Royal College of Physicians

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NHS England education funding agreement 2027–30 consultation

RCP consultation response | October 2026

About the Royal College of Physicians

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing around 40,000 fellows and members worldwide, we advise and work with government, patients, healthcare professionals and the public to improve health and healthcare.

Summary response

The RCP welcomes the opportunity to respond to the consultation on the NHS England education funding agreement for 2027–30. We support the intention to strengthen provider responsibilities, make contractual requirements clearer and align the agreement more closely with the NHS England education quality strategy and framework. We particularly welcome:

- the stronger requirements for providers to make appropriately qualified and up-to-date educators and supervisors available
- the requirement for providers to assure NHS England that education and training meet the relevant quality standards
- the replacement of discretionary wording with mandatory requirements in several clauses
- the strengthened expectations concerning learner and educator safety and wellbeing
- the requirement for providers to complete an annual education and training self-assessment
- the strengthened provisions for reporting concerns and engaging with remedial and quality-improvement action
- the clearer expectation that staff undertaking funded programmes should have protected learning time and access to appropriate education, training and supervision
- the requirement for providers to ensure financial transparency, assign funding to education and training, and provide NHS England with an itemised financial report on request.

The proposed agreement confirms that NHS-funded education is a contractual responsibility rather than an optional activity. However, the RCP believes that the agreement should go further if it is to secure meaningful improvements in postgraduate medical training.

While we welcome the shift from discretionary language such as ‘should’ towards mandatory requirements such as ‘must’, stronger wording will only improve training if there are clear mechanisms for monitoring and enforcing compliance. The final agreement should include how concerns will be identified and escalated, the improvement action providers will be required to take, and the consequences where persistent failure is not resolved This is particularly important given the findings of

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the Medical Education and Training Review, which identified substantial concerns about the current medical training system and concluded that the gap between current practice and future need is significant enough to require reform.

There is a gap between the duties placed on providers and the financial and governance information that providers must supply to demonstrate that those duties are being fulfilled. Although the agreement includes an important financial transparency requirement, this appears to rely principally on NHS England requesting information from an individual provider. It does not establish routine, consistent and sufficiently transparent reporting that connects funding with educational capacity, delivery and outcomes. Providers may be required to deliver effective supervision, safe learning environments and appropriate training opportunities, but they are not clearly required to show routinely and consistently how education funding has been used to create the capacity needed to deliver them.

The RCP therefore recommends that the final agreement should:

1. require providers to report transparently on their use of postgraduate medical education funding
2. clarify the permitted and excluded uses of postgraduate medical education funding
3. establish named executive and non-executive accountability for educational quality and capacity
4. require providers to demonstrate that educators have sufficient protected, job planned time
5. introduce measurable indicators of whether training opportunities are being delivered, not simply whether processes exist
6. strengthen the relationship between educational performance, improvement and continued funding
- set out how NHS England will routinely test and enforce compliance with financial transparency requirements
- set out clear consequences where providers fail to comply with the agreement, including escalation where persistent non-compliance is not resolved
7. require providers to monitor the displacement of training by service pressures
8. support equitable educational and career development for locally employed doctors and other doctors outside formal training programmes
9. ensure that resident doctor and educator experience informs contractual assurance
10. make education and training a visible part of provider governance and workforce planning.

These changes would support the agreement's stated purpose and help ensure that public funding intended for education produces identifiable educational outcomes. They would also provide the practical financial and organisational foundations needed for wider reform of postgraduate medical training to succeed.

The importance of postgraduate medical training

High-quality postgraduate medical education is fundamental to safe, effective and sustainable patient care. Resident doctors are not only delivering care today; they are developing the knowledge, judgement and specialist capabilities needed to become the consultants, clinical leaders, educators and researchers on whom patients will depend in future. Training should therefore be treated as a core function of the NHS, alongside patient care and research. It should not be viewed as discretionary activity that can routinely be suspended when services come under pressure.

