Position statement on the role of the independent sector in education and training

The NHS is one of the largest employers in the world, with a workforce of around 1.3 million.[1] Excellence in education, training and continuous professional development (CPD) are all fundamental to creating and supporting this workforce and enabling the highest standards of patient care to be achieved.

At any one time there are about 160,000 students in undergraduate or postgraduate medical education. The NHS invests almost £5billion each year in central funding for the training and development of its workforce and that of the public health system.[2]

All hospitals delivering NHS care have a responsibility to provide appropriate education and CPD for healthcare professionals.

Summary

The Royal College of Surgeons (RCS) is concerned that, for a number of reasons, the independent sector is still not contributing as fully as it should to educating and training the healthcare workforce.

The sector should play a larger role in providing, delivering and funding education and training opportunities, since many independent providers currently benefit from staff trained at the public expense. Moreover, as an increasing number of surgical procedures (such as hip and knee replacements) move into the independent sector, this will increasingly become the most appropriate place for some specialty training to take place.[3]

The College recognises that there have been a number of positive shifts towards increasing the independent sector's participation. This position statement sets out why the RCS feels their involvement should be augmented further and how this can be encouraged, as well as noting issues that need further consideration, such as the extent to which NHS hospital rotas can be viable while trainees are based in the independent sector .

Background

The role of the independent sector in education and training has come under scrutiny in recent years; the issue was considered as part of the NHS Future Forum's report on *Education and training – the next stage* (2012) and Monitor's *Fair Playing Field* review.

[1] http://www.parliament.uk/documents/joint-committees/Draft%20Care%20and%20Support%20Bill/Oral%20evidence%20volume.pdf, p249
[2] http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/01/Our-Strategic-Intent-web-Feb20131.pdf
[3] Research from the NHS Partners Network shows that the independent sector now accounts for 19% of all hip and knee replacement operations in the NHS: http://www.nhsconfed.org/Networks/NHSPartners/Pages/Data.aspx

The NHS Future Forum acknowledged that there was some support for the idea that *any* organisation in receipt of NHS funding (including those in the independent sector) should be "expected to have a duty to provide training". Ultimately, it recommended that not all organisations, employers and practices *should* train, but that independent and charitable sector organisations across all care environments should be considered among "those that may".

Monitor's review noted concerns that the independent sector was able to employ clinical staff without facing the cost of training them but also recognised that some providers in the sector felt disadvantaged by their lack of access to public funds for, and the benefits associated with, training (for example, in recruiting clinical staff).

There is growing consensus that the independent sector has a valuable role to play in education and training. The NHS Partners Network, which represents independent sector providers, has said that it supports "the very sound principle that anybody who is appropriate to do training should be allowed and used to do it".[4]

We agree with this principle but would wish to emphasise that anybody providing medical education and training should be appropriately qualified. The GMC, for example, has a statutory responsibility for quality assuring education and training and recognising medical trainers in undergraduate education and in other postgraduate specialties. The GMC expects local education providers such as hospitals and general practices 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 standards also.

Government action

The Government has put in place measures to deliver the Secretary of State's education and training duty by amending the commissioning contracts and supporting regulations.[5] This means that all providers of NHS services are expected to co-operate on education and training. Where appropriate, this co-operation will involve them providing education and training.

Measures in the Care Bill also look to strengthen the requirements on all providers to promote and engage with education and training. One of its clauses requires *all* providers to co-operate with local education and training boards (LETBs).

Why and how should the independent sector contribute to training?

Doctors-in-training need to be exposed to a variety of different experiences, and that this can only be ensured if they are rotated through different organisations. At present, trainees are primarily

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[4] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/607.htm
[5] http://www.england.nhs.uk/wp-content/uploads/2013/03/contract-gen-conds.pdf

rotated through NHS organisations; the College believes they need to be exposed to the independent sector as well, particularly given the role of the sector is likely to expand.

The availability of opportunities allowing exposure to surgical procedures which form the core of the surgical training programme may well reduce within the NHS if services are commissioned more frequently from the independent sector, without clarity around the mechanisms by which training within these organisations can be built into surgical training programmes at local level.

'Surgical Training in the Independent Sector' Group

During 2006, the College hosted a 'Surgical Training in the Independent Sector' Group, comprising representatives from the College, Deans, the Department of Health and independent providers. The Group discussed the practicalities of providing surgical training in the independent sector, for which there was considerable support.

The group identified areas within the sector where there was potential to deliver training. They suggested a number of specialist modules in the intermediate and final phases of training: general surgery, trauma and orthopaedics, urology, paediatric surgery, thoracic surgery and plastic surgery.

Surgical procedures undertaken in the independent sector

In some specialties, such as plastic surgery, many procedures that are part of the syllabus for doctors-in-training are predominantly undertaken in the independent sector. Local commissioning and the implementation of the 'any qualified provider' system may move further amounts of surgery into the independent sector. Without involving new providers in education and training this could undermine the ability of local training programmes to deliver sufficient training opportunities. Inadequate exposure to some procedures will undermine a trainee's ability to reach levels of competence required to achieve independent practise as a consultant and to deliver safe surgical care.

Role of independent sector treatment centres

There have been concerns about the impact of local independent sector treatment centres (ISTCs) on surgical training:

- research suggests that fewer primary hip and knee replacements are carried out by specialist registrars once an ISTC is established at their hospital;[6]
- another study found that, after the introduction of a local ISTC, the proportion of *complex* ophthalmological cases requiring consultant supervision increased fourfold in the associated

[6] Clamp JA, Baiju D Sr, Copas DP, Hutchinson JW, Rowles JM. "Do independent sector treatment centres (ISTCs) impact on specialist registrar training in primary hip and knee arthroplasty?" *Ann R Coll Surg Engl* 2008;90:492-6.

NHS hospital, leading to a decline in suitable cases for training. The authors concluded that this was likely to have a serious impact on microsurgical training.[7]

Fortunately, some ISTCs have begun to work with surgical training programmes. For instance, an article in *BMJ Careers* last year detailed training offered by the Southampton NHS Treatment Centre, an ISTC based at the Royal South Hants Hospital.[8] The treatment centre, run by Care UK, allowed surgical trainees based at Wessex Deanery to assist in routine elective general surgical; ear, nose and throat; ophthalmological, and orthopaedic operations.

The NHS Partners Network has also suggested that ISTCs offer a desirable training environment because they provide the high volumes of procedures needed for trainees to achieve full competence quickly.[9]

What more can be done to involve the independent sector?

Funding education and training

The RCS is pleased to note that the current Care Bill puts tariff-based funding for education and training on a statutory footing. Under a tariff system, "the money follows the student" rather than providers receiving a block grant.

Getting the tariff right for education and training should help to ensure that:

- Funding for the provision of all education and training is allocated in a fair and transparent manner. (The *Fair Playing Field* review suggested current funding was not fairly allocated.)[10]
- Funding is linked to quality standards.

Health Education England has previously indicated that it is reviewing its tariff for postgraduate medical training in secondary care and that it hopes to introduce this from 1 April 2014.[11]

Levy

In *Equity and Excellence* (July 2010), the Government said that it wished to see all providers of healthcare services pay to meet the costs of education and training.

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[7] Barsam A, Heatley CJ, Sundaram V, Toma NM. "A retrospective analysis to determine the effect of independent treatment centres on the case mix for microsurgical training". *Eye* 2008;22:687-90.
[8] http://careers.bmj.com/careers/advice/view-article.html?id=20008704
[9] http://www.nhsconfed.org/Publications/Documents/A-positive-partnership_121011.pdf
[10] Monitor, *A fair playing field for the benefit of NHS patients: Monitor's independent review for the Secretary of State for Health* (March 2013)
[11] http://www.dh.gov.uk/health/2013/02/implementation-tariffs/

The idea was to ensure that those training the future workforce were rewarded for doing so and those that undertook less training than they benefited from would contribute to the training provided by others.

The Health Select Committee were supportive of the levy principle and felt it was "clearly right" for the independent sector to contribute.[12] They were unconvinced by arguments from independent sector representatives that this would put them at an unfair disadvantage. The Committee recognised that there were particular concerns about the potential effect on smaller voluntary-sector organisations, but felt workable exemption arrangements should be possible.

In September 2012, the Government responded to the Committee's inquiry, suggesting that the diverse range of views indicated "the need for detailed work". During the Committee Stage of the Care Bill (June 2013), the Government reiterated this stance:

> Given the size of such a change and the range of views received, before we produce firm proposals for consultation we will undertake further work and consult widely on how such a levy could be designed and the possible impact it would have.

Earl Howe said it was something the Government was "considering". He added that, "the extent to which the independent sector will be participants in training or will fund training has yet to be determined". The College is keen to monitor the progress made with implementing the tariff and forthcoming discussions around the possibility of introducing a levy on providers. We would like to see that those providers who support the training and education of the future workforce are appropriately rewarded and incentivised.

The role of commissioners

As the RCS made clear in its statement 'Commissioning a competent surgical service' (May 2011), commissioners also have a responsibility to ensure all organisations delivering NHS care provide appropriate education and CPD for healthcare professionals.

The NHS Standard Contract 2013/14, which is used when commissioning healthcare services, states that providers must cooperate with, and provide support to, LETBs and HEE, by helping them to understand education and training needs and plan the provision of education and training.[13]

During debates on the Government's procurement, patient choice and competition regulations earlier this year, we said that new providers must demonstrate *how* they will support training and education. Monitor's draft guidance to commissioners on the regulations addressed some of our concerns, by stating that commissioners can specify education and training (as well as research) in their tendering criteria for new services.

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[12] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6i.pdf
[13] http://www.england.nhs.uk/wp-content/uploads/2013/03/contract-gen-conds.pdf

Issues for further consideration

Lack of alignment between commissioning systems

The College has raised concerns about the lack of clarity concerning how the different commissioning systems will be aligned. We feel it is unclear how the service commissioning process for clinical commissioning groups (CCGs) and NHS England will be aligned with the commissioning of education and training by LETBs. We have queried what would happen if a LETB had an existing contract with a hospital-based training provider whose service was then de-commissioned by a CCG.

Consideration of hospital rotas

The RCS is aware that, if a greater proportion of training was carried out in the independent sector, then hospital rotas could be destabilised. This is because, alongside their training, trainees have a crucial role to play in providing day-to-day NHS care. If more of their training was based outside of an NHS context, this role could be undermined.

As the *Time for Training* report (2010) recognised, "there has always been a tension between service [provision] and training".[14] This has been exacerbated in recent years by the implementation of the European Working Time Directive (EWTD).

In his report, Professor Sir John Temple acknowledges that the EWTD has already made some rotas "increasingly fragile and inflexible". By cutting the average working week of a junior doctor from 56 to 48 hours,[15] the number of hours available to trainees for both training and experience has been significantly reduced. The EWTD has also left more hospital rotas understaffed.

It is important that these problems are not aggravated further by junior doctors undertaking more of their training in an independent sector setting. The College believes that it is the responsibility of hospitals, working with LETBs, to ensure that hospital rotas are viable in the absence of these trainees, and that day-to-day care is not compromised. Rotas must be designed and managed effectively.

There are various solutions to help ensure that trainees gain experience in the independent sector whilst fulfilling their role in NHS rotas. For example, the system for training at the Southampton NHS treatment centre allows surgical trainees to use the free sessions during their normal working week to attend ISTC operating lists. Reports suggest the trainees are keen to make use of opportunities for more theatre time. [16]

[14] http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf
[15] http://bma.org.uk/news-views-analysis/news/2013/may/juniors-push-for-longer-training-programmes
[16] http://careers.bmj.com/careers/advice/view-article.html?id=20008704

Conclusion and recommendations

Ultimately, the College would like to see the independent sector play a more prominent role in the delivery of education and training, where it is appropriately qualified to do so.

In order for this objective to be achieved, we recommend that:

- The independent sector embraces the opportunity to educate and train the future workforce where providers feel they have the resources and expertise to do so.
- HEE ensures that all private providers co-operate with LETBs, as set out in the current Care Bill. This should include providers supplying data about their workforce.
- HEE progresses with its plans to implement a tariff for postgraduate medical training in secondary care. Providers who support the training and education of the future workforce should be appropriately rewarded and incentivised.
- The Government clarify how the arrangements for service commissioning and the commissioning of education and training can be best aligned.

August 2013