NHS
Health Education England

Guidance for placement of Doctors in Training in the Independent Sector

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Background

1. The NHS has always incorporated education and training with service delivery. The expectation is that multi-professional education for undergraduate and postgraduate health professionals will be designed into all areas where NHS service is delivered.

2. Most NHS hospitals, Trusts and Foundation Trusts employ Doctors in Training (DiT) to help support delivery of care at many levels of service. Training occurs within service delivery as part of a clinical post, supplemented by face-to-face, simulation and lecture-based training as needed, ensuring curricula are fully delivered.

3. With a clear recognition that the NHS needs to increase its workforce to meet patient demand, future service expansion and to reduce vacancy gaps, and given that the NHS model is one of education and training where patients are cared for, it will be essential to embrace independent sector providers as an extension of that education capacity and specifically if NHS patients are being treated by them.

4. This guidance applies only to doctors in training in possession of a national training number (NTN) and for the care of NHS patients only.

5. Those contracts that are non-standard will require local discussion between the independent sector (IS) provider, the Clinical Commissioning Group (local commissioner) and HEE local Postgraduate Dean. The same principles as stated in this document should apply with regards to educational and clinical governance.

Doctors in Training (DiT)

6. Postgraduate medical trainees on HEE sponsored, time-restricted programmes with specific curriculum requirements must be supported to maximise learning opportunities to meet those requirements and demonstrate and record that those requirements have been met. Equally trainees working under supervision in clinical placements contribute to service delivery as part of the practical experience they need to acquire to support their learning and training. This has become particularly visible during the COVID19 pandemic.

7. DiT are not only the NHS consultants of the future, but also those that the independent sector (IS) will employ or engage and thus as essential to the future IS business model.

8. Many IS specialists and consultants also work in the NHS. Any additional work in the IS requires discussion as set out in the Consultant Contract. With too limited a pool of future Consultants, this may reduce future availability for the independent sector.

9. It is therefore in everyone's interest to ensure that training occurs in all settings where NHS patients are seen including independent sector settings as well as the NHS.

Financial contributions to salary for DiT

10. Postgraduate DiT are supported through the Postgraduate Deaneries in each Region across England. Postgraduate Deans (PGDs) in England are employed by HEE and are responsible for ensuring training meets General Medical Council (GMC) standards.

11. The salary of 80% of all DiT is supported by an average 48% contribution by HEE to the employing NHS trusts. Detail of this funding is set out in the 'Education Funding' section below and in the NHS Education Funding Guide. In addition, some trusts have supported an increase in the number of DiT through trust-only funded posts, which account for the other 20% of DiT positions.

12. Where a DiT is placed in the IS, their salary will remain fully funded in this way without the requirement for the IS provider to contribute to the salary. Some 80% of posts for doctors in training in England are supported financially by HEE.

13. Therefore salary costs for DiTs will not be a burden to the IS.

Contracting

14. The NHS Standard Contract is used for the commissioning by CCGs and NHS England of all NHS-funded clinical services (except primary care), whether from NHS or independent providers. General Condition 5.7 of the 2020/21 NHS Standard Contract states:

    "The Provider must cooperate with the LETB and Health Education England in the manner and to the extent they request in planning the provision of, and in providing, education and training for healthcare workers, and must provide them with whatever information they request for such purposes. The Provider must have regard to the HEE Quality Framework".

15. Time for training, reflection, assessment, logbook review etc. should be taken into account by contractors and commissioners when setting up contracts locally. However it is anticipated that formal clinical and educational supervisor roles will continue to be delivered at the host NHS Trust as part of normal clinical and educational supervision arrangements.

16. Although the Consultant supervising may not be the DiTs named Educational Supervisor/Clinical Supervisor they should be trained to this standard and be on the local PGD's trainer database for GMC purposes.

Education Funding

17. The responsibility for funding DiT is shared between Health Education England (HEE) and NHS England (NHSE). Funding flows via the respective tariff payment mechanisms and HEE makes two payments as part of the Education and Training (E&T) tariff mechanism to NHS providers:
    1. A contribution to the basic salary costs of all DiT. The amounts payable from HEE for postgraduate salaries have been uplifted for 2020-21 and vary to reflect national, fringe and London pay scales. These are set out at Annex A of the DHSC Healthcare E&T 2020-21 Tariff Guidance.
    2. A placement fee of £11,703 multiplied by the appropriate Market Forces Factor (MFF) index for the individual provider, which contributes to the direct costs of

the provider from delivering education and training activity. The placement fee supports training infrastructure at NHS trusts such as libraries, educational and clinical supervisors and administrative costs.

18. NHS Commissioners provide salary funding for service delivery in accordance with the National Tariffs (national prices and local prices). Unlike the funding from HEE, this funding is included as part of all the national tariff prices, which means that all activity which attracts a tariff payment includes a contribution to salary and this flows to all providers. This means that all activity which attracts an NHSE tariff payment includes a contribution to DiT salary costs.

19. The responsibility for paying the salaries for DiT will remain with the NHS employer.

20. There are challenges associated with extracting the DiT salary funding from the national tariffs (NHSE).

21. The current approach to funding means that any training activity that takes place in the IS does not typically attract the E&T tariff, but equally does not require the IS to pick up the salary costs associated with the DiT, despite the funding being included in the national NHSE tariff payments that flow to the IS.

22. Discussions should take place locally to determine whether there is a legitimate rationale for the E&T tariff payment to be shared across the DiT employer and IS provider. As in 13, the salary costs will not be required to be met by the IS.

23. Where this is not seen as sufficient to cover the costs of the training being provided within the IS, discussions should take place locally to agree the appropriate amount of additional funding required to cover costs.

24. The IS will need to itemise the additional costs for training which could be administrative support or senior medical educator support.

25. The HEE Regional Director and Regional PGD will need to decide how this may best be financially supported. This might require funding to be taken from the E&T Tariff funding provided to NHS providers.

26. The overall amount paid per trainee should not exceed the current published E&T tariff price (including MFF). The distribution of the available funding should be agreed locally to reflect the delivery of the activity and the associated costs to the placement providers. The appropriate amount to transfer needs to be agreed locally to reflect:
    - what training activity and costs are being asked of the placement provider
    - that IS providers currently receive additional income for service delivery (in relation to salaries for doctors in training) through national and local prices for delivery of services.

Local Agreements

27. It is incumbent on the service commissioner, as part of the Integrated Care System and wider NHS, to ensure that service commissioning enhances and does not disrupt the NHS responsibility to educate the future workforce.

28. Where NHS funded services are being provided in the IS, commissioners of that service should seek to ensure that, wherever necessary, the opportunity to extend the education and learning environment to include this service is explored and realised with the support and advice of the HEE PGD.

Accountability and clinical/educational governance

29. The trainee/doctor in training must be employed by an NHS Trust.

30. This employing trust must approve the movement of DiT from NHS sites to work with their Consultants when they are undertaking NHS-funded work in IS facilities.

31. The employing trust must confirm NHS indemnity is in place for the DiT to work in the independent sector site for the NHS work undertaken (please see Indemnity section below).

32. DiT are always strongly advised to have additional personal indemnity. If this is in place already, then the DiT should advise the indemnity provider of the additional site of working.

Educational Governance

33. The PGD is responsible to the GMC for the quality of training and confirmation that training has occurred locally to the required standard.

34. Clinical and educational supervisors are responsible to trust Directors of Medical Education (DMEs).

35. PGDs quality manage NHS Trusts for the delivery of postgraduate medical training, and so the DME is required to provide assurance to the PGD.

36. Independent provider sites must be recognised as educational providers by the GMC. This will be applied for by the PGD once the local need has been identified.

37. The PGD is the Responsible Officer for DiT and must be made aware of any issues that may give rise to any Fitness To Practice concerns.

38. The DME of the host trust will be responsible for educational governance and reporting to GMC standards. The DME will be responsible for updating the PGD as necessary and providing assurance that training that is occurring in the independent sector meets GMC and HEE standards and requirements

39. Training Programme Directors (TPDs) and Heads of School are also accountable to their local PGD.

Individual DiT

40. The training provided must be open to trainees in a recognised specialty training programme, regardless of level (including core trainees) with appropriate levels of supervision, tailored to meet the needs of the individual trainee.

41. The grade and stage of training should not be a barrier to training in the IS.

42. The PGD must approve any move. For example, in surgery, the TPD and Head of School of Surgery must agree local arrangements for the delivery of training in the IS, ensuring that the PGD is kept informed. The other required steps must be in place before DiT can work clinically at an independent site.

43. DiT must always be supervised by a recognised clinical or educational supervisor in the NHS. This information should be known prospectively and timetabled as part of the list/session.

44. The CQC has confirmed that IS providers must ensure that postgraduate medical trainees comply with staffing regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Namely:
    - Regulation 18 (staffing);
    - Regulation 19 (fit and proper persons employed); and
    - Schedule 3 (information required in respect of persons employed or appointed for the purposes of a regulated activity).

45. The Care Quality Commission has confirmed that there are various mechanisms that an independent provider may be able to evidence that the requirements of the Regulations have been complied with. The most recent ARCP form and form R (Part A, Part B) may be used to provide evidence of some of these requirements.

46. The receipt of the most recent ARCP form as well as form R which can only be issued if the prerequisite employment and other checks have occurred. This should negate the need for any other additional pre-employment checks although to fulfil requirements of the CQC Schedule 3 the Independent Healthcare provider will need to obtain this evidence from the NHS employer of the DiT with their consent to do so. The form also defines the training programme, grade as well as full scope of practice.

47. The DiT must give permission for release of the forms or provide the forms personally. If this is not possible then the DiT cannot work/train at the independent sector site.

48. The Postgraduate Dean will approve, prospectively, those DiT who are able to work at the independent site and provide additional assurance that there are no Fitness To Practice concerns.

49. The Consultant supervisor remains the clinician with overall responsibility for the care of the patient being treated.

50. The PGD remains responsible for quality of education and training and can stop the arrangements/withdraw the DiT if concerns arise.

Delivery

51. DiT should be included in the planning for service delivery in all settings.

52. DiT must be given the opportunity to gain a wide range of competencies. This will mean in specialties like surgery, taking part in theatre sessions. DiT should be involved in the consent process, but responsibility for consent will remain with the consultant.

53. Although Out-of-Hours cover should normally be provided by the independent provider's RMO/consultant, the Consultant remains the clinician with overall responsibility for the care of the patient being treated. Trainees are almost always needed to cover unscheduled care in NHS providers so should not normally be considered in this role. Determination of peri and post operative care and Out-of-Hours cover is a clinical matter between the commissioner and the provider. As such it does not form part of this educational agreement. The DiT is not personally or professionally responsible for ensuring the provision of that care.

54. Consideration should be given to deploying members of the wider multi-professional team and consultants to cover gaps in rotas etc within the host NHS site to allow DiT to work in the IS if attendance would support educational progression.

55. These are high level principles and the logistics of allowing trainees to participate in activity across multiple sites will necessarily vary depending on local circumstances. PGDs should be involved in local discussions as needed.

Out-of-Hours cover and post treatment complications

56. The employing trust and independent provider must have an agreement in place clearly setting out the arrangements of who is responsible for providing specialist post treatment care of complications.

57. The arrangement for post treatment care must include arrangements for anaesthetic and surgical care in the event of unplanned return to theatre or an unexpected medical event.

58. The arrangement must include clear lines of responsibility and how medical, surgical and anaesthetic cover will be made available within a 30 minute time frame.

Indemnity

59. NHS staff in the training grades who work in independent hospitals as part of their NHS training, are covered by NHS Indemnity (the Clinical Negligence Scheme for Trusts membership of the employing Trust), provided that such work is covered by an NHS contract of employment (as per Annex A of the NHS Indemnity Arrangements for Clinical Negligence Claims in the NHS) and the trainee is under the supervision of an NHS consultant. Please also see Joint Committee on Surgical Training 'Guidance on Training Implications and Principles to Consider'.

Acknowledgements for the development of this document.

- The Confederation of Postgraduate Schools of Surgery.
- The Royal College of Ophthalmologists.
- Independent Healthcare Providers Network.
- NHS England & NHS Improvement colleagues: Strategic Finance, Contracts and Independent Sector Co-ordination.
- HEE: Education Funding Strategy, Deans of Postgraduate Medical Education.

December 2020

Appendix A: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Schedule 3

Information Required in Respect of Persons Employed or Appointed for the Purposes of a Regulated Activity

1. Proof of identity including a recent photograph.

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(1), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(2).

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to -
   (a) health or social care, or
   (b) children or vulnerable adults.

5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.

6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

9. For the purposes of this Schedule—
   (a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
   (b) "satisfactory" means satisfactory in the opinion of the Commission;
   (c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.