Title: Introduction of tariffs for education and training IA No: 8050-MEF Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA) Date: 18/01/2013 Stage: Final Source of Intervention: Domestic Type of measure: Other Contact for enquiries: Jenny Firth (jennifer.firth@dh.gsi.gov.uk)

Summary: Intervention and Options

RPC: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, One-Out?	Measure qualifies as
£93.5m	£0m	£0m	No	NA

What is the problem under consideration? Why is government intervention necessary?

There are significant costs associated with the delivery of education and training and it is important that providers are reimbursed efficiently, equitably and transparently to deliver clinical placements so that education commissioners can secure a sufficient number of high quality placements to train the future workforce. At present payments to service providers for the provision of clinical placements for students and trainees are based on historical agreements, resulting in inequities in payment levels to providers within and between regions. The current system, based on historical payments does not provide a fair playing field because some providers are receiving more than the cost of the placements with some receiving less.

What are the policy objectives and the intended effects?

The policy objectives are to develop a fair and transparent payment system for education and training so that funding more closely reflects the costs of providing clinical placements. Commissioning decisions can then be based on quality rather than price. The intended effects are that there is a fair playing field in the provision of education and training and for services and that the quality of education is improved.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 0 - do nothing

Option 1 - introduce national tariffs for education and training clinical placements, initially in secondary care and subsequently in primary care [preferred option]

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro No	< 20 No	Small No	Medium No	Large No
What is the CO2 equivalent change in greenhouse gas emissions? (Million tonnes CO2 equivalent)			Traded: 0	Non-traded: 0	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ..... Date: 13 FEB 2013

URN 11/1109 Ver. 3.0

Summary: Analysis & Evidence

Policy Option 1

Description: Implement tariffs for education and training

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 12	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** £93.5m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	1	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£7.5m		£8.6m	£93.5m

Description and scale of key monetised costs by 'main affected groups'

The transition costs in year 1 are due to the additional cost of introducing tariffs for non-medical education and undergraduate medical placements in secondary care. The average annual costs reflect the implementation costs once tariffs for postgraduate medicine in secondary care are introduced. The year 1 costs are therefore the difference between the costs of implementing the two sets of tariffs.

Other key non-monetised costs by 'main affected groups'

None

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	0

Description and scale of key monetised benefits by 'main affected groups'

None

Other key non-monetised benefits by 'main affected groups'

Fair reimbursement for placements

Fair playing field

Competition based on quality rather than price leading to improved quality of education and training

More equitable distribution of funding

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5%

Quality of placements at losing organisations may be at risk

Losing organisations may be destabilised

Assumption that data provided and validated by SHAs is correct

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits: 0**	**Net: 0**	No	NA

Evidence Base (for summary sheets)

1. Current funding for clinical education and training is based on local agreements between SHAs and providers. This has led to inequity in the funding of similar placements across the country. In particular, the distribution of funding for clinical placements varies widely across clinical placement providers, is not related to volume or quality of training provided, and does not cover all clinical professions. The average funding per FTE medical student varied from £10k to over £90k in 2011-12.
2. In addition, there is little investment currently made by SHAs in clinical placements for non-medical education and training.
3. The current funding arrangements for postgraduate medical education were not changed when the structure of the training programmes changed in 2007.
4. SHAs are currently responsible for commissioning education and training, including the clinical placements for healthcare students and trainees. SHAs are being abolished in 2013 and Health Education England (HEE) will take over their responsibilities from this date, with Local Education and Training Boards (LETBs) leading local commissioning decisions and quality management of education and training. HEE will therefore inherit an inequitable system of funding if no changes are implemented. [From this point onwards, the term 'education commissioners' will be used to refer to the organisation responsible for commissioning education and training, be that SHAs, HEE or LETBs].

Rationale for intervention

5. The variation in levels of funding paid for undergraduate medical education has created an inequity between providers, with those receiving higher sums receiving an unfair advantage over those receiving lower sums. This has resulted in cross-subsidisation of service from education and training money. There is little evidence that those receiving larger sums of money are providing placements of a higher quality.
6. This inequity in funding may be a barrier to those wishing to provide placements and it is right that we introduce new funding arrangements that pay the same price to all providers who are able to provide the same placements.
7. A costing sample in 2008 suggested that undergraduate medical placements in secondary care are overfunded by £120m. This suggests that the funding available does not reflect the cost of delivering the placements. The uneven distribution of this funding also means that services in some organisations are receiving significant subsidisation.
8. The lack of funding for non-medical placements means there is very little leverage to improve the quality of placements or to deliver innovative approaches to education and training. Education and training has been identified as one of the ways to deliver improvements to the care delivered by healthcare professionals but it is difficult to achieve this without formalising the funding arrangements.
9. The funding for postgraduate medical training is currently based on training structures that existed prior to the fundamental review that resulted in a new training structure from 2007. The funding reflects assumptions that date back over a decade on the amount of service a trainee provided at each stage of the old training structure. The funding arrangements need to be updated to reflect the current training structures and the service contribution provided by trainee doctors.
10. We already have a benchmark price as a national tariff paid to higher education for the tuition costs of most NHS-funded pre-registration education programmes. This approach has been effective in delivering high quality, value-for-money programmes.
11. Currently the distribution of the Multi-Professional Education and Training (MPET) budget is also inequitable. This means that the distribution of training funded from MPET across the country is based on historical activity rather than need. The establishment of HEE and LETBs means that the method for allocating funds to education commissioners needs to be reviewed to address

these inequities. It is not possible to roll forward the historical budgets into the new structures because of the complexity of mapping historic agreements into new geographies.

