

# Position Statement

## October 2018



Royal College  
of Surgeons

ADVANCING SURGICAL CARE

## Surgical training in the independent sector

### Introduction

Faced with growing demand for services fuelled by an ageing population, the NHS has increasingly looked to the independent sector to relieve capacity. In 2016-17, the independent sector undertook almost a third of all NHS-funded knee replacements and carried out over half a million planned NHS surgical procedures. Although the Royal College of Surgeons (RCS) recognises the need to use the independent sector to enable patients to be treated more quickly in the short term, any transfer of activity carries long term risks to the NHS and we would ultimately like to see an expansion of NHS capacity to meet patient need. Yet the trend of using the independent sector looks set to continue as waiting times in England have slipped consistently since their low in 2012/13 and the number waiting more than 18 weeks in England crossed half a million in April 2018 – the first time since August 2008. Last winter saw the worst waiting times on record and NHS England's unprecedented announcement that hospital trusts should plan to cancel non-urgent surgery during January. Moreover in October 2018, University Hospitals Plymouth NHS Trust announced plans to outsource up to 75% of its non-urgent orthopaedic surgery to the private sector for 18 months to improve waiting times for patients.

The RCS is concerned that this transfer of a substantial volume of NHS work to the independent sector has negatively impacted surgical trainees through the loss of training opportunities and a subsequent decrease in morale. The RCS

has heard from members that private providers often choose patients who are the lowest clinical risk for them to treat. This means patients who are generally fitter, without major comorbidities, or who require relatively low-risk operations (such as hip and knee replacements). As these are ideal training cases, surgical trainees have less opportunity to develop the technical and operative skills required for their Annual Review of Competence Progression (ARCP) as their contracts generally do not permit them to work in the independent sector. We are also aware that obstetrics and gynaecology trainees are experiencing similar issues with the loss of training opportunities as benign gynaecology procedures, such as treatment for fibroids and endometriosis, are increasingly taking place in the independent sector.

In response to this issue, the RCS hosted a roundtable event in May 2018 to debate practical solutions for how the NHS and the Government could encourage the independent sector to provide more education and training in their hospitals. Attendees included a range of stakeholders involved in this issue, such as Health Education England, the General Medical Council and surgical trainee associations, along with private providers undertaking a large amount of NHS work. This paper outlines the recommendations that were discussed at the event.

### Examples of good practice

The NHS Partners Network, which represents independent sector providers, recently undertook an informal scoping

exercise within its member hospitals and found a number of them have made arrangements with local NHS Trusts or medical schools to support education and training.

For example, Ramsay Health Care offers training of surgeons and anaesthetists at Clifton Park Hospital (primarily an orthopaedic hospital), administered by the local NHS Trust. As part of their seconded agreement with the Trust there is an arrangement that certain consultants have a registrar or fellow follow them on a six-monthly rotation. Similarly, Spire Healthcare has been working with the regional NHS training programme for plastic and reconstructive surgery in Cheshire for a number of years. They have a registrar grade doctor allocated at Cheshire Spire Hospital for a couple of months through the year to learn cosmetic techniques with one of their surgeons. In addition, Leicester Spire Hospital has helped with the training of fellows in plastic surgery based at the Leicester Royal Infirmary by providing surgical exposure to cosmetic cases that would not routinely undergo procedures in the NHS.

In addition, the Association of Surgeons in Training (ASiT) surveyed their members to understand the experience of trainees working in the independent sector. They found that some private providers support this through reciprocal arrangements with local NHS hospitals, whereas others have honorary contracts. For example, in Southampton, the local private provider runs a weekly andrology (men's health) clinic which is the only dedicated one in the region. There is an arrangement where trainees attend the private hospital for four days on a four weekly rota, with exposure to urology, ear nose and throat, general surgery and orthopaedics procedures. However in the Severn region, a trainee started a lasting initiative with the local private hospital where trainees were rostered monthly for a six month period on an honorary contract to undertake procedures such as hernia repair, carpal tunnel and vasectomy. Although the sessions were timetabled and ward cover was organised, trainees

were expected to do the work outside of their NHS contracted hours.

ASiT also highlighted the case of plastic surgery trainees as they have to undertake more than 100 aesthetic procedures to achieve Certificate of Completion of Training (CCT) and some of these are not offered by the NHS. Trainees feel an expectation from their consultant to be in the private sector; anywhere from once a week to once a month. Yet all this operative experience is in addition to their full-time NHS contracted hours and they are required to pay for additional indemnity.

Therefore although these local arrangements exist, the RCS believes that a national framework for the independent sector to provide training would help to ensure consistent standards of training, streamlined funding and indemnity arrangements, and compliant hospital rotas. It would also help to ensure that all providers of NHS services across the country have the opportunity to contribute to the education and training of the surgical workforce.

### Barriers to training in the independent sector

At the RCS roundtable on surgical training in the independent sector in May 2018, attendees explored the barriers to the independent sector facilitating more training in the sector. These are outlined below.

#### Standards of training

Although the RCS is keen to enhance training opportunities in the independent sector, we would emphasise that anybody providing medical education and training should be appropriately qualified. The GMC has a statutory responsibility for quality assuring education and training, and recognising medical trainers in undergraduate education and in other postgraduate specialties. As the regulator, they expect hospitals to use a number of criteria to show how they identify, train and appraise trainers. We would expect providers in the independent sector to

meet these criteria to ensure standards of training are consistent wherever trainees are working. There should also be robust systems for learning from mistakes if things go wrong.

In addition to operations, we would expect training in the independent sector to be provided on pre- and post-operative care, e.g. clinics beforehand and following up with patients afterwards. This would also help to ensure continuity of care for patients.

## **Funding**

The independent sector provides healthcare that is paid for in a number of ways, including self-funding by patients, through private and company medical insurance arrangements, or directly commissioned by NHS organisations and clinical commissioning groups. Although private providers may be able to support training for all of these patient groups, the RCS would only support surgical training in the treatment of NHS-funded patients. This would also align with patient expectations as NHS treatment is currently provided with the understanding that trainees may be involved in their care.

As highlighted above, private providers are already supporting surgical training in some areas. Yet this is being done on a 'goodwill' basis and in order to encourage the independent sector to deliver more training, the RCS understands it would be important that the process is properly funded. This could take place under a tariff based system where the funding follows the patient, instead of hospitals receiving a block grant. It would also be helpful for trainees, trusts and private providers if the education and training model could be a year-round arrangement for training, and not just when there are winter pressures, to ensure sustainability.

## **Indemnity**

A key consideration for surgical trainees looking to gain experience in the independent sector is whether they will have indemnity cover for the work or will have to pay additional fees. ASiT has

found wide local variation regarding indemnity arrangements when treating NHS patients in the independent sector. When private providers have reciprocal arrangements with the NHS hospital, trainees tend to be covered by NHS indemnity through the Clinical Negligence Scheme for Trusts (CNST). However where there are honorary contracts with the private provider, indemnity arrangements appear to be decided at a local level. ASiT believe there is currently insufficient information for trainees regarding their need for indemnity for this type of work and are concerned that this may leave trainees vulnerable to litigation. They would not support further financial expense to trainees to cover the cost of additional indemnity in order to achieve the training outcomes outlined by the surgical curriculum.

In order to streamline indemnity arrangements and avoid placing any financial burden on trainees, the RCS recommends that there should be reciprocal arrangements between private providers and NHS hospitals, instead of honorary contracts, when trainees undergo training opportunities in the independent sector. This should ensure that trainees are covered by NHS indemnity and patients have access to compensation if things go wrong.

## **Hospital rotas**

Alongside their training, surgical trainees have a crucial role to play in providing day-to-day NHS care. As such, NHS trusts may be wary of releasing trainees to undertake training in the independent sector in case this role is undermined and hospital rotas are destabilised. Moreover, if there is a substantial transfer of NHS work to the independent sector, hospitals may need to look at increasing staffing levels as more people move between the sectors.

The RCS believes it should be the responsibility of hospitals, working with deaneries, to ensure that hospital rotas are viable in the absence of trainees and other staff, and that day-to-day care is not compromised. Rotas must be designed

and managed effectively to ensure they take into account factors such as continued care, and travelling time to and from the host hospital. Any agreed training opportunities in the independent sector should also be included in trainees' NHS contracted hours. The RCS would be happy to work with the private providers and local NHS trusts that already have local arrangements in place to support training to understand how trainees can gain experience in the independent sector whilst fulfilling their role in NHS rotas.

## Summary

Excellence in education and training are fundamental to creating and supporting the surgical workforce and enabling the highest standards of patient care to be achieved. The RCS is keen to work with the NHS, the Government and private providers to overcome the barriers to the provision of education and training in the independent sector. Not only would this enable trainees to develop and demonstrate the skills required to progress and deliver safe surgical care, it would also help to improve morale which continues to be low among the surgical workforce.

The key recommendations to improve and support surgical training in the independent sector are below:

- NHS hospitals should work with deaneries and private providers to ensure that hospital rotas are viable in the absence of trainees and other staff, and that day-to-day care is not compromised.
- There should be reciprocal arrangements between private providers and NHS hospitals, instead of honorary contracts, when trainees undergo training opportunities in the independent sector. This will help to ensure that training takes place within NHS contracted hours and trainees are covered by NHS indemnity.
- The independent sector should be supported to educate and train the future surgical workforce where it is appropriately qualified to do so. To ensure standards of training are consistent, private providers should adhere to GMC criteria in demonstrating how they identify, train and appraise trainers.
- Surgical training in the independent sector should be properly funded and provided on a year-round basis where NHS-funded patients are being treated.
- Trainees treating NHS patients in the independent sector should be covered by NHS indemnity through the Clinical Negligence Scheme for Trusts (CNST) to ensure patients have access to compensation if things go wrong.