and training, and to cover more types of practice placements. More currencies also provides the opportunity to incentivise activity if required.

The mandate from the DHSC to HEE³ requires HEE to develop proposals for ERGs to form the basis of future tariffs. HEE are required to analyse the costing data, and

¹ <https://www.gov.uk/government/publications/developing-the-healthcare-workforce-from-design-to-delivery>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629492/2017-18_ET_tariff_guidance_FINAL_July_v2.pdf is the latest published tariff. The 2018-19 tariff is imminent.

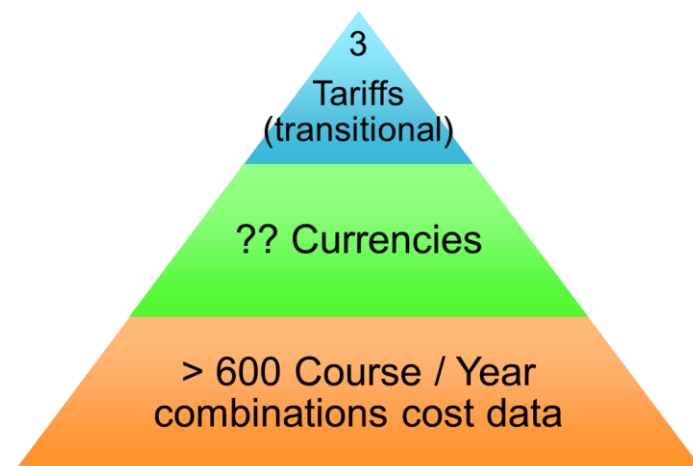
³ <https://www.gov.uk/government/publications/health-education-england-mandate-2017-to-2018>

to create and refine the Education Resource Groups in light of the findings. The DHSC will then set the tariff price. The analysis for currency design started with earlier cost data and has been updated to reflect the 2016-17 cost data, which is the latest data available.

1.2. Why develop ERGs?

The objective of refining tariffs through development of appropriate ERGs on which future tariffs will be based is to ensure that funding is distributed fairly across the placement providers, and to better explore the relationship between service and training spend and the overall quantum of costs. Having a national tariff will allow commissioners and providers of placements to focus on the quality of training and the student experience rather than price.

The current transitional tariff has only three groups covering most, but not all of placement activity. Training outside of professions eligible for tariff is subject to historic local prices. The cost collection collects data for each profession and year of training which results in over 600 combinations of course and year. Three tariffs are considered to be too blunt, whereas over 600 would be an administrative burden disproportionate to the increased transparency. ERGs provides an intermediate option to refine tariffs and keep the admin burden proportionate.



1.3. Process and timescales

HEE convened a Currency Development Group (CDG) that comprised representatives from HEE – including representatives nominated by HEEs Advisory Groups⁴, the DHSC, NHS Improvement and NHS placement providers to consider analysis of the cost collection data, provide educational context to the creation of ERGs and to develop proposals for further consideration. Details of membership can be found at Appendix 1.

The group has met regularly since November 2014 and provided input and discussion on draft proposals, this was considered further by HEE's Executive Team and resulted in this document.

⁴ HEE Advisory Groups existed at the start of the currency development work covering distinct clinical areas. They have subsequently been reformed, but the representatives were asked to continue to participate.

Stakeholder engagement will take place during September, following which the proposals will be reviewed in light of comments received and final proposals for currencies determined.

Once currencies have been developed it is for the DHSC to use these to set tariffs based on the new currencies and latest cost data. It is anticipated that the earliest that revised currencies will be introduced is 2019-20, although they could be used in shadow form within 2018-19 to ensure that administrative processes are in place in the provider sector in order to allow them to collect and record data at this level, even if the new currencies map to the existing transitional tariffs.

The CDG were mindful of developments in the education and training of healthcare professionals including the 'Shape of Training' and 'Shape of Caring' reviews. The potential for changes arising from the 'Five Year Forward View' and early work from the Sustainability and Transformation Partnerships could impact on the skillmix required and sectors providing placements was also noted. In the development of ERGs the CDG has sought to support current and future workforce needs. Once currencies have been developed it is the intention that there is an annual review process to ensure that they are still fit for purpose in light of the annual cost collections.

HEE is currently piloting 'Place Based Placement Funding' which will pool all placement funding for nursing, midwifery and AHP placements within a geographical area (i.e. 'place') together. The rationale is to improve alignment between local health priorities and the delivery of education and training. It is considered that refinements to currencies and tariffs will complement this as whether funding is allocated directly to a placement provider or to a place there will need to be a mechanism for distribution equity. Another benefit of more refined tariffs is the ability to target and incentivise support for shortage specialties.

1.4. Education and training cost data

To underpin the work on developing currencies and tariffs, placement providers in secondary care have been required to submit cost data on how much it costs them to provide placements for students and to host trainees within their organisations. There have been two annual collections of education and training cost data so far.

Prior to this collection DHSC and HEE worked with a pilot group of trusts in order to develop the methodology, provide guidance and put on events for providers to help them understand the methodology. There was also an initial six-month collection to enable Trusts to test their internal processes and provide benchmarking data so they could refine their own costing processes prior to the first annual collection.

It is recognised that the quality of the data arising from the first 2013-14 Education and Training Cost Collection was highly variable. This was due to it being the first annual collection of education and training costs. Since the beginning of the cost collection the data quality has improved due to revisions to the guidance, collection template and the validations carried out.

Known data quality issues have been discussed with the CDG who accept that the data are imperfect and that there are some extreme outliers that have been removed from analysis in order to avoid distortion.

Whilst concern about variable quality of the 2013-14 data meant that it was not of sufficient quality on which to base a tariff the CDG considered it acceptable to inform discussions regarding groupings. Subsequent data collection have been used to re-run the analysis and refine initial ERG proposals. This resulted in either confirming the proposal or prompting a revision.

Some of the analysis considered by the CDG included an impact assessment of the potential for tariffs based on different groupings to advantage or disadvantage certain types of placement provider. This analysis uses estimated cost per hour for non-salaried and cost per trainee for salaried, it also uses activity based on information collected from placement providers. It is used only to inform impact assessment, it did not represent what the final tariff may be as this is for the DHSC to determine. It was also surprising that different groupings led to similar range of impacts for potential gainers and losers of new currencies.

The data analysis was only one consideration when developing ERGs and other factors were also considered. The multi-disciplinary nature of the CDG proved invaluable for providing insight into non-quantifiable considerations about what was educationally meaningful, and for providing potential reasons for variation in cost.

The scope of the Education and Training cost collection was secondary care placement providers, this includes community trusts. There is a separate project that is considering placement activity within General Practice. Ambulance Trusts are not within the scope of the cost collection and where data is available for paramedics this relates to paramedic placements within secondary care.

1.5. Scope of Currency Design Work

Whilst the scope of the data analysis to support currency design is those professions within the current scope of the secondary care education and training cost collection the CDG have been mindful of the other sectors of the NHS and sought to 'future proof' its work through developing principles that can be applied to other settings when appropriate data becomes available.

There was concern that this is limited to NHS secondary care placement providers and excludes placements that are provided by private and third sector healthcare providers. However, as they are outside the scope of the cost collection there was no data on their costs to include in the analysis. Any comments on the proposed ERGs would still be welcome from these sectors, recognising that they are becoming increasingly important in the provision of placements.

At present, the transitional tariff excludes some categories of trainee; for these trainees local arrangements remain in place. However, just as the costing exercise has tried to be all inclusive of all placement activity it is suggested that ERGs will be developed for all placement activity. This will enable trainees to be brought into the scope of tariff at a future date if the DHSC who are responsible for setting the tariff consider this to be relevant.

1.6. Summary

This section has covered the purpose, rationale and process for currency design. The data upon which some of the deliberations are based has also been explained and whilst it is recognised that there are weaknesses in the data the quality has improved over the four collections.

Following this section the principles which underpin currency development are discussed, and then the proposals are presented.

2. Currency design principles

2.1. Consideration of principles

One of the first tasks of the CDG was to consider principles by which to test the proposals for ERGs. As noted above the need for the principles to apply both to the secondary care NHS placements for which data was available, but to also be suitable for applying to other sectors such as the private and voluntary sector and for the development of primary care currencies and tariffs.

The DHSC have already asked HEE to consider four principles when distributing budgets to their local offices and it seems sensible to replicate these when designing ERGs. In addition to the four principles that the DHSC required HEE considers quality to be an over-arching principle. The four principles are:

- **Transparency.** There should be a clear line of sight as to how the distribution is calculated.
- **Equity.** Funding should be distributed to local areas based on the healthcare workforce to support the need of their population. ⁵
- **Stability.** The methodology should ensure that there are not significant fluctuations between years that might destabilise planning or the provider sector.
- **Flexibility.** The methodology should be able to react to changes in training activity or practices.

However, experience has shown that these principles include some tensions. As we move to a more **flexible** system then the **stability** of the existing system is likely to be challenged as funds follow activity. Similarly, the most **transparent** system could be considered to be based on simple calculations, whereas to achieve **equity** and allow for different variables complexity will be increased, which could compromise transparency.

Another source of learning to guide development of currencies is the work undertaken by NHS Digital to initially develop HRGs (healthcare resource groups) for services. The principles that underpinned the initial development of HRGs (and suggested read across to ERGs) are:

- Iso-resource – activities within a group should consume a similar amount of resource
- Clinically meaningful – similar activities should be grouped together, not disparate activities. *This has been interpreted as educationally meaningful with respect to ERGs.*
- Minimum coverage – there are minimum thresholds for the amount of activity within a HRG. *This has been interpreted as minimum thresholds for the amount of activity with an ERG.*

⁵ There may be occasions where placement capacity to train the healthcare needed does not exist in the local area, or there are quality issues that might necessitate training being commissioned from a different area.

During discussion of the principles the CDG identified the following practical considerations:

- a. That potential for perverse financial incentives should be avoided or reduced
- b. The need for the currencies to support and not obstruct the objectives of HEE, DHSC or placement providers
- c. The need for commissioners and providers to believe in the currencies, and subsequent tariffs, trusting that they broadly reflect costs (or in a cost constrained scenario they reflect the relative cost of delivering activity)
- d. The principles should be met with the fewest number of currencies possible, in order to make the system workable in practice for commissioners and providers
- e. That where tensions between principles occurs, then this should be identified and conclusions justified.

2.2. Principles adopted

The principles to be taken forward are:

Quality	Equity
Stability	Flexibility
Transparency	Iso-resource
Educationally meaningful	Minimum coverage

Engagement questions: Do you broadly agree with the principles proposed?

Can you suggest anything that is not addressed through one of these principles?

3. Non-salaried currencies

Non-salaried education refers mostly to students undertaking a specific course to achieve a professional registration. This registration could be medical, dental, or other healthcare professions.

The non-salaried description refers to the majority of students, however, there are some exceptions where students that have previously worked in the NHS continue to receive discretionary salary support whilst studying rather than a student or maintenance loan (for example, a healthcare assistant who is supported to undertake nurse training). In these cases their placement is treated as non-salaried and it only applies to the placement element and not any salary support.

There have been many different options presented to the currency development group as to how the non-salaried currencies may look. These have included combining all of them in one group so that all are seen as being important as each other and supporting the provision of multi-professional education. This is a move away from the historic distinction between SIFT and NMET payments.

We have also looked at grouping them in their separate categories such as pre-registration and post-registration nursing, having separate currencies for medical and dental undergraduate. We considered combining some of the non-medical professions together and splitting them up into groups where the group would be split at a certain cost breaks.

3.1. Costs reported

The total costs⁶ reported for different professions can be seen in Table 1. The table shows that the largest percentages of costs reported by trusts are for medical undergraduates and nursing and midwifery therefore these two professions have the potential to dominate the other professions when grouping more than one profession together.

Table 1: Proportion of total cost for different groups of non salaried students

	Total Hours	Total Cost	% of Total Cost
Physician Associate	107,909	1,414,140	0.1%
Pharmacy Undergraduates	147,433	1,556,101	0.2%
Professional & Technical	467,745	6,610,949	0.6%
Dental Care Professionals	656,153	9,362,085	0.9%
Operating Department Practitioners	1,487,861	15,444,301	1.5%
Allied Health Professionals	5,193,101	62,593,797	6.0%
Dental Undergraduates	2,902,607	72,251,894	7.0%
Nursing & Midwifery	40,777,067	416,055,342	40.2%
Medical Undergraduates	23,657,004	449,457,030	43.4%
Grand Total	75,396,880	1,034,745,640	100%

⁶ The costs used for this consultation document are based on the 2016-17 cost collection

3.2. Preferred Option

The CDG concluded that the best option for the non-salaried professions would be to create a single currency for each single profession, therefore there would be 48 ERG's for the non-salaried professions.

The benefits of this are that the resulting currency is fair, transparent and clearly defined for each profession, the biggest drawback of this method is that it has the potential to create instability within the provider sector in the short term and an increased administrative burden whilst processes are put in place. However, the CDG considered that because placements were already being arranged and managed on a profession by profession basis and cost collection is at a lower level combining profession and year of training the administration should be manageable for placement providers.

In order to decide upon the preferred option the CDG considered both quantitative and qualitative factors and used the principles that the group had set itself at the start of this work, these are discussed in section 2.2 above. Out of all the options which the CDG considered suitable for non-salaried, four of these options are compared against the principles in

Table 2 overleaf.

Details of the activity, total cost and average hourly rate is shown in Figure 1, this shows that the lowest average cost reported is £4.36 for Rehabilitation Engineering and the highest cost reported is £44.43 for Clinical Photography. However, there is no discernible correlation between the type of profession and the average hourly cost that would suggest grouping together similar professions.

Figure 1: Hourly cost of all non-salaried placements

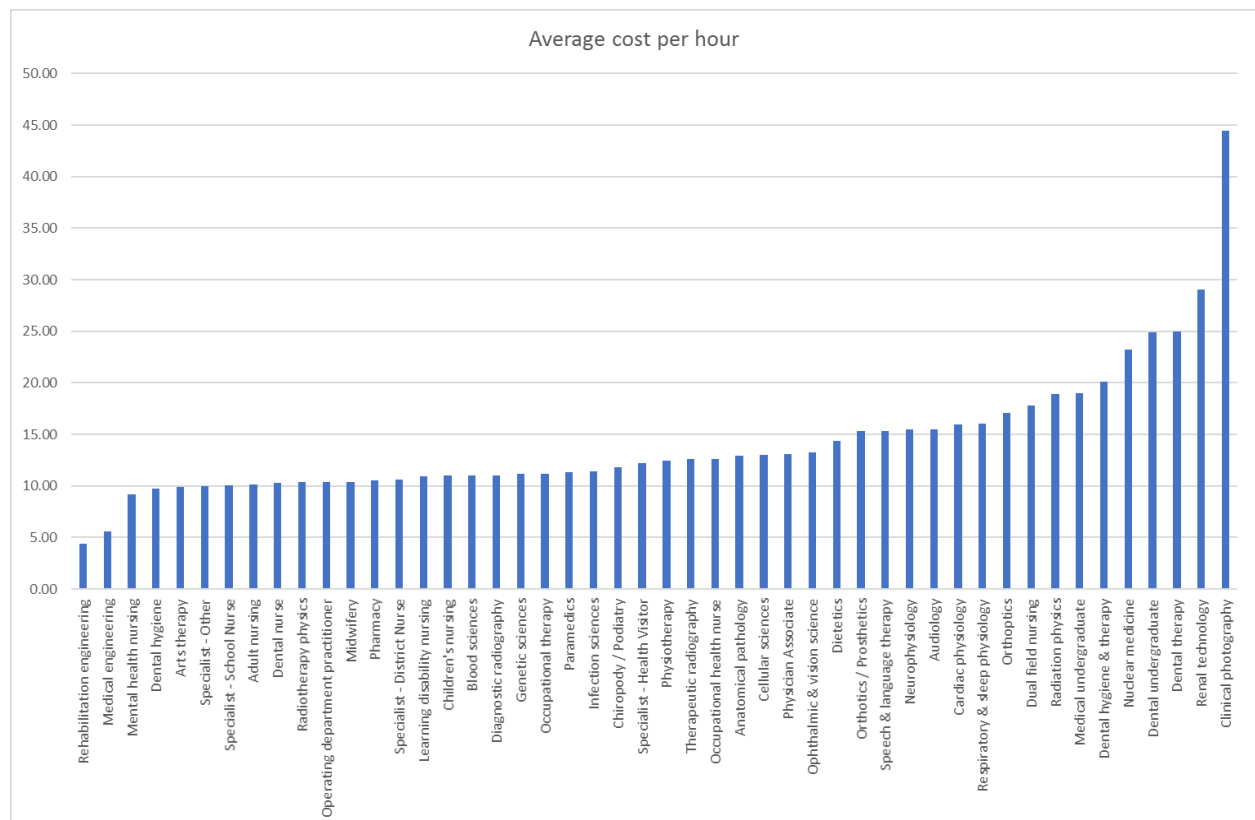


Table 2: Principles matrix for non-salaried options

Non - Salaried	Current Situation 3 tariffs	Preferred Option non-salaried Single professional groups	Grouping by Costing group	Grouping into 3-6 Iso-resource	Single professional except low number of providers (<9)
Quality: Other levers to drive quality, such as quality framework	Limited impact currently	Better ownership at local level Cost matching curriculum should drive up quality (affordability)	Worse – could disincentivise providers from training for professions that are 'high cost'	Worse – could disincentivise providers from training for professions that are 'high cost'	Better ownership, except for the smaller professions that are grouped which could have negative impact
Stability	Transition to current tariff has destabilised providers that were historically above tariff, may have created perverse disincentives	Initial instability, but longer term greater stability if providers reimbursed for actual activities and mix of training, rather than averages	Less instability, and greater longer term stability, but may have some disincentives for higher cost professions within a group	Less instability, and greater longer term stability. Some issues regarding buy-in for diverse professions within a group	Initial instability, but longer term greater stability if providers reimbursed for actual activities and mix of training, rather than averages
Transparency	Less transparent as tariffs are blunt and a one fits all solution	Much more transparent as currencies set on costs submitted by trusts	Less transparent as different costing groups incur different costs	Less transparent as different costing groups incur different costs	Much more transparent as currencies set on costs submitted by trusts
Educationally meaningful Align placements to curriculum	Not meaningful except for Medical and Dental	Much more meaningful if costs are attributed to each training programme.	More meaningful, but not as meaningful as preferred option	Not meaningful and would not have professional buy-in	Much more meaningful if costs are attributed to each training programme.
Equity	Very inequitable, relative tariff between medical and non-medical not reflected of differences in costs	Much more equitable	Slightly more equitable, provide an illusion of improvement. Less robust than preferred option	More robust than current situation or group by costing group, but not as good as preferred option.	Much more equitable
Flexibility Funding following the placements, enabling shifts of activity	Lack of granularity disincentivising movement where cost is perceived to be in excess of tariff	Most flexible and responsive to changes, but more tariffs may require longer conversations	Better flexibility, but not as flexible as preferred option	Better flexibility, but not as flexible as preferred option	Most flexible and responsive to changes
Iso-resource Similar cost of activity within groups	Doesn't really exist as tariffs too blunt so no consideration for activity differences	Some of the professions only have small cost as large numbers are not being trained	Better than single profession as categories are grouped together	Better consideration of similar costs in these groups however arbitrary splits	Some of the professions only have small cost as large numbers are not being trained
Minimum coverage Having sufficient providers or total activity so as cost data does not skew tariffs	No concerns around minimum coverage as one size fits all approach	Worst option as it exposes small groups with limited providers for a small number of professions. Could need some mitigating actions	No concerns around minimum coverage	No concerns around minimum coverage	Worst option as it exposes small groups with limited providers for a small number of professions

The creation of 48 ERG's places an administrative burden on trusts however it has been suggested by the CDG that this will influence positive behaviour through rewarding actual activity provided and also encourage trusts to collect data at profession level which would allow them to have a better understanding of their costs.

HEE is also undertaking a separate project to review and make consistent the information it requires to support commissioning of clinical placements. It is hoped having a standardised activity collection will ensure administration is not overly onerous.

Stakeholder question: Do you agree with the preferred option of one ERG for each profession?

If you do not agree, what are your concerns?

3.3. Other options considered and discounted

Some of the options considered and discounted by the CDG are noted below.

- o **Separate groups for different years of training**

The CDG considered splitting the professions into separate years but ultimately concluded that this could create perverse incentives as some placement providers may want to only take students in certain years depending on whether this was perceived to be advantageous for them or not, this could create problems with obtaining an appropriate mix of placements for the students. Assessment of data by year of training also indicated that very few placement providers only provided training for certain years and not across all years.

The tariff includes flexibilities where some services are provided by one organisation on behalf of other placement providers and these could be used if there is inequitable distribution of placement activities. If the 'Place based funding pilot' is successful and rolled out, this would also provide a good platform on which to discuss and agree how the placement funding might be distributed across all placement providers within a 'place'.

- o **One group for all non-salaried**

This was suggested by one of the CDG members as a way of encouraging more multi-disciplinary training. On further consideration it was considered inequitable to put all the professions into one ERG whose average cost would be £13.72 as different providers undertake a different mix of training for professions that are below or above this average.

Following this further methods of grouping the 48 professions into currency groups was explored but most were considered arbitrary at best and that it would not improve the paying for education and training placements. It would also place an additional administrative layer when placements would have to be grouped for commissioning and billing purposes.

- o **Separate currency groups for medical and dental undergraduates**

As it can be seen in Table 1 both these groups combined comprises 50.4% of the total costs reported in the non-salaried section of the cost collection. The CDG concluded that there is a clear distinction between medical and dental undergraduates therefore the group considered having separate currencies for both medical and dental undergraduates. This was due to a number of reasons, such as different curriculums, facilities requirements, placement settings, number of placement providers, etc.

The analysis undertaken showed that it was more educationally meaningful if medical and dental undergraduates had separate currencies as there was a different cost base for both courses. The average cost per hour overall was also significantly different for medical undergraduates this is £19.00 and for dental undergraduates this is £24.89.

- o **Separate currency groups for pre-registration and post-registration nursing and midwifery**

The CDG originally considered having separate groups for pre-registration and post-registration nursing and midwifery. This would be achieved by grouping all pre-registration courses together to achieve an average cost per hour of £10.18 and by grouping all post-registration courses together to achieve an average cost per hour of £11.34. It was also found that there is a different cost composition for the different courses under the nursing and midwifery category with varying levels of staff input.

This option was discounted by the CDG after much thought and consideration because having the same price for children's nursing and adult nursing for example would not recognise the difference in curriculum's or the size of the cohorts. It was therefore concluded by the group that by creating separate ERG's for each nursing course there could be more stability introduced and the distinction between them would remain clear cut.

- o **Two or Three currency groups for the remaining healthcare professions in non-salaried**

The CDG then discussed how the remaining 35 professions which fall under the non-salaried category should be grouped, the average cost per hour for this would be £12.03. The group agreed that it would be inequitable for all 35 professions to have the same cost per hour, therefore several options were presented to the group which included having a similar number of professions / hours / cost in each group.

The average cost per hour for these 35 professions ranges from £4.36 to £44.43 if you see figure 6 on page xx in the supplementary document you can see the differences in cost between the different professions.

This option was discounted on the basis that the splitting of the 35 professions into a number of different cost bands would be arbitrary at best and would disadvantage the trusts providing placements as there costs would not be truly reflected and by being an average cost for all professions they could gain less than other trusts.

4. Salaried currencies

The programmes collected under the salaried category are split between postgraduate medical and dental and other professions. The majority of the programmes and costs fit under the postgraduate medical and dental category, the current funding model for these programmes comprises two distinct payments for placement tariff and salary. Medical uses the national tariff in secondary care, Medical in other settings and Dental is subject to local arrangements. Despite the differences in the current payment model for both postgraduate medical and dental it has been decided to treat them the same in order to build equality and transparency into the currency development process.

The other professions cover 48 different professions under 9 categories and do not fit under the under the normal postgraduate medical and dental heading. Currently these other professions are outside of the national tariff arrangements and funded using historic local arrangements with variation throughout England.

4.1. Costs reported

The total costs reported under the salaried programmes is £2.2 billion this equates to 64% of the total costs reported under the 2016/17 education and training cost collection. Of this the costs reported for the postgraduate medical and dental is £2.0 billion this equates to 93.6% and the costs for the other professions is £137 million this equates to 6.4%. Due to the differing nature of the training these have been considered separately.

Table 4: Proportion of total cost for different professions

	Salary cost £m	% Salary cost	Placement cost £m	% Placement Cost	Total cost £m	% of Total
Medical and Dental Trainees	920.5	45.5%	1,104.7	54.5%	2,025.2	93.6%
Other Salaried Professions	71.6	52.0%	66.1	48.0%	137.6	6.4%
Total Salaried	992.1	45.9%	1,170.8	54.1%	2,162.9	100.0%

4.2. Proposed groupings

The development of the currencies for the salaried categories was a slow process due to the complexity of there being two distinct payments for the majority of the programmes which are paid national tariff as well as a number of historic local funding arrangements for the other salaried programmes. This has meant that progress has been slow as there have been a number of complex factors we have had to consider and consult with during the development process. The data collected from the annual education and training collections has shown that there is significant variability between programmes and even between the different years of a programme. It is also consider that the split between training and service delivery during the training received by trainees is subjective and difficult to accurately assess.

4.3. Medical groupings

Whilst developing currencies we have taken many of the principles that were set up and agreed by the members of the currency development group into consideration. There are three main ways in which the grouping of options have been determined.

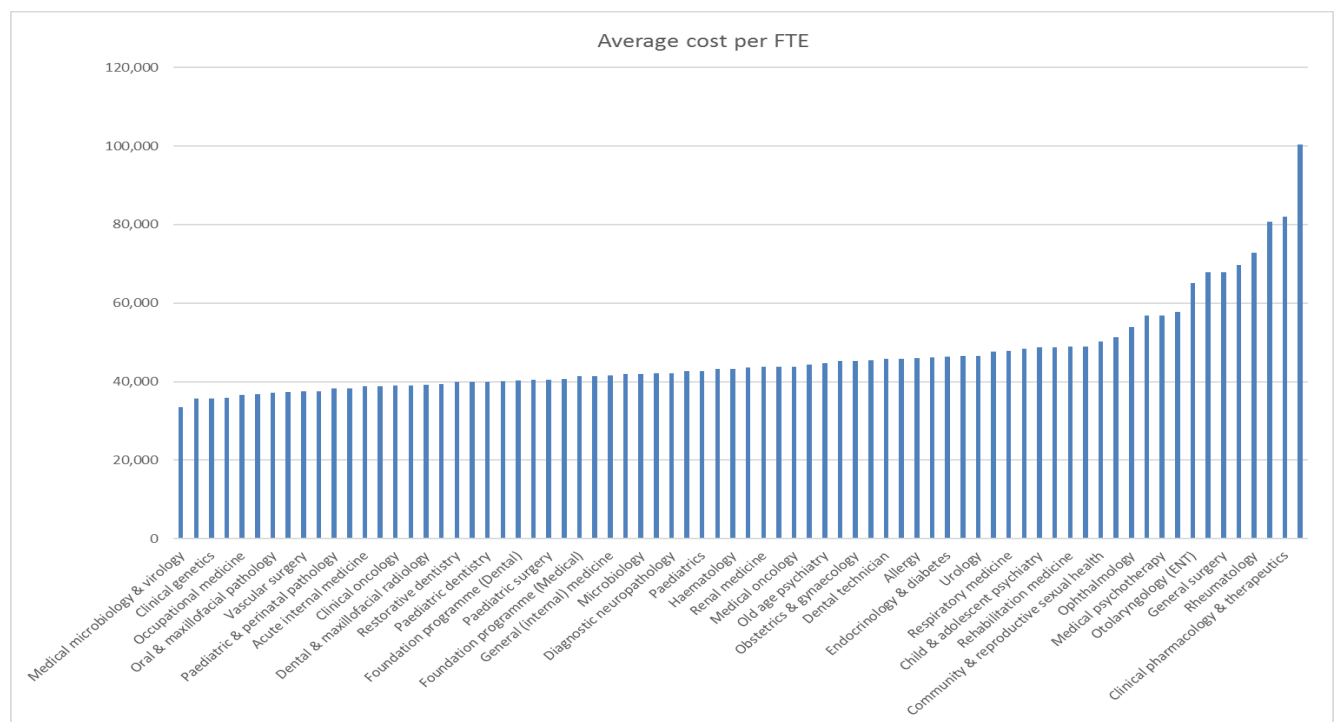
Firstly the main specialty that the trainees are hosted in, secondly, the category (which is a grouping of similar specialties), and thirdly the stage and length of training that needs to be undertaken as part of core and higher training.

In order to develop currencies for postgraduate medical and dental, the currency development group has had to take into account both quantitative and qualitative factors which may impact on the preferred option and the thus the overall implementation of the currencies.

Once again a number of methods – such as one group for each specialty, for each category, putting together specialties with similar costs were all considered as options. Also, the potential for a tariff to be a single tariff for a trainee compared to separating placement support and salary contribution was considered.

Details of the activity, total cost and average cost per fte is shown in Figure 2, this shows that the lowest average cost per FTE reported is £33,390 for medical microbiology and virology and the highest cost reported is £100,388 for Anaesthesia. However, there is no discernible correlation between the type of specialty and the average cost per FTE.

Figure 2: FTE cost of all postgraduate medical and dental specialties



The preferred option, after discussion with the CDG and also separate discussions with some of the Post Graduate Deans of HEE was for a grouping that reflected educational stages and specialties – including where some specialties are grouped together for core training, before progressing to higher specialist training. “Table 3: Proposed groupings for Medical and Dental Trainees” on the following page shows the proposed groupings.

Table 3: Proposed groupings for Medical and Dental Trainees

Currency Code	Description	Salaried FTE	Total costs '£'	Avg Cost/Student	Placement Costs	Placement Cost/Trainee	Salary Costs	Salary Cost/Trainee
AC1	Core training acute -Years 1 to 2/3	3,083	126,307,643	40,969	66,137,785	21,453	60,169,857	19,517
AC2	Specialty training Acute Internal medicine - Years 3 to 6	337	11,402,838	33,830	17,435	5,876,616	5,526,222	16,395
AC3	Specialty training , Anaesthesia- Years 3 to 7	2,203	97,039,168	44,053	50,376,965	22,870	46,662,203	21,183
AC4	Specialty training Emergency medicine - Years 4 to 6	588	23,400,344	39,815	11,882,654	20,218	11,517,689	19,597
AC5	Specialty training Intensive care medicine - Years 3 to 7	288	14,294,194	49,569	8,160,971	28,300	6,133,222	21,268
DF1	Core dental training Years 1 & 2	237	15,436,163	65,135	9,875,387	41,671	5,560,776	23,465
DT10	Dental & maxillofacial radiology training - Years 2 to 4	3	290,884	72,851	232,564	77,911	67,095	22,477
DT2	Oral & maxillofacial pathology training - Years 3 to 5	4	520,807	67,938	132,260	33,124	158,624	39,727
DT3	Oral Medicine training - Years 2 to 5	8	1,519,018	67,845	287,208	37,465	233,599	30,472
DT4	Oral Surgery training - Years 1 to 4	22	3,150,244	57,709	1,053,059	47,034	465,958	20,812
DT5	Orthodontics training - Years 1 to 3	55	7,661,161	56,786	1,738,719	31,851	1,411,525	25,858
DT6	Paediatric Dentistry training - Years 1 to 4	135	2,821,092	80,661	4,441,177	32,919	3,219,985	23,867
DT7	Restorative dentistry training - Years 1 to 5	35	2,142,979	69,659	1,726,914	49,376	1,094,178	31,285
DT8	Special care dentistry training - Years 1 to 3	31	886,237	82,084	1,255,078	40,797	887,901	28,862
DT9	Prosthodontics from Year 1	11	299,658	100,388	613,799	56,851	272,439	25,234
GP1	GP vocational training scheme - Years 1 & 2	1,798	65,711,306	36,551	35,099,192	19,523	30,612,114	17,027
MD1	Core medical training - Years 1 to 2/3	2,988	114,022,988	38,163	59,936,459	20,060	54,086,529	18,102
MD10	Specialty training, Allergy - Years 3 to 7	421	262,975	42,600	8,535,602	20,279	7,758,924	18,434
MD11	Specialty training Audiovestibular medicine -Years 3 to 7	140	697,513	36,723	2,463,885	17,562	2,355,877	16,792
MD12	Specialty training Cardiovascular medicine - Years 3 to 7	97	21,655,843	40,590	2,457,056	25,236	1,814,598	18,637
MD13	Specialty training Clinical Genetics - Years 3 to 6	620	2,190,654	53,385	11,882,199	19,167	11,198,181	18,064
MD14	Higher specialty training Clinical Neurophysiology - Years 4 to 6	342	1,326,189	52,300	7,332,171	21,425	6,279,768	18,341
MD15	Specialty training Clinical Pharmacology & therapeutics - Years 3 to 6	32	517,541	33,995	777,119	24,387	598,659	18,787
MD16	Specialty training Dermatology - Years 3 to 6	117	7,424,653	43,990	2,493,809	21,295	2,132,016	18,206
MD17	Specialty training Endocrinology and diabetes - Years 3 to 7	207	11,463,391	37,745	3,802,247	18,369	3,229,565	15,602
MD19	Specialty training Gastroenterology - Years 3 to 7	272	16,294,526	38,713	6,706,645	24,615	5,835,351	21,417
MD2	Specialty training general internal medicine - Years 3 to 5	6	4,819,762	34,354	158,724	25,712	104,251	16,888
MD20	Specialty training Genito urinary - medicine - Years 3 to 6	12	4,271,647	43,873	367,108	31,111	302,391	25,626
MD21	Specialty training Geriatric medicine - Years 3 to 7	34	23,080,380	37,231	798,340	23,823	700,421	20,901
MD22	Specialty training Haematology - Years 3 to 7	30	13,608,929	39,766	788,069	26,128	497,699	16,501
MD23	Specialty training Immunology - Years 3 to 7	94	1,375,778	43,174	2,217,464	23,633	1,818,501	19,381
MD24	Specialty training Infectious diseases - Years 3 to 7	64	4,625,825	39,501	1,703,225	26,806	1,271,552	20,012
MD25	Specialty training Medical oncology - Years 3 to 7	255	7,031,813	33,971	5,376,644	21,089	4,546,691	17,834
MD26	Specialty training Neurology - Years 3 to 7	469	12,541,997	46,032	10,002,741	21,312	8,259,444	17,598
MD27	Specialty training Nuclear medicine - Years 3 to 5	202	669,499	56,737	4,387,782	21,722	4,387,782	16,997
MD28	Specialty training Occupational medicine - Years 3 to 6	18	1,498,761	44,724	515,839	28,060	401,943	21,864
MD3	Specialty training Paediatric cardiology - Years 4 to 8	19	1,285,768	42,629	390,220	20,544	307,293	16,178
MD4	Specialty training Palliative medicine - Years 3 to 6	534	4,035,965	43,013	11,721,458	21,970	9,934,386	18,620
MD5	Specialty training Rehabilitation medicine - Years 3 to 6	41	2,974,777	46,818	1,332,313	32,468	858,342	20,917
MD6	Specialty training Renal medicine - Years 3 to 7	25	9,923,335	38,923	758,774	29,923	567,415	22,377
MD7	Specialty training Respiratory medicine - Years 3 to 7	15	18,262,185	38,910	321,801	21,137	195,741	12,857
MD8	Specialty training Rheumatology - Years 3 to 7	169	7,821,168	38,718	3,885,477	23,021	3,539,176	20,969
MD9	Specialty training Sports and exercise medicine - Years 3 to 6	304	917,782	49,924	6,155,955	20,269	5,307,437	17,475
MF1	Foundation medical training - Years 1 & 2	12,256	460,351,756	37,562	250,783,323	20,462	209,568,433	17,099
OB1	Core training Obstetrics & Gynaecology - Years 1 & 2/3	772	32,052,486	41,516	17,204,436	22,284	14,848,050	19,232
OB2	Specialty training Community & reproductive sexual health - Years 4 to 6	7	340,089	51,560	181,331	27,491	158,758	24,069
OB3	Specialty training Obstetrics & gynaeology - Years 3 to 7	1,185	46,937,693	39,601	25,145,023	21,215	21,792,669	18,386
OP1	Core training Ophthalmology - Years 1&2	179	7,827,150	43,754	4,347,111	24,300	3,480,039	19,453
OP2	Specialty training Ophthalmology - Years 3 to 7	409	20,486,314	50,127	11,405,955	27,908	9,080,360	22,218
PD1	Core Paediatrics training - Years 1 to 3	1,509	58,668,933	38,878	30,507,941	20,217	28,160,992	18,661
PD2	Specialty training Paediatrics - Years 4 to 8	1,490	59,184,056	39,711	31,990,499	21,465	27,193,556	18,246
PG1	Specialty training Chemical pathology - Years 3 to 5	50	2,080,800	41,282	1,088,047	21,586	992,753	19,696
PG10	Specialty training Diagnostic neuropathology - Years 3 to 5	114	393,938	46,452	2,941,442	25,729	2,318,208	20,277
PG2	Specialty training Forensic Histopathology - Years 3 to 5	8	164,761	40,721	214,311	25,271	179,627	21,181
PG3	Specialty training Histopathology - Years 3 to 6	4	12,148,828	45,805	84,744	20,945	80,017	19,776
PG4	Specialty training Medical microbiology & virology - Years 3 to 5	205	4,626,173	49,424	6,892,879	25,988	5,255,949	19,817
PG5	Specialty training Microbiology - Years 3 to 5	94	2,109,067	36,620	2,588,262	27,652	2,037,911	21,772
PG6	Specialty training Paediatric & perinatal pathology - Years 3 to 5	58	109,035	48,942	1,188,249	20,632	920,818	15,988
PG7	Specialty training Virology - Years 3 to 5	2	320,536	38,850	54,685	24,546	54,350	24,396
PG8	Core Histopathology training - Years 1 to 2	8	5,259,651	46,006	170,142	20,622	150,393	18,228
PS1	Core Psychiatry training - Years 1 to 3	1,496	61,416,293	41,062	35,329,331	23,621	26,086,962	17,441
PS2	Specialty training Child & adolescent Psychiatry - Years 4 to 6	157	6,581,901	42,011	3,572,760	22,804	3,009,142	19,207
PS3	Specialty training Forensic Psychiatry - Years 4 to 6	104	4,281,242	41,163	2,216,610	21,312	2,064,632	19,851
PS4	Specialty training General Psychiatry - Years 4 to 6	530	23,240,591	43,840	12,195,425	23,005	11,045,166	20,835
PS5	Specialty training Medical Psychotherapy - Years 4 to 6	33	1,468,976	44,460	830,306	25,130	638,670	19,330
PS6	Specialty training Old age psychiatry - Years 4 to 6	159	6,970,432	43,950	3,808,884	24,016	3,161,548	19,934
PS7	Specialty training Psychiatry of learning disabilities - Years 4 to 6	61	2,944,132	47,910	1,546,541	25,167	1,397,591	22,743
RD1	Core Radiology training Years 1 to 3	526	24,386,070	46,359	13,200,164	25,094	11,185,906	21,265
RD2	Specialty training Clinical Oncology - Years 3 to 7	285	11,270,442	39,508	5,694,074	19,960	5,576,368	19,548
RD3	Specialty training Clinical Radiology - Years 4 to 6	485	21,856,043	45,033	11,128,877	22,931	10,727,166	22,103
SG1	Core surgical training - Years 1 & 2	1,528	64,893,508	42,481	35,158,496	23,016	29,735,012	19,465
SG10	Specialty training Cardiothoracic Surgery - Years 3 to 8	287	5,775,962	47,484	7,081,568	24,702	5,705,190	19,901
SG11	Specialty training General Surgery - Years 3 to 8	62	39,789,460	41,272	1,611,922	26,172	1,180,525	19,168
SG2	Specialty training Neurosurgery - Years 3 to 8	122	7,531,099	45,670	3,423,352	28,143	2,352,609	19,341
SG3	Specialty training Oral & maxillofacial surgery - Years 3 to 7	964	7,510,126	47,653	21,206,723	21,997	18,582,737	19,275
SG4	Specialty training Otolaryngology - Years 3 to 8	165	12,868,499	42,120	3,906,945	23,692	3,624,154	21,977
SG5	Specialty training Paediatric surgery - Years 3 to 8	158	3,690,353	48,384	4,054,435	25,726	3,455,691	21,927
SG6	Specialty training Plastic surgery - Years 3 to 8	306	10,538,131	40,552	6,881,224	22,523	5,987,275	19,597
SG7	Specialty training Trauma and Orthopaedic - Years 3 to 8	76	41,355,698	42,192	2,105,684	27,608	1,584,668	20,777
SG8	Specialty training Urology - Years 3 to 7	260	12,786,758	44,603	5,548,122	21,350	4,990,009	19,202
SG9	Specialty training Vascular surgery - Years 3 to 8	980	2,792,447	45,340	21,989,860	22,434	19,365,839	19,757
		43,517	1,754,494,806	40,317	945,439,146	21,726	809,055,661	18,592

Table 4: Principles matrix for postgraduate medical and dental options

<p>Salaried</p> <p>Postgraduate Medical & Dental</p> <p>Quality:</p> <p>Other levers to drive quality, such as quality framework</p>	<p>Current Situation</p> <p>Medical: 1 tariff 50% basic salary</p> <p>Dental: 100% salary, no tariff</p> <p>All postgraduate medical paid the same no matter the training year.</p> <p>Dental paid 100% salary with no recognition of service.</p>	<p>Preferred Option</p> <p>Salaried – postgraduate medical and dental</p> <p>Single specialty – core and higher (81 currencies)</p> <p>Different salary and placement funding for the different specialties, the recognition that they are being paid on true costs will incentivise trusts to drive up quality of training.</p>	<p>Grouping by specialty and splitting by Foundation and new contract groups</p> <p>Worse – could disincentivise providers from training for specialties that are deemed to be 'high cost'</p>	<p>Iso resource to split into 3-6 groups</p> <p>Worse – could disincentivise providers from training for specialties that are deemed to be 'high cost'</p>	<p>Grouping of currencies into categories with merging</p> <p>(26 currencies)</p> <p>Less than the preferred option as different categories are merged together.</p>
<p>Stability</p>	<p>Transition to current tariff has destabilised providers that were historically above tariff, may have created perverse disincentives.</p>	<p>The right amount of funding per specialty will provide stability and stop the cross subsidisation that currently takes place.</p>	<p>Less instability, and greater longer term stability, but may have some disincentives for higher cost specialties within a group.</p>	<p>Less instability, and greater longer term stability for smaller specialties.</p>	<p>Less instability, and greater longer term stability for smaller specialties.</p>
<p>Transparency</p> <p>Ed meaningful</p> <p>Align placements to curriculum – placement content drives resource requirement. Stages of curricula, when would sub-specialisation occur</p>	<p>Less transparent as tariffs are blunt and a one fits all solution, no recognition of differences between specialties</p> <p>No – the tariff is blunt and the salary was determined on a 50/50 split between training and service delivery.</p>	<p>Currencies based on actual costs submitted by trusts so they are receiving true funding.</p> <p>Much more meaningful if costs are attributed to each training programme.</p>	<p>Less transparent as different costing groups incur different costs some have a larger number of specialties.</p> <p>Does following contract make sense educationally?</p>	<p>Less transparent as different groups of specialties incur different costs, i.e. dental specialties have a higher cost base.</p> <p>Not meaningful and would not have professional buy-in.</p>	<p>Less transparent as 81 currencies are grouped together into 26 currencies in an arbitrary manner.</p> <p>Not really meaningful and would not have professional buy-in as merging is arbitrary.</p>
<p>Equity</p>	<p>No – there is no true recognition of the varying levels of service delivery throughout the different specialties.</p>	<p>Much more equitable than previous method of funding.</p>	<p>Slightly more equitable than current funding model, provides an illusion of improvement.</p> <p>Less robust than preferred option.</p>	<p>More robust than current situation or group by contract groups, but not as good as preferred option.</p>	<p>More robust than current situation or group by contract groups, but not as good as preferred option.</p>
<p>Flexibility</p> <p>Funding following the placements, enabling shifts of activity</p> <p>Iso-resource</p> <p>Similar cost of activity within groups</p>	<p>The funding doesn't always follow the trainee, i.e. study leave is an issue for example.</p> <p>Doesn't really exist as tariffs too blunt so no consideration for activity differences.</p>	<p>Most flexible and responsive to changes, but more tariffs may require more frequent and longer conversations.</p> <p>Some of the specialties only have a small cost as large numbers are not being trained depending on the specialty.</p>	<p>Better flexibility, but not as flexible as preferred option.</p> <p>Better than single specialties as categories are grouped together so no small currencies.</p>	<p>Better flexibility, but not as flexible as preferred option.</p> <p>Better consideration of similar costs in these groups however arbitrary splits.</p>	<p>Better flexibility, but not as flexible as preferred option.</p> <p>Better consideration of similar costs in these groups however arbitrary splits.</p>

This results in 81 groupings, compared with 417 combinations of specialty and year of training. The grouping of 74 specialties into 11 categories was considered, but within each group would be a wide range of costs and providers might have a different mix of trainees that are above or below the average for the category.

The creation of 81 ERG's for postgraduate medical and dental places an administrative burden on trusts however it has been suggested by the CDG that this will influence positive behaviour through rewarding actual activity provided. HEE is in the process of rolling out a new national Trainee Information System which will also help with providing standardised information about training posts and trainees. The system will be available for providers and trainees to access as well as HEE staff.

Stakeholder question: Do you agree with the preferred option of an ERG for stages of training and grouping together related specialties at core level?

If you do not agree, what are your concerns or suggestions for improvement?

4.4. Other salaried groupings

Historically these professions have been funded under local negotiation and thus remained out of scope of the national tariff arrangements. Developing currencies based on the data collected from the education and training cost collections provides Health Education England with the opportunity to review the current funding streams and bring consistency across other professions. This may enable them to be brought within into the scope of a new national tariff developed by the Department of Health and Social Care at some future date.

The table below shows the proportionate spread of total costs over the nine categories which comprise 48 different professions. The table shows that the professions in the Pharmacy category incur the most costs.

Table 5: Proportion of total cost for different professions in other professions

Category	Total Cost	Salaried Number of FTEs	Total Cost per FTE	% of Total
Dental	1,738,177	55.56	31,284	1.3%
Health Care Scientist	1,500,744	30.92	48,541	1.1%
Higher Specialist Scientist	2,550,850	64.10	39,794	1.9%
IAPT	13,912,911	610.10	22,804	10.1%
Pharmacy	43,583,636	1,086.40	40,117	31.7%
Psychology	40,898,485	1,064.77	38,411	29.7%
Psychotherapy	1,175,515	31.07	37,839	0.9%
Science Training Programme	32,271,065	656.61	49,148	23.4%
Grand Total	137,631,383	3,599.53	38,236	100.0%

As shown in Table 6 on the next page there is considerable difference in costs within the groups. This lead to the CDG proposing the creation of 48 ERG's for the other professions. It should be noted that some of the professions are very small, or provided by only one or two key organisations. This may influence the statistical accuracy of average costs and limit the opportunity to develop tariffs relative to actual costs.

Stakeholder question: Do you agree with the preferred option of one ERG for each other salaried profession?

If you do not agree, what are your concerns?

Table 6: Individual professions within categories – total cost and cost per FTE

Category	Course	Total Cost	Salaried Number of FTEs	Total Cost per FTE
Dental	Dental nurse (salaried)	1,738,177	55.56	31,284
Dental Total		1,738,177	55.56	31,284
Health Care Scientist	Nuclear medicine	667,723	10.96	60,905
	Radiation physics	171,103	2.92	58,597
	Radiotherapy physics	661,917	17.03	38,859
Health Care Scientist Total		1,500,744	30.92	48,541
Higher Specialist Scientist	Higher specialist scientific training	2,550,850	64.10	39,794
Higher Specialist Scientist Total		2,550,850	64.10	39,794
IAPT	High intensity therapist	5,782,954	212.32	27,237
	Psychological wellbeing practitioner	8,129,957	397.78	20,438
IAPT Total		13,912,911	610.10	22,804
Pharmacy	Pharmacist pre-reg	25,589,449	540.51	47,343
	Pharmacy technicians	17,994,187	545.89	32,963
Pharmacy Total		43,583,636	1,086.40	40,117
Psychology	Clinical psychology	37,320,395	891.91	41,843
	Counselling psychology	1,118,038	72.02	15,523
	Forensic psychology	1,062,035	53.50	19,851
	Health psychology	1,398,016	47.34	29,535
Psychology Total		40,898,485	1,064.77	38,411
Psychotherapy	Psychotherapists	1,175,515	31.07	37,839
Psychotherapy Total		1,175,515	31.07	37,839
Science Training Programme	Audiology	2,882,340	60.91	47,320
	Bioinformatics (Genomics)	279,355	7.00	39,908
	Bioinformatics (Health Informatics)	394,296	6.60	59,742
	Bioinformatics (Physical Sciences)	469,008	7.14	65,654
	Cardiac science	3,319,478	54.16	61,293
	Clinical biochemistry	1,927,859	35.70	54,005
	Clinical immunology	746,365	19.08	39,115
	Clinical measurement & development	156,430	3.00	52,143
	Clinical Microbiology (including: infection control & epidemiology, virology, bacteriology, mycology, parasitology)	1,161,364	31.35	37,051
	Clinical pharmaceutical science	425,221	6.81	62,478
	Critical care science	369,545	6.65	55,560
	Cytopathology	879,471	6.75	130,292
	Gastrointestinal physiology	295,296	6.33	46,680
	Genomic Counselling	77,632	1.70	45,544
	Genomics Science	1,374,312	24.80	55,406
	Haematology and transfusion science	830,988	32.34	25,698
	Histocompatibility & immunogenetics	360,180	8.90	40,470
	Histopathology	588,894	12.23	48,150
	Imaging (ionising radiation)	1,528,196	30.09	50,795
	Imaging (non-ionising radiation)	876,033	17.52	50,001
	Medical device risk management & governance	116,630	2.00	58,315
	Neurophysiology	897,874	31.62	28,391
	Ophthalmic & vision science	469,077	8.83	53,103
	Radiation safety physics	445,461	9.37	47,565
	Radiotherapy physics	4,075,516	84.69	48,124
	Reconstructive science (Maxillofacial prosthetics)	278,156	5.00	55,631
	Rehabilitation engineering	988,107	19.59	50,434
	Reproductive science	1,035,871	15.02	68,953
Respiratory & sleep science	632,990	13.45	47,051	
Un-defined clinical engineering	144,331	2.58	55,870	
Un-defined medical physics	1,646,263	33.60	48,996	
Urodynamic science	852,096	21.78	39,116	
Vascular science	1,746,431	30.01	58,187	
Science Training Programme Total		32,271,065	656.61	49,148
Grand Total		137,631,383	3,599.53	38,236

5. Other related issues and conclusions

There are a number of issues that have arisen during the course of designing education currencies. Some are directly related to the proposals, some are issues which introducing currencies provides an opportunity to address.

5.1. Quantum of costs reported compared to HEE expenditure

There is a gap between the quantum of costs reported and HEE's expenditure for those areas that are currently within the scope of the tariff. It was initially hoped that having robust data on the cost to deliver education and training activities might provide the evidence to support a rebasing of funding between education and training and service.

However, there are a number of reasons why this is not considered appropriate:

- Concern regarding the accuracy of the data, particularly the subjective nature of service : training split for postgraduate medical trainees and other salaried trainees.
- The impact of training posts funded by Trusts, research and other bodies that were included in the data capture.
- Potential for greater financial instability if service investment changes meant changes to the service tariff.

In all likelihood this means that any tariff set by the DHSC will continue to be restricted by bounds of affordability. However, HEE is keen that the E&T cost data is used to develop tariffs that bear more relationship to the actual costs than the current transitional tariffs.

5.2. Primary Care placements for Undergraduate Medical Students

Concern has been expressed that rates that HEE pay GP Practices for hosting undergraduate medical students vary considerably and are currently lower than those paid for secondary care placements. A report into how medical students are supported towards careers in General Practice⁷ recommended that there was an urgent review of funding for medical placements to ensure equity and quality of learning.

A separate working group managed by the DHSC has worked with a sample of GP Practices that provide clinical placements to collect cost data and this shows that the costs are broadly similar to what secondary care are reporting. Therefore, there is a proposal that the scope of tariff is widened and covers placements in both primary and secondary care.

5.3. Dental undergraduates

Back in 2017 there was an exercise undertaken to harmonise the rates paid for dental undergraduate placements. Since then different local application of MFF and inflation has caused the rates to diverge, but not by much. Therefore, it is proposed

⁷ <https://www.hee.nhs.uk/our-work/supporting-medical-students-towards-careers-general-practice>

that the scope of tariff is widened to incorporate existing expenditure on dental undergraduates.

Stakeholder questions: Do you agree with the currency for medical undergraduates also including placements within primary care?

Do you agree with scope of tariff widening to include dental undergraduates?

5.4. Conclusions and next steps

HEE is grateful to all the Trusts that have invested time to provide cost data which has formed a valuable part of the analysis of different currency groupings. It is also very grateful to all those listed in Appendix 1 who have contributed to the Currency Development Group and their insights, challenges and feedback has helped shape the proposals presented in this document.

The next step is a series of engagement events at the end of September 2018 to enable direct discussion of these proposals. We would also encourage stakeholders to provide written feedback via email to tariffs@hee.nhs.uk by Friday 5th October 2018.

All feedback received will be reviewed and impact on the proposals for new currencies considered. It is our intention to produce a final list of proposals in late October.

Appendix 1: Currency Development Group Membership

Over the course of the work a number of people have very helpfully contributed as part of the currency development group. The main attendees and their affiliations at the time of their attendance are noted below.

Name	Job Title	Organisation
Health Education England		
Jenni Field (Chair)	Head of Finance Strategy	
Rozeen Mahroof	Finance Manager (Projects & Developments)	
Asad Qureshi / Arslan Tariq	Information Analyst	
Dr Colin McInness	Head of Finance - South	
Pat Saunders	Senior Education and Policy Manager	
Angie Tindall	Admin support	
Health Education England Advisory Group Representation:		
Mary John	Deputy Head of School of Psychology	Mental Health HEEAG
Dr Iain Beith	Head of School of Rehabilitation Sciences / Associate Dean (Practice Education)	AHP HEEAG
Roz Cheeseman	Commissioning Manager	Pharmacy HEEAD
Jane Luker	Postgraduate Dental Dean and COPDEND Chair	Dental HEEAG
Liz Jones	Postgraduate Dental Dean and COPDEND Chair (deputy)	Dental HEEAG
Lynne Hall	Clinical Lead – Community & Practice Nursing	Nursing and Midwifery HEEAG
Sharon Harrison	Clinical Lead – Community & Practice Nursing (deputy)	Nursing and Midwifery HEEAG
Michael Bannon	Lead Dean for Public Health	Public Health HEEAG
David Kidney	CEO of Voluntary Register (deputy)	Public Health HEEAG
Anne Gilford	Head of Education and Quality	Healthcare Scientists HEEAG
Gareth Woods	Healthcare Science Programme Manager (deputy)	Healthcare Scientists HEEAG
Sheona MacLeod	Post Graduate Dean, Health Education East Midlands	Medical and Dental

Department of Health Representation:

Ian Newton	Financial Strategy, Workforce Development
Craig Hewitt	Financial Strategy, Workforce Development
Beth Bradley <i>To Dec. 2015</i>	Financial Strategy, Workforce Development

NHS Placement Provider Representation:

Debbie Jurasz	Associate Director NMATH (Non medical education)	Barts Health NHS Trust
Jana Kristienova	Assistant Director of Integrated Care Education	Whittington Hospital
Peter Collier	Information Analyst	Royal Devon & Exeter NHS Foundation Trust
Rachel Cooke	Head of Library Services & Knowledge Management	Surrey & Sussex Healthcare NHS Trust
Scott Jarvis <i>1st meeting only</i>	Deputy Director of Finance	Derby Hospitals NHS FT
Jeremy Brinley-Codd <i>from Feb.2016</i>	Associate Director of Finance	Guy's and St Thomas' NHS Foundation Trust
Joanne Wilson <i>From Feb.2016</i>	Head of Commissioning Finance	Derbyshire Healthcare NHS Foundation Trust