Policy objective

12. There are a number of policy objectives, as follows;

- To create a fair playing field between providers so that they can compete to provide placements based on the quality of those placements rather than the price for which they are able to deliver them.
- To create a funding stream for non-medical placements that allows education commissioners to lever quality improvements.
- To support fair and transparent budget setting to fund the LETBs.
- To compensate providers, as much as possible within the current economic environment, for the cost of providing clinical placements and reduce or remove the cross-subsidisation between service and education and training.

Description of options considered (including do nothing)

13. Two options have been considered. They are;

- Option 1 - Do nothing
- Option 2 - Introduce national tariffs for education and training clinical placements

14. Both of these options are explained in detail below.

<u>Option 1 - Do nothing</u>

15. Under this option, education commissioners would continue to fund clinical placements in the same way they are currently funded. Set out below is a description of how this would work, both in terms of budget setting and payments, for each group of clinical placements covered by this IA.

Undergraduate medical placements in secondary care

16. At present, the allocations for 'old' medical schools are based on two elements; facilities funding and a placement fee. The facilities funding for each institution is fixed and the placement rate is approximately £10,000 per student (with an adjustment for London weighting). The allocations for medical schools created since 2000 are based on business cases that were developed when they were established. LETB budgets would continue to be set in the same way as described by mapping the historic funding to the new structures. Where SHAs are splitting into more than one LETB this would involve negotiation to agree what proportion of the budget would go to each LETB.
17. Payments to providers will continue to be based on historic agreements. This could result in the provider-led LETBs having agreements with some providers in their region to make payments of around £10k to some providers and over £90k to others. This will also be true between, as well as within, LETBs. LETBs are committees of HEE so, in effect, HEE will have a range of prices it pays to providers to deliver the same placements.

18. Over time, as LETBs mature, they may be able to negotiate a consistent price between providers within their LETB area but this is likely to take some time and may not be achievable without a national pricing structure within which to work.
19. At present, education commissioners spend approximately £770m on placements for medical students in secondary care.

Postgraduate medical training programmes in secondary care

20. At present, the allocations are based on activity in 2007 and have been rolled forward each year since then, with adjustments only being made for known changes to activity or pay rates. The amount of funding provided for each level of training is as follows;

- Foundation Year 1 – 100% of basic salary plus £2,000 non-pay costs
- Foundation Year 2, Core Training/Speciality Training Years 1 and 2 – 50% of basic salary plus £2,800 non-pay costs
- Specialty Training Year 3 and above – 100% of basic salary plus £2,800 non-pay costs

21. Funding allocations are based on the minimum point of the pay spine for foundation programme and year 1 specialty training. Year 2 specialty trainees are funded at spine point 1 of the specialty registrar pay scale and move up a spine point for each subsequent year of training.
22. LETB budgets would be set in the same way as now, with adjustments needing to be made for any historical movements of funds.
23. SHAs are responsible, through their postgraduate deaneries in most cases, for paying providers to deliver the training programmes. Some SHAs follow the funding structure on which their budget is based. However, some SHAs make changes to both the amount of salary paid, and the spine point on which the salary is calculated. They also vary how much of the non-pay costs budget is passed to providers. This results in a lack of transparency.
24. The proportion of salary funded reflects the training system prior to 2007 when junior doctors were required to undertake a one year pre-registration house officer post before undertaking a series of senior house office posts, prior to applying to be a specialist registrar. The funding reflected that a significant proportion of the senior house officer posts involved the delivery of service and only 50% of their salary was funded from MPET. The funding for specialist registrar posts assumed that the trainees were delivering no service.
25. Since 2007, junior doctors have undertaken a 2 year Foundation Programme before commencing specialty training. Training and service delivery for junior doctors are very closely linked and it is reasonable that the funding reflects the service contribution of trainees. The new structure of training has provided the opportunity to review how the funding responsibility is shared between service and education and training.
26. At present, SHAs spend approximately £1,267m on postgraduate training programmes in secondary care.

Non-medical clinical placements

27. At present funding is allocated to SHAs based on a roll forward of activity from 2005-06. The allocation does not provide any specific funding for non-medical clinical placements and it is for SHAs to decide whether to fund any support for the placements. At present, SHAs fund some support such as library services and placement facilitators on an ad hoc basis. The level of support nationally amounts to approximately £22m but is inconsistent across the country.
28. If we make no changes to the funding, providers will have to continue to negotiate with education commissioners to receive funding for their clinical placements. As LETBs mature, they may reach the position whereby they are funding the same support for each provider but this is likely to take

time and, without any additional investment in non-medical clinical placements, will be hard to achieve a meaningful price whereby LETBs can lever quality improvements or incentivise providers to create placements.

Option 2 - Introduce tariffs for education and training

29. Under this option, we will introduce tariffs for education and training at minimal net cost. These tariffs would be phased in to ensure that providers are not destabilised by the introduction of the tariffs.
30. We will initially introduce the tariffs for undergraduate medical placements in secondary care and non-medical placements in April 2013. The tariffs for postgraduate medical placements in secondary care will be implemented in April 2014.
31. The tariffs will be as follows;
    - Undergraduate medical placements in secondary care - £34,623 (adjusted by the market forces factor (MFF))
    - Non-medical placements - £3,175 (adjusted by the MFF)
    - Postgraduate medical placements in secondary care – 50% of trainees' basic salary plus placement fee of £12,400 (adjusted by the MFF)
32. The tariffs have been calculated as follows;

Undergraduate medical tariffs in secondary care

33. The Department commissioned a cost collection in 2008 to inform the development of the tariff. Costs were collected from 21 providers across 3 SHAs – London, Yorkshire and the Humber and the South West. The costs were submitted for the 2007/08 financial year.
34. Those commissioned to undertake the cost collection felt that the providers offered sufficient information in terms of geography, type and size (volumes of education provided) to enable an average national cost to be estimated.
35. The consultants who undertook the cost collection calculated the average cost from those submitted and then undertook adjustments to the average to take account of the difference in providers, as indicated by their MFF. This resulted in an adjusted weekly tariff of £890. In addition, it was felt that inflation should be applied to the tariff up to 2010-11 but frozen after that year. This reflects that approximately 50% of the costs identified in the costing exercise related to staff costs and there has been a pay freeze since 2010-11. Taking into account these adjustments for geography and inflation, we have agreed that a tariff of £34,623 is appropriate and affordable.
36. Analysis of the national cost based on this tariff and 2011-12 activity and funding shows that undergraduate medical education in secondary care is currently funded at £120m more than would be required if the tariff were implemented.

Tariffs for non-medical education and training

37. Of the 21 providers who submitted undergraduate medical costs, 12 also submitted costs for some of their non-medical clinical placements (nursing, physiotherapy, occupational therapy, radiography and pharmacy).
38. The estimates were felt to be high in light of earlier assessments made by academics. This, coupled with the small sample size, suggested that we should do further work to calculate what

an appropriate tariff would be that reflected the cost of providing non-medical placements. We will undertake this work through the reference cost collection outlined later in this document.

39. Despite the costs reported by providers, very little MPET funding is being invested in non-medical clinical placements.

40. We have therefore decided to create a non-medical placement rate from the available budget. The tariff will be funded by the money currently invested in non-medical placements (£22m) and the savings generated by introducing a tariff for undergraduate medical placements (£120m). The introduction of a tariff is a positive step in introducing the principles of tariffs to ensure that providers are not disadvantaged in taking a student and that all are able to compete for students and the associated benefits. An explicit payment will help lever quality improvements.

Tariffs for postgraduate medicine in secondary care

41. Of the 21 providers who submitted undergraduate medical costs, 18 also submitted costs for their postgraduate medical training programmes. The exercise attempted to establish the cost of providing the placement, both in terms of the non-salary costs (support provided by the teaching staff and the infrastructure used), and the payment of the trainee's salary whilst they were training.

42. The data provided suggested a weighted average for the non-salary costs of £34,000/FTE. However, there was considerable variation in the data provided regarding the amount of time a trainee spends training and delivering service, therefore making it difficult to draw any conclusions about how much funding should be provided for the trainee's salary.

43. The average service commitment reported by the providers is set out in the table below, along with the anticipated service commitment reported by postgraduate deans.

Grade	Current service contribution implied by current funding arrangements	Average service contribution reported by providers	Average service contribution reported by postgraduate deans
F1	0%	83%	20%
F2	50%	73%	20%
ST1	50%	60%	50%
ST2	50%	68%	50%
ST3	0%	75%	50%
ST4	0%	61%	75%
ST5	0%	44%	75%
ST6	0%	72%	75%
ST7	0%	79%	75%

44. Given the variation in the reported service contribution and the significant difference between that reported by both providers and postgraduate deans and the level assumed by the current funding model (see paragraph 20), we felt the costing exercise did not provide a robust basis to set a tariff.

45. Following the cost collection, we therefore established a working group to consider the most appropriate way of funding postgraduate medical training in secondary care, within the current funding envelope. The options were evaluated by the SHAs and postgraduate deaneries to consider the impact on providers. The options consider were;

- Option 1 – fund 100% of the basic salary for all posts
- Option 2 – fund 50% of the basic salary for all post plus a placement rate
- Option 3 – fund 50% of the basic salary

- Option 4 – do nothing.