Service delivery and training are mutually dependent. Well-designed clinical work provides valuable learning, while properly supported doctors are better equipped to deliver safe, high-quality care.

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However, service delivery does not automatically constitute effective training. Learning requires appropriate clinical exposure, observation, feedback, reflection, progressive responsibility and access to skilled educators with sufficient time to support development.

The experience reported by RCP fellows and members is that these conditions are not reliably present throughout postgraduate medical training. Clinics, procedures and other educational opportunities can be lost because of rota gaps or service demand. Educational supervision may become principally a portfolio exercise when supervisors do not have sufficient time to observe residents, understand their development and provide meaningful feedback. Training quality can therefore depend too heavily on individual persistence, local goodwill and the organisation in which a doctor happens to work.

This agreement is also being developed at an important point in the reform of postgraduate medical training. NHS England's Medical Education and Training Review has identified substantial concerns with the current training system, including the relationship between service delivery and training, the quality and flexibility of training and the environment in which doctors learn and work. The next phase of the review is now developing proposals for reform. The 2027–30 education funding agreement should therefore provide the contractual and financial foundations needed to implement that reform, rather than operate separately from it. NHS England should make explicit how the agreement will support the objectives and emerging recommendations of the Medical Education and Training Review.

Transparency in the use of education funding

The RCP strongly recommends that the final agreement should require providers to report transparently on how postgraduate medical education funding is used. This is an important opportunity to move from broad expectations towards clearer organisational accountability for ensuring that training is delivered.

We welcome the requirement for providers to ensure financial transparency, assign funding to education and training rather than other services, and make an itemised financial report available to NHS England on request. This establishes an important principle: providers should be able to account for the education funding they receive and demonstrate that it has not been used for unrelated services.

The 2026–27 education and training tariff guidance identifies activities supported by the postgraduate medical placement tariff, including direct teaching, educational supervisors and assessors, pastoral and wellbeing support, study leave, educator development and the infrastructure required to support training. The guidance also encourages education teams and professional leads to understand the tariff income received by their organisations and how that income is used.

However, a requirement to produce information following a request from NHS England is not equivalent to routine, consistent and transparent assurance. The agreement does not establish a regular reporting mechanism connecting the funding received with expenditure on educational capacity, the training delivered and the outcomes secured. Nor does it appear to require providers to publish a proportionate account of how postgraduate medical education funding is used.

The guidance should also state more clearly what postgraduate medical placement tariff funding may not be used for. The undergraduate medical tariff guidance identifies certain excluded uses, but equivalent exclusions do not appear to be set out as explicitly for postgraduate funding. NHS England should establish consistent national guidance on eligible and ineligible postgraduate expenditure, including the treatment of general overheads and funding that cannot be clearly demonstrated to support eligible education and training activity.

The RCP recommends introducing an annual provider-level education funding statement covering:

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- total postgraduate medical placement tariff income received
- other NHS England postgraduate medical education funding received
- expenditure on educational and clinical supervisor time
- expenditure on direct teaching and assessment
- expenditure on protected educational activity
- study leave funding and access
- pastoral, careers and wellbeing support
- educator recruitment, training and professional development
- educational administration, facilities, simulation, library and digital resources
- any funding transferred between organisations
- funding carried forward or redirected
- any expenditure on organisational overheads, together with an explanation of how it supports eligible education and training activity
- an explanation of any material variance between planned and actual expenditure.

This reporting should be proportionate and based on consistent national categories. Its purpose should not be to create an onerous new accounting exercise, but to establish a clear line of sight between NHS education funding, provider decisions and training delivery. Providers should publish a summary of this information as part of their annual reporting. More detailed information should be available to NHS England for assurance, audit and quality improvement purposes.

This approach would strengthen and routinely apply the financial transparency principle already contained in the draft agreement. It would ensure that financial information is not available only when NHS England makes a specific request or when concerns have already arisen. This would implement the principle already set out in the RCP report, *Training physicians for the future*, that organisations receiving educational funding should demonstrate how those resources contribute to supervision, educator time, facilities, assessment, resident support and protected educational activity.

Protected educator time

The RCP welcomes the draft agreement's strengthened requirements relating to supervision, including the expectation that learners should have access to appropriately qualified educators and supervisors. We also welcome provisions requiring protected learning time for staff undertaking funded programmes. However, the agreement should make the corresponding requirement for protected educator time more explicit. Effective supervision cannot be delivered solely through a contractual statement that an educator or supervisor must be available.

Educators need sufficient, formally recognised time to:

- understand the relevant curriculum and learning outcomes
- observe resident doctors' clinical practice
- provide timely and constructive feedback
- undertake meaningful educational supervision
- assess capability and progression
- identify and support doctors in difficulty
- participate in training and educator development

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- engage with quality management and improvement processes
- contribute to programme design and review.

We recommend that the agreement require each provider to demonstrate that its educational and clinical supervisors have sufficient protected, job planned time to fulfil their responsibilities.

This should include assurance that:

- educational responsibilities are recognised within job planning and workload allocation
- educator capacity reflects the number and needs of learners
- supervisors are not routinely expected to complete educational work in unpaid personal time
- providers monitor whether allocated educational time is available in practice
- pressures on educator capacity are identified through workforce planning and escalated through organisational governance.

We are not suggesting that a single uniform allocation will be appropriate for every specialty, setting or learner. However, the agreement should establish the principle that protected educator capacity is a necessary input to the delivery of funded training and must be demonstrable.

Named organisational accountability

The draft identifies the chief medical officer, medical director or nominated representative as the provider's authorised representative for postgraduate education services. We welcome the recognition of senior medical responsibility but recommend a stronger governance requirement.

Each provider should be required to identify:

- a named executive director accountable for the quality and capacity of education and training
- a named non-executive director responsible for seeking assurance
- an appropriate board or committee through which education performance is reviewed
- a senior operational lead responsible for delivering improvement action
- clear escalation routes where training is being compromised by workforce or service pressures.

The agreement should require regular reporting to the provider board on:

- education quality indicators
- learner and educator experience
- delivery of supervision
- access to protected training opportunities
- use of education funding
- persistent or material concerns
- improvement plans and progress
- educational capacity within workforce and service plans.

Educational quality should receive a level of organisational attention proportionate to its importance for patient safety, workforce sustainability and the future quality of care. It should not be treated solely as

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the responsibility of postgraduate education teams, which may identify problems but lack the authority to resolve the underlying staffing, finance or service-design issues.

Measuring the training that is delivered

The RCP welcomes the move towards clearer and more measurable key performance indicators. The proposed provisions require providers to assure NHS England that they meet the education quality strategy and framework, report concerns and complete an annual self-assessment. However, process assurance should be complemented by evidence. A provider may have policies, committees and escalation routes while resident doctors continue to lose access to clinics, procedures, teaching and supervision. The final agreement should therefore require providers to monitor selected indicators of training delivery. Depending on specialty and setting, these could include:

- whether educational and clinical supervisors are allocated promptly
- whether scheduled supervision takes place
- access to direct observation and meaningful feedback
- access to clinics, procedures, multidisciplinary activity and other curriculum-relevant experience
- access to study leave and funded professional development
- cancellation or displacement of protected educational activity
- learner-reported quality and consistency of supervision
- educator-reported capacity to meet their responsibilities
- progress against local educational improvement plans.

Measures should be developed with resident doctors, educators, royal colleges, specialty bodies and providers. They should focus on meaningful indicators of learning rather than creating unnecessary data collection or encouraging superficial compliance. Data should also be interpreted in context. The purpose should be to identify variation, uncover barriers and support improvement.

Monitoring training displaced by service pressures

The agreement should require providers to identify and monitor occasions when planned educational activity is lost because of service pressures. This is particularly important for activities that may be difficult to recover, including:

- outpatient clinics
- specialty procedures
- community and same-day experience
- multidisciplinary meetings
- simulation and formal teