Guidance for placement of resident doctors in non NHS settings

Independent, charitable and voluntary sectors

Background

1. The NHS has always incorporated education and training with service delivery. The expectation is that multi-professional education for undergraduate and post-graduate health professionals will be designed into all areas where NHS service is delivered. Much progress has been made in working collectively with colleagues and providers in recent years. This revised guidance builds on those successes and the 2021 guidance.
2. This guidance refers to postgraduate medical training that will occur in Private, Independent, Charitable and Voluntary settings/providers in England and for NHS patients ***only***.

3. Most NHS Trusts and Foundation Trusts employ resident doctors, who are in training (RD) 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 GMC approved curricula are fully delivered.

4. With the publication of the Long-Term Workforce Plan (LTWP)[1], there is a clear recognition that the NHS needs to increase its workforce to meet patient demand, future service expansion and to reduce vacancy gaps. Given that the NHS model is one of education and training where patients are cared for, it will be essential to embrace non-NHS providers as an extension of that education capacity, and specifically if NHS patients are being treated by them.

5. RDs provide clinical service under supervison. Although substantive Consultants are trained through this process, the clinical service also delivered by doctors as they train is not insignificant. In light of the LTWP ideally discussion with regards to education and training should occur simultaneously with the award of the clinical service contract.

6. This guidance sets out the approach for qualified doctors, in Postgraduate Medical Training in possession of a national training number (NTN), may be core or higher RDs, and for the care of NHS patients only.

[1] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

7. Usually clinical service contracts have already been awarded by commissioners, or sub contracted form NHS providers and to standard specifications. Any contracts that are non standard will require local discussion between the clinical service provider, the commissioner and Postgraduate Dean. The same principles as stated in this document should apply with regards to educational and clinical governance.

Resident Doctors (RDs)

8. RDs (also known as trainees/Postgraduate medical trainees) on NHSE 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. 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.

9. These RDs are not only the NHS consultants of the future, but also those that non NHS providers will employ or engage and thus as essential to the future sustainability of charitable and voluntary providers and to the independent sector business model.

10. Many specialists and Consultants also work in the NHS. Any additional work out with the main NHS employer requires discussion with their substantive NHS Employer as set out in the Consultant Contract.[2]

11. Some NHS services are increasingly delivered in charitable voluntary sectors and current models of postgraduate medical training must adapt to meet patient need.

12. It is therefore in everyone's interest to ensure that training occurs in all settings where NHS patients are seen and treated.

13. NHS services are increasingly being contracted with non NHS providers.

    When more than 11% of the procedure/service that is required to meet curriculum or workforce training requirements is no longer within the NHS, the Head of School/TPD should ensure regular sessions are timetable for the RD at the non NHS provider.

Financial contributions to salary and education funding

14. RDs are supported through the Post Graduate Deaneries across England. Postgraduate Deans (PGDs) in England are employed by NHSE and are responsible for ensuring training meets GMC standards.

15. The salary of approximately 80% of all RDs is supported by NHSE to the employing NHS trusts . In addition, some trusts have supported an increase in the number of RDs through trust-only funded posts, which account for the other 20% of RD positions.

16. Where a RD is placed in a non NHS provider, their salary will remain fully funded in this way (see tariff section below) ***without*** the requirement for the non NHS provider to contribute to the salary.

17. NHSE makes two payments as part of the Education and Training (E&T) tariff mechanism to NHS providers:

[2] https://www.nhsemployers.org/articles/consultant-contract-2003

i. A contribution to the basic salary costs of all RDs within the scope of the tariff arrangements. The amounts payable from NHSE for postgraduate salaries have been uplifted for 2024-25 and vary to reflect national, fringe and London pay scales. The salary rates for 24/25 are set out at Annex A of the 24-25 tariff guidance.[3]

ii. A placement fee of £12,890 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. Separately, NHS commissioners pay providers for delivering healthcare services under NHS Standard Contracts and in accordance with the NHS Payment System (NHSPS). For most elective hospital services, which are the services which non-NHS providers are most involved in delivering and which RD are mostly likely to be placed in, the NHSPS involves nationally-set prices (known as "unit prices"). These unit prices reflect actual costs (pay and non-pay) in delivering services, and the contribution to RD salaries is therefore built into these prices.

19. This means that all activity which attracts a tariff payment includes a contribution to salary and flows to all providers. Therefore activity which attracts an NHSE tariff payment includes a contribution to RD salary costs. There are challenges associated with extracting the value of the RD salary funding from clinical service tariffs.

20. The current approach to funding means that any training activity that takes place in non NHS settings does not typically attract the education placement tariff, but equally there is no financial pressure to pay salary costs associated with the RD, despite the salary funding being included in the NHSE clinical service tariff payments.

21. The NHSPS also includes rules for local pricing. For some services to which unit prices would normally apply, some commissioners are paying lower prices. The NHSPS allows for locally-agreed adjustments to unit prices to be agreed only where the "payment principles" in section 3.1 of the main Payment Scheme document are followed. Commissioners should be careful to avoid setting lower prices in such a way as would impact negatively on both service provision and the ability of providers to provide medical training.

22. Early discussion by commissioners and providers with the Postgraduate Dean when the clinical contract is awarded may help both understanding and to put in place any mitigating actions. This is particularly important for 'in source' providers.

23. Where this is not seen as sufficient to cover the costs of the training being provided, discussions should take place locally to agree a way forward.

24. Any additional costs for training which could be administrative support or senior medical educator support (see later guidance), will require itemisation to consider if further financial support may be required or available. This may require the non NHS provider having an Education Funding Agreement (EFA)[4] in place.

[3] https://www.gov.uk/government/publications/healthcare-education-and-training-tariff-2023-to-2024/education-and-training-tariffs-2023-to-2024

[4] https://www.england.nhs.uk/terms-and-conRDions-2/new-nhs-education-contract/the-nhs-education-funding-agreement-2024-2027/

The establishment of an EFA with a new education provider should be discussed with the Chair of the Training in non NHS Settings committee on behalf of NHSE, in the first instance.

25. The overall amount paid per trainee should not exceed the current published E&T tariff price (including MFF).

Contractual requirements on providers

26. NHS commissioners are mandated to use the NHS Standard Contract when commissioning secondary healthcare services from both NHS and non-NHS providers, so providers will deliver services to the NHS under the Standard Contract and are required to comply with the Contract provisions.
The Contract provisions on training are found in General Condition 5 (GC5) (04-NHS-Standard-Contract-2024-to-2025-General-Conditions-full-length-version-1-February-2024.pdf), which says:
5.5 The Provider must have in place systems for seeking and recording specialist professional advice and must ensure that every member of Staff receives:
5.5.1 proper and sufficient induction, continuing professional and personal development, supervision, training and instruction;

5.5.2 full and detailed appraisal (in terms of performance and on-going education and training) using where applicable the Knowledge and Skills Framework or a similar equivalent framework; and
5.5.3 professional leadership appropriate to the Services,
each in accordance with Good Practice and the standards of their relevant professional body (if any), and having regard to the Core Skills Training Framework and, in relation to clinical supervision for nurses and midwives, to A-EQUIP Professional Advocate Guidance. Training for Staff must include specific training in learning disability and autism, appropriate to their role, in accordance with the requirements of the Oliver McGowan Code of Practice and having regard to the recommendation of DHSC and NHS England of the Oliver McGowan Mandatory Training Package.

5.6 At the request of the Co-ordinating Commissioner, the Provider must provide details of its analysis of Staff training needs and a summary of Staff training provided and appraisals undertaken.

5.7 The Provider must:

5.7.1 co-operate with NHS England, local ICBs and local NHS Trusts and NHS Foundation Trusts in such manner and to such extent that they reasonably request in the implementation of the NHS Long Term Workforce Plan, in the development and delivery of local healthcare workforce plans, in planning the provision of, and in providing education and training for healthcare workers;

5.7.2 provide NHS England with such information as it reasonably requests in that regard; and

5.7.3 have regard to the Health Education and Training Quality Framework and to Guidance for Placement of Doctors in Training.

27. If the provider uses the NHS sub-contract, the Contract provisions on training in GC5 are applicable to the sub-contractor. If the provider does not use the NHS sub-

contract, the provisions will not apply unless the provider adds them to its sub-contract.

28. The NHS Standard Contract is mandated by NHS England for use by commissioners (Inegrated Care Boards or NHS England) for all contracts for NHS-funded healthcare services other than primary care, whether from NHS or independent providers.

29. The reference in 5.7.3 to “Guidance for Placement of Doctors in Training” is reference to this document. Having regard to this guidance means that providers must make sure that they is aware of the content of the guidance and take account these expectations in their decisions and actions. Providers should assume that they would require a good reason to justify departing from requirements outlined in this guidance. These requirements automatically apply to any sub-contractors that a provider may employ.
30. In source provision is where an independent provider uses NHS facilities but use staff who are employed directly by them. The clinical contract is usually a subcontract for the NHS provider whose facilities are used. If access to these lists/procedures are required by RDs locally for curriculum coverage, then the DME of the trust should make the PGD aware of the arrangement. Local discussion with the In source provider to enable training should occur.

31. If local discussion does not resolve the issue, then the Postgraduate Dean and Head of Quality should raise this as a concern on the Quality Issues log as part of usual quality processes.

32. 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.

33. Supervising consultants must be willing to contribute to on-going assessments of RDs when they are being placed in a non-NHS setting.

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

Local Agreements

35. 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.

36. Where NHS funded services are being provided in non-NHS settings, 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 PGD.

Accountability, Clinical and Educational governance

37. The trainee/doctor in training must be employed by an NHS trust.

38. This employing trust should support the movement of RD from NHS sites to work with their consultants when they are undertaking NHS-funded activity elsewhere to meet curriculum or workforce need.
39. The employing trust must confirm to the Postgraduate Dean NHS indemnity is in place for the doctor in training to work in the non-NHS site for the NHS work undertaken.

40. The GMC advises that all doctors should have adequate indemnity in place.[5] RDs are always strongly advised to have adRDional personal indemnity. If this is in place already, then the doctor should advise the indemnity provider of the adRDional site of working.

Educational Governance

41. The Postgraduate Dean (PGD) is responsible to the GMC for the quality of training and confirmation that training has occurred locally to the required standard.

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

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

44. Non-NHS provider sites must be recognised as educational providers by the GMC[6]. This will be applied for by the PGD once the local need has been identified.
45. The PGD remains the Responsible Officer for doctors in training and must be made aware of any issues that may give rise to any fitness to practice concerns.
46. The non-NHS provider will be responsible for educational governance and reporting to GMC standards. Local discussion will be required to ensure that appropriate training and support is in place to enable this.
47. Training Programme Directors (TPDs) and Heads of School are also accountable to their local PGD. They will seek information from non NHS providers as part of their overall approach to Quality Management
48. The NHSE Workforce Training and Education Quality teams, overseen by PGDs, will ensure all quality concerns are reported and monitored as is the case in any setting where any learner is based.

Individual Doctors In Training

49. 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.
50. The grade and stage of training should not be a barrier to training.
51. The PGD must approve training in a non-NHS setting For example, in surgery, the TPD and Head of School of Surgery must agree local arrangements for the delivery of training, ensuring that the PGD is kept informed. The other required steps must be in place before doctors in training can work clinically in a non-NHS setting.
52. RD must always be supervised by a recognised clinical or educational supervisor This information should be known prospectively and timetabled as part of the list/session. Activities carried out by the RD should align with their current level of training and specific educational requirements.

[5] Domain 4 Trust and professionalism - GMC
[6] https://www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/programme-and-site-approvals

Local arrangements for GMC trainer recognition can be obtained from the Postgraduate dean.

53. The CQC has confirmed that all providers must ensure that postgraduate RD comply with staffing regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Appendix A). namely as follows:
    - 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).

54. The CQC 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[7] form and form R[8] [9] may be used to provide evidence of some of these requirements.

55. No ARCP outcomes are considered as a barrier for training in non-NHS settings. The Postgraduate Dean will ensure that the doctor is suitable for training.

56. 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 IS provider will need to obtain this evidence from the NHS employer of the RD with their consent to do so. The form also defines the training programme, grade as well as full scope of practice.

57. The RD must provide a copy of these forms either electronically or via hard copy to non NHS provider administrative teams.

58. If provision of this essential documentation is not possible then the RD cannot work/train at the independent sector site.

59. The PGD will approve, *prospectively*, those RD who are able to work at the site, and provide additional assurance that there are no fitness to practice concerns.

60. The Consultant supervisor remains the clinician with overall responsibility for the care of the patient being treated, not the RD.

61. The clinical service contract will articulate the pathway of care and management of any complications. This is not a barrier for RD to see patients at higher risk of complications

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

Delivery

63. The needs of RD should be considered in the planning for service delivery in all settings.

[7] https://www.jcst.org/key-documents/ Trainee assessment form
[8] https://madeinheene.hee.nhs.uk/Portals/42/Form%20R%20Part%20A%20-%20Nov2018.pdf
[9] https://madeinheene.hee.nhs.uk/Portals/42/Form%20R%20Part%20B%20Nov2018_1.pdf

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

65. If the training programme is not providing full curriculum coverage or the number of procedures/training exposure is not adequate then the TPD must alert the Head of School. Local discussion should occur with regards to independent sector use.

66. Providers and requirements will vary from deanery and specialty. TPDs/Heads of School/Postgraduate Deans should contact the relevant national Chief Medical Officer of the independent/charitable voluntary provider to provide correct local links to facilitate training.

67. If there are issues the Postgraduate Dean should contact the Chair of the Training in non NHS settings Committee.

68. Although out of hours cover should normally be provided by the independent RMO/consultant, as per section 1, the Consultant remains the clinician with overall responsibility for the care of the patient being treated. RDs are almost always needed to cover unscheduled care in NHS providers so should not normally be considered in this role in a non-NHS provider. 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 any training educational agreement or any subsequent Education Funding Agreement. The RD is not personally or professionally responsible for ensuring the provision of that care.

69. Consideration should be given to deploying members of the wider multiprofessional team and consultants to cover service within the host NHS site, to allow RD to work and train in non-NHS settings if attendance would support educational progression.

70. 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.

71. It is essential to maintain open and clear communication with host NHS sites, with the aim of enhancing the educational experiences available. This approach would allow for the RDs to be released from their NHS commitments in a managed fashion, ensuring that both their learning needs and the operational needs of the host NHS sites are met as far as possible.

Out of hours cover and post treatment complications

72. The employing trust and independent provider must have an agreement in place clearly setting out the arrangements of who is responsible for providing any specialist post treatment care of complications. The agreed arrangements (across provider, ICB and Trust) for dealing with post-operative complications in patients treated by the IS provider must ensure that any role for RD is clinically appropriate and properly supported.

73. The arrangement must include clear lines of responsibility and how medical, surgical and anaesthetic cover will be made available within a 30 mins time frame.
74. It is essential to maintain open and clear communication with host NHS sites, with the aim of enhancing the educational experiences available. This approach would allow

for the RDs to be strategically released from their NHS commitments, ensuring that both their learning needs and the operational needs of the host NHS sites are met.

75. RDs must not be left to manage critical situations alone. Especially in private facilities with limited resources, such as those without intensive care units or sufficient blood supplies. It is crucial to ensure that RDs are always supported by a full professional team.

Indemnity

76. NHS staff in training grades who work in independent sector (IS) hospitals as part of their NHS training are covered by NHS indemnity (via the Clinical Negligence Scheme for Trusts membership of the employing Trust), provided that such work is covered by an NHS contract of employment and the doctor in training's employer has given permission for the training to occur in the IS. This is regardless of whether the supervising Consultant is an NHS Consultant or employed/engaged directly by the IS (and regardless of hours worked).

77. NHS students (nurses, medical students and AHPs) who spend time in IS hospitals as part of their NHS training placement are covered by NHS indemnity (via the Clinical Negligence Scheme for Trusts membership of the Trust providing the training placement to that student), provided that the student's activities are covered by the placement contract and the trust providing the placement has given permission for the student to spend time in the IS.

78. NHS trusts employing doctors in training or hosting student placements would be required to give permission for the training/placements to take place in non-NHS settings, and this permission should be given as part of the responsibilities of NHS trusts to support the education and training of the future NHS workforce.

79. If the supervising Consultant in the non-NHS provider is not working as an NHS Consultant, but is directly employed or engaged by the non-NHS provider in respect of their supervisory role then NHS indemnity will not be available to the Consultant. However, if the Consultant is directly employed or engaged and also holds an honorary contract with an NHS Trust, they may have indemnity from this Trust for their NHS work, if the NHS work includes supervising NHS training and placements undertaken. It is possible that the Trust providing indemnity to the Consultant may be different from the one providing indemnity to RDs, for example where a lead employer arrangement is in place for the trainees.

80. All supervising Consultants will need to be trained to GMC standards and on the local Postgraduate Dean's trainer database to ensure GMC standards are met. It remains the responsibility of the Postgraduate Dean to ensure all GMC standards are met.

See also: JCST Guidance on Training Implications and Principles to Consider here

Acknowledgements for the development of this document.

ASiT

BOTA

JCST

CoPSS

RCOphth

IHPN

NHS Resolution

DHSC

CQC

RCOG

RCOpth

RCOA

Jan 2025

Appendix A – 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 conRDions 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.

Appendix B – Glossary of training roles

Clinical Supervisor: The consultant or GP who holds overall clinical responsibility for patients being seen. This is the consultant that the RD is responsible to on any shift. RD also have named clinical supervisors who oversee ongoing clinical development during the placement.

Director of Medical Education (DME): Provides leadership, strategic direction and vision for the assurance, management and delivery of potraduate medical education in the Local Education Provider. Works with te Medical Director to develop effective medical workforce plans, oversees appropriate and transparent use of educational tariff and works with others to promote interprofessional education.

Educational Supervisor: Oversees and monitors progress of a RD over a specified period of time. They may be based in a different department and may remain the role as the RD moves through different clinical placements. The Educational Supervisr agrees the RDs work schedule and reviews against learning objectives.

Head of School: Head of School is an NHS E appointment whose role is to advise and support NHS E WTE in their role as commissioners of specialty educational programmes.

Post Graduate Dean (PGD) The Responsible Offcer for RD. PGDs are responsible for developing and have oversight of delivery of training programmes across educational provider units that meet curriculum requirements.

Training Programme Director: (TPD): Training Programme Directors (TPDs) are responsible for the operational delivery of the specialty training programme and are accountable to the Head of School. Training programmes are led by Training Programme Directors (TPDs), who can work at a local educational organisation (e.g. with foundation doctors) or at a system level (e.g. with specialty postgraduate doctors in training).