46. An overview of the options considered and the outcome of the evaluation is at Annex A.

47. The favoured options were option 2 and option 4. However, given the reasons set out in this document to move away from the historical funding arrangements, option 4 was not felt to be viable. As a result of this, option 2 has been selected.

Future setting of tariffs

48. We aim to start collecting costs for education and training as part of the annual reference cost collection from 2013-14. This would allow us to base the tariffs on those reference costs and also reduce the amount of cross-subsidisation between service and education and training by netting off education and training costs, rather than income as is currently the case, from the service reference costs. If we collected education and training reference costs in 2013-14, we would be able to use these costs to set the 2016-17 tariffs, if the data was sufficiently robust. The collection of reference costs would be an annual process that would allow us to review the appropriate level for the tariff each year. We will also review the appropriateness of tariffs for education and training if any changes are made to the way service is funded.

Impacts, costs and benefits of option 2

49. At present, SHAs have a range of methods for paying providers to deliver placements. The annual sum they will pay is set out in the Learning and Development Agreement (LDA) that each provider has with the SHA. In some cases, payments are varied each year to reflect changes in activity. In others, payments reflect the level of infrastructure in place and do not vary with the number of placements provided. The number of placements provided for pre-registration courses is a tri-partite agreement between the SHA, providers and Higher Education Institutions (HEIs). SHAs have different systems in place to monitor the number of placements at each provider.

50. In the future LETBs will be responsible for agreeing the number of placements with providers and HEIs and calculating the tariff income payable. As now, this will be set out in the LDA.

51. The placements for postgraduate medical trainees are agreed between SHAs (through the postgraduate deaneries) and the providers. As with pre-registration tariffs, LETBs will be responsible for agreeing the number and grade of placements and calculating the tariff payable. Again, this will be reflected in the LDA.

52. Based on 2011-12 education and training activity levels, the introduction of tariffs is expected to result in some providers gaining income and some losing income. The impact of the introduction of the tariffs for undergraduate medical placements in secondary care and non-medical placements are summarised in the following table by the change in income in monetary terms and as a proportion of total provider income.

Impact of the introduction of education tariffs for undergraduate medical placements in secondary care and non- medical placements			
Change in income (£m)	Number of providers	Change in income (% of total provider income)	Number of providers
Loss of more than £2m	24	Loss of more than 2%	2
Loss between £1m and £2m	6	Loss between 1% and 2%	16
Loss between £0 and £1m	20	Loss between 0% to 1%	32
No change	58	No change	58
Gain between £0 and £1m	188	Gain between 0% and 1%	253
Gain of more than £1m	75	Gain of more than 1%	10
Total	**371**	**Total**	**371**

53. The tariffs for postgraduate medical training will also result in changes to income and they are set out in the following table.

Impact of the introduction of education tariffs for postgraduate medical placements in secondary care			
Change in income (£m)	Number of providers	Change in income (% of total provider income)	Number of providers
Loss of more than £2m	4	Loss of more than 2%	0
Loss between £1m and £2m	9	Loss between 1% and 2%	0
Loss between £0 and £1m	117	Loss between 0% to 1%	130
No change	85	No change	85
Gain between £0 and £1m	153	Gain between 0% and 1%	156
Gain of more than £1m	3	Gain of more than 1%	0
Total	**371**	**Total**	**371**

54. The combined impact of the introduction of tariffs for non-medical placements and undergraduate and postgraduate medical placements in secondary care are set out in the following table.

Combined impact of the introduction of education tariffs for undergraduate medical and postgraduate medical placements in secondary care and non-medical placements			
Change in income (£m)	Number of providers	Change in income (% of total provider income)	Number of providers
Loss of more than £2m	24	Loss of more than 2%	2
Loss between £1m and £2m	10	Loss between 1% and 2%	16
Loss between £0 and £1m	57	Loss between 0% and 1%	73
No change	12	No change	12
Gain between £0 and £1m	180	Gain between 0% and 1%	247
Gain of more than £1m	88	Gain of more than 1%	21
Total	**371**	**Total**	**371**

55. All of the data to support the above analysis has been provided by, and validated by, the SHA finance teams.

56. The introduction of the tariffs was intended to be cost neutral. However, SHAs amended the 2011-12 activity and funding, on which the model is based, after the impact of the tariffs had been evaluated by providers. For this reason, we decided not to make a further change to the tariff and there is therefore a small financial pressure associated with implementing the tariffs.

57. The following table summarises the net costs in each year of implementation.

	£000s												
Year	1 2013-14	2 2014-15	3 2015-16	4 2016-17	5 2017-18	6 2018-19	7 2019-20	8 2020-21	9 2021-22	10 2022-23	11 2023-24	12 2024-25	**Total**
Constant prices	16,139	8,597	8,597	8,597	8,597	8,597	8,597	8,597	8,597	8,597	8,597	8,597	**110,704**
Discount factor (based on 3.5%)	1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	0.71	0.68	
Net present value	16,139	8,306	8,025	7,754	7,492	7,238	6,994	6,757	6,529	6,308	6,094	5,888	**93,524**

58. The costs in year 1 are due to the additional cost of introducing tariffs for non-medical education and undergraduate medical placements in secondary care, created by the changes to activity and the funding being made available for tariff in 2011-12. The costs reduce from year 2 because the the tariffs for postgraduate medicine in secondary care that are introduced from this year cost slightly less than the current funding envelope.

59. There are a number of non-monetised benefits associated with implementing the tariffs. The tariffs will result in a fairer reimbursement for placements which will, in turn, support a fair playing field because providers will be able to offer placements knowing that there is little financial incentive or disincentive in doing so. This will allow education commissioners to agree placements based on quality rather than price.

Primary care

60. The tariffs described above do not include tariffs for medical placements in primary care. We are continuing to develop these tariffs.
61. The development for tariffs in primary care is following the same process set out above – a cost collection to identify the costs of providing the placements, followed by evaluation to assess the impact and the agreement of transitional principles, if necessary.
62. The intention is that the costs of the introduction of tariffs for medical placements in primary care will be contained within the current budget for medical education and training in the primary care setting and will not involve any transfer of funds from other settings. The aim of the tariffs is to provide funding which accurately reflects the differential costs of delivering the 3 different types of placements – undergraduate placements, foundation placements and specialty registrar posts. This will ensure that practices feel able to offer sufficient numbers of each type of placement, without one being favoured over another.
63. At present, the price paid for undergraduate medical placements in primary care varies across the country, creating inequities. The introduction of a national tariff will address this and create a fair playing field. In addition the current funding arrangements for postgraduate medical training in primary care provide funding for 100% of the trainee's salary, taking no account of whether the trainee provides any service (benefit) whilst they are training. Introducing tariffs, based on the costing exercise, will allow us to address this and remove any advantage there may be to a practice who takes trainees.

Risks and assumptions

64. Some risks were identified during the project to develop education and training tariffs. These are;
    - Lack of support for tariffs
    - Risk of destabilisation to providers
    - Cross-subsidisation between different funding streams
65. During the project, we have ensured we have stakeholder input into proposals and shared information widely with interested parties to secure support. We have specifically had a number of stakeholder groups that we have used to provide expert advice on the development of tariffs and to share information through their networks. Support for the tariffs has improved as a result of this stakeholder engagement and providers are generally accepting of the principles of tariffs but want to ensure that there is no unnecessary destabilisation as a result of their introduction.
66. Given the changes in funding associated with the introduction of tariffs, there is the risk that some providers could be destabilised if funding is removed from them too quickly.
67. To avoid destabilisation, we have agreed that no provider should lose funding greater than 0.25% of their total provider income, or £2m if that is a lower sum, in any year. Given that the tariffs are cost neutral, this means that providers gaining income have to do so in a phased way. This results in a 12 year transition for the biggest loser, meaning all gaining providers have to wait until the 12th year to be paid at full tariff. However, given the small number of providers who are losing more than 1.5% of their income, the majority of gains can be paid by year 6.
68. The analysis in this document relates to the steady state position, rather than the transition. The following table shows the proportion of the gains that will be paid in each year during transition if the losses are capped as described.

		Losses cap (% trust income)	% non-med gains available	% u/g medical gains available	% p/g medical gains available
Year 1	2013-14	0.25%	64.7%	0.0%	No change
Year 2	2014-15	0.25%	100.0%	1.6%	46.7%
Year 3	2015-16	0.25%	100.0%	29.6%	65.3%
Year 4	2016-17	0.25%	100.0%	55.3%	71.8%
Year 5	2017-18	0.25%	100.0%	75.3%	75.8%
Year 6	2018-19	0.25%	100.0%	88.9%	83.4%
Year 7	2019-20	0.25%	100.0%	96.2%	95.1%
Year 8	2020-21	0.25%	100.0%	98.7%	99.5%
Year 9	2021-22	0.25%	100.0%	99.3%	100.0%
Year 10	2022-23	0.25%	100.0%	99.5%	100.0%
Year 11	2023-24	0.25%	100.0%	99.7%	100.0%
Year 12	2024-25	0.25%	100.0%	99.9%	100.0%
Year 13	2025-26	0.25%	100.0%	100.0%	100.0%

69. The costing sample suggested that there was cross-subsidisation between service and education and training – in the case of undergraduate medical education the subsidisation was from education and training to service, and for non-medical placements it was in the opposite direction. We intend to identify and reduce this through collecting education and training costs as part of the annual reference cost collection, therefore enabling both sets of tariffs to be based on the costs, net of any cross-subsidisation. We aim to be able to set tariffs in this way by 2016-17 and the transition principles we have put in place mean that there will not be a significant change in income for providers in either direction before the revised tariffs are introduced.
70. The data to inform the modelling and this impact assessment has been provided by the SHAs who have validated it with their providers. The risk that the data is incorrect is therefore minimal.
71. The modelling has used the reported provider income from 2010-11 to calculate any capping of losses. This is the latest year that accounts were available to inform the modelling. We have therefore assumed that there have been no significant changes in provider income that would have resulted in a smaller or larger cap on losses.
72. The modelling assumes steady levels of students and trainees. The number of clinical placements that will attract the tariffs are controlled by the education commissioners, with national oversight from HEE. If education commissioners, with the agreement of HEE, choose to increase the number of clinical placements, they will need to take account of the financial impact and utilise other elements of their education and training funding to pay the tariff. If there is a strategic shift in the number of students and trainees required, DH will be responsible for ensuring HEE has sufficient resource to fund the change.

Wider impact

73. During the development of the tariffs, the impact on equalities has been evaluated. The equality impact analysis at Annex B outlines the methodology for this evaluation.
74. In summary, no impact on equalities has been identified if the tariffs are implemented.

Summary

75. The current funding arrangements are based on historical agreements and have created inequities in the funding provided to providers for the same type of placements. There is no justification for the different funding levels, particularly those providing placements to students from ‘old’ and ‘new’ medical schools. The lack of transparency about funding makes it difficult to hold placement providers to account for delivering high quality placements.

76. To create a fair playing field between providers, this needs to be addressed.

77. Furthermore, given the level of cross-subsidisation, we need to move towards a funding system that is based more closely on the actual costs of delivering placements to remove the distortion within service funding. It is unsustainable to continue with the historic arrangements when other funding is tariff based.

78. The current position whereby very little funding is provided for non-medical placements makes it hard to increase the quality of placements.

79. Introducing tariffs will address these inequities and enable education commissioners to agree a number of placements with providers based on quality rather than price.

80. The first stage of tariffs, for non-medical clinical placements and undergraduate medical placements in secondary care, will be implemented from 1 April 2013. The second stage, for postgraduate medical training in secondary care, will be implemented from 1 April 2014. An implementation date for the medical placements in primary care will be agreed once a cost collection has taken place and the impact of the tariffs assessed.

81. To avoid destabilisation, the implementation of the tariffs will be phased so that losses are capped. To remain cost neutral, the gains will also therefore be phased.

82. We will continue to review the basis of the tariffs and aim to collect education and training reference costs from 2013-14 to inform the prices.

Option	RAG status of questions (no of responses from SHA)			Overall RAG status	Summary
	Green	Amber	Red		
1 – 100% salary support	1	5	3	AMBER / RED	In general, the SHAs felt that this option would deliver a range of benefits with providers more likely to take placements and additional funding allowing more investment in training and potential for increased quality. However due to the significant rebasing required, the SHAs felt that this option was not realistic and that any benefits may not be real but would be at the detriment of service.
2 – 50% salary support plus a placement rate	5	5.5	0.5	AMBER / GREEN	In general, the SHAs felt that this option would support the movement of trainees. However there may be risks that providers would be reluctant to take the most senior trainees and those in particular specialties where the level of service contribution is lower.
3 – 50% salary support only	0	1.5	7.5	RED	In general, the SHAs felt that this option was not realistic. The reduction in funding was seen as too large and would result in a number of significant risks around activity levels and quality. However, it is possible that the potential for service funding increases through rebasing from training funding had not been taken into account when assessing this option.
4 – existing arrangements with quality focus	7	4	0	AMBER / GREEN	In general, the SHA supported this option, as it is close to status quo funding for MADEL, with a topslice to fund quality. There would be minimal, or no risk, to activity, movement of placements of stability of providers under option 4. Therefore there would only need to be a short transition period, should this be implemented.

Implementation of education and training tariffs – summary of equality analysis

Purpose

1. The purpose of this document is to set out the evidence that has been received and the analysis undertaken to consider the equalities impact of introducing tariffs for education and training.

Background

2. Current funding for clinical education and training is based on local agreements between strategic health authorities (SHAs) and providers. These arrangements can result in inequities in the funding of similar placements across the country.

3. Moving to a tariff-based system enables a national approach to the funding of all clinical placements to support a fair playing field between providers.

4. The introduction of tariffs will result in some providers receiving additional income for their placements, whilst other providers will lose income. The current modelling suggests 263 organisations will receive additional income when the first set of tariffs are introduced in April 2013 and 50 will have their income reduced. Of the 50 organisations who will lose income, 20 of them will lose less than £1m, 6 of them will lose between £1m and £2m and a further 24 providers will lose more than £2m.

5. When the second set of tariffs are introduced in April 2014, 156 organisations will receive additional income for the placements covered by these tariffs. 117 organisations will lose less than £1m and a further 13 will lose more than £1m.

6. These changes are unlikely to have a direct impact on staff because the funding is paid to providers for education and training, not to trainees or students. However, if a provider receives additional funding, the quality of the education and training provided may improve, this would have a positive impact on the future workforce and could also have a positive impact on existing staff, who will be better resourced to provide the education and training to the students and trainees. This may have a positive impact on patients if trainees and students are receiving better training.

7. Conversely, there is a risk that the quality of education and training provided may decline at those providers who lose income. We are taking steps to mitigate these risks through Health Education England ensuring that all placements meet required education quality standards, and by basing the tariffs on costing exercises, where possible, so that the tariff reflects the average cost of delivering education and training.

8. An analysis of the equalities impact of the entire reforms to education and training, of which tariffs are one element, has been published (http://transparency.dh.gov.uk/2012/05/18/ia-no-8008/). This includes an analysis of the approach to the quality of education and training.

Evidence, engagement and involvement

9. In order to assess the impact of the introduction of tariffs, we are required to assess the impact of the proposals against the following protected groups;

    - Disability
    - Sex
    - Race
    - Age

- Gender reassignment (including sexual orientation)
- Sexual orientation
- Religion or belief
- Pregnancy and maternity
- Carers
- Other identified groups

10. We are required to assess the impact through the gathering of evidence and engaging stakeholders in the policy development. The specific activity we have undertaken to assess the impact of the introduction of the tariffs is set out below. Additionally, work has been undertaken to assess the equality impact of the wider reforms to eduction and training. In the main, the engagement has also included the proposals to reform the way we fund education and training. Please refer to the equality analysis for further detail of this work (http://transparency.dh.gov.uk/2012/05/18/ia-no-8008/).

SHA evaluation

11. In December 2010, DH asked Strategic Health Authorities (SHAs) to evaluate the proposed tariffs for non-medical education and training and undergraduate medical placements. The SHAs were asked to evaluate the proposals against the following topics;

    - The rates
    - Education activity
    - Behavioural changes
    - The period of transition
    - Performance and quality outcomes
    - Value for Money, especially at gaining trusts
    - Accountability (evidence of spending)

12. Although there was no direct question with regard to equalities, there were a number of questions that we would have expected SHAs to raise equalities issues in response to, if they had identified any. Some examples of these are;

    Are the rates appropriate?
    Will they create additional placements in innovative settings?
    Will the rates result in any behavioural changes?
    Will the rates create any risks?

13. All 10 SHAs responded to the evaluation. None of the SHAs submitted evidence that the proposed changes to the way placements are funded would have a positive, or negative, impact on any of the protected groups.

14. In August 2011, DH asked the SHAs to evaluate the proposed tariffs for postgraduate medicine in secondary care. The SHAs were asked to evaluate the proposals against a range of questions.

15. All 10 SHAs responded to the evaluation. Although not directly asked about the impact on equalities, SHAs were asked to identify any other risks or unintended consequences. This gave the SHAs the opportunity to identify any concerns they had that the proposals may have an adverse impact on equalities. None of the SHAs raised any concerns.

Consultation

16. DH communicated its proposals to introduce tariffs in Liberating the NHS: Developing the healthcare workforce in December 2010. The consultation asked the following questions in relation to the tariffs;

    - How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

- If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?
- Are there alternative ways to determine the education and training tariffs other than based on the average national cost?
- Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

17. In addition, the following questions were asked with regard to the proposed reforms to the education and training system;

    - Will these proposals meet these aims and enable the development of a more diverse workforce?
    - Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief, pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address this?

Consultation – tariff questions

18. No respondents submitted evidence that the proposed introduction of tariffs would have a positive or negative impact on the protected equalities groups. The responses to the tariff questions are set out below.

19. Respondents supported the need for a safe transition to education and training tariffs that ensured stability and minimised disruption to education and training. A small number of respondents proposed that tariffs be piloted before being introduced. Others suggested a phased approach to introducing tariffs. It was proposed that this could be achieved by capping the losses and gains of each provider in each transitional year.

    "The RCM would suggest that if tariffs are envisaged there should be a process of piloting the system and evaluating it prior to rolling it out into the service"

    "tariffs should be introduced with a transitional period for capping potential gains and losses to individual institutions" [AUKUH and Foundation Trusts Network]

    The need for clear transition plans for providers and good communications about why tariffs are being introduced and how transition would operate was also highlighted.

    "[…we would] suggest that early consultation takes place and that a degree a transparency and openness is incorporated into that consultation" [RCN]

    "a clear transition plan for implementation is required but over a single spending review period; it is essential to maintain momentum and minimise any opportunity for derailment of the objectives of equity and transparency to be delivered" [National Commissioners Network]

20. Some respondents stated that they do not support the move towards tariffs for education and training, whilst others believe that further work should be undertaken to understand the impact of introducing tariffs before implementation begins.

    "We don't support the transition to tariffs, as we do not believe there is evidence that transition to tariffs will improve on the current system and may have significant negative consequences" [Royal College of General Practitioners]

    "a formal project should be initiated by the Department of Health to enable a controlled transition to the new funding arrangements" [the Health Foundation]

"committing to tariffs at the outset, before an assessment of the impact of their implementation has been made, may be short-sighted. There are major implications….and policy makers need to have a full understanding of the potential impact before proceeding further" [NHS North West]

21. There were mixed views among respondents whether the education and training tariffs should be managed as part of the same framework as service tariffs. A number of respondents felt that, as the costs associated with education and training are different to those of delivering service, a separate framework is necessary.

    "No, the costs for education and training are based on different principles" [Universities UK]

    "[it is] critical to the stated principles of stability, fairness and minimining risk that there is a real time parallel process to pick up such unrecovered costs into the setting of tariffs for clinical services for the concurrent financial year at the point where implementation of the revised clinical education tariffs begin" [University Hospitals Birmingham NHS Trust]

    "Placing costs and tariffs within the same framework runs the significant risk that service demands will unduly influence training plans in the short-term" [BMA]

22. Other respondents felt that it would be too difficult to separate the costs of education and training from service costs so tariffs should be set as part of the same framework.

    "Untangling service contribution from the costs of training is fraught with difficulty. We should accept that it is impossible to do it with any degree of precision – some degree of cross-subsidisation will occur and is an inevitable feature of current arrangements" [NHS North West]

    "Yes, although education and training tariffs should be clearly identifiable from service tariff" [NHS West Midlands]

23. Very few respondents commented on whether there was an alternative to an average national cost. Of those who did respond, there was some support to use average national cost as the basis for tariffs, with some caveats.

    "average costs should be the starting point but there should be some discretion for local skills networks" [University Hospitals Birmingham NHS Trust]

24. There were very few suggestions for alternatives to a national average cost as the basis for education and training tariffs. Those who thought there may be alternatives suggested that further work be done to understand the cost differentials between providers to determine whether an average national tariff was appropriate.

    "needs to be more understanding of why costs seem to vary so greatly between education providers before a decision is taken to establish an average national cost-based tariff" [BMA]

    "smaller branches of nursing e.g. learning disability, cost more than larger ones" [RCN]

    "a weighted capitation approach, with local variations, to meet local priorities and e.g. allow for historical levels of investment, would be more appropriate" [RCGP]

    "average costs should be the starting point but there should be some local discretion for local skills networks" [University Hospitals Birmingham NHS Trust]

25. Again, there were a limited number of responses to the question regarding alternative approaches to a bottom-up costing exercise. Of those who did respond, there was some support for a bottom-up approach to setting the education and training tariffs. However, it was suggested by some respondents that there need to be clearer definitions of the various elements that determine the costs.

"For fairness and transparency, we would expect a costing exercise to be necessary – this would need to be carried out nationally and be sensitive to regional variations" [RCGP]

"A bottom-up costing exercise is the most effective way of ensuring consistency and avoiding unintended consequences from the introduction of a tariff for education and training" [NHS East Midlands]

"the network believes that the current bottom-up exercise is sufficient, however a broader consultation on interpretation of associated costs and scope of funding would add greater transparency" [National Commissioners Network]

26. There were very few alternative approaches proposed.

"a national average reference cost approach with top down costings based on expenditure across total activity would provide a useful starting point, suitably segmented by staff group through our FTN benchmarking shows that a bottom up approach is better as an end point once the market has developed the necessary information and sophistication" [Foundation Trusts Network]

27. And, a small number of respondents who feel a costings exercise is not justifiable, with a proposal that the tariffs should continue to be based on those developed through the MPET Review, rather than updated through a costing exercise once implemented.

"This would not be an effective use of resource given the work that has already been undertaken in at least three reviews over the last decade" [AUKUH]

Consultation – equalities questions

28. None of the responses to the questions on equalities suggested that the introduction of tariffs would create a positive or negative impact on the protected groups.

29. There was no clear consensus in response to the question about whether the proposals to reform education and training would enable the development of a more diverse workforce, with a large number of respondents believing that the new framework will not impact on the current diversity of the workforce either positively or negatively. There were requests for the publication of a full equality analysis and for further detail on how the new framework aimed to encourage widening participation. It was suggested that the aim to diversify the workforce should be embedded in the accountability frameworks for the new organisations.

"We strongly support the focus on widening access, participation and diversity to develop a more diverse workforce, and delivering excellence. Our standards for postgraduate training require that training must be fair and based on principles of equality." [GMC]

30. The majority of respondents did not believe the protected groups would be disadvantaged by these proposals, but skills networks would need to work closely with representative groups and align education commissioning plans and curricula to the needs of the various minority groups. It was widely believed that flexibility in training and service provision is needed both for an appropriate work-life balance and to ensure equity of access. Also, that care must be taken not to disadvantage part time workers or neglect Bands 1-4.

"In the NHS there are many part-time workers, mostly female and many with caring responsibilities. The funding system should not disadvantage part-time staff as this could lead to indirect discrimination" [NHSBT]

Agreeing the transition plans

31. In August 2012, DH wrote to the SHAs and shadow Local Education and Training Boards to ask them to agree transition plans with providers. In doing so, they were asked to identify any potential issues with regard to equalities so that this could be analysed once the plans were submitted.

32. No equalities issues were identified.

Summary of analysis and next steps

33. The evidence set out above indicates that we have not identified any positive, or negative, impact on the protected groups when tariffs are introduced. The other points raised by respondents to the consultation and the evaluation of the proposals by the SHAs have informed the development of the proposals on tariffs, and will continue to inform the work to develop reference costs for education and training to provide the basis of the future tariffs.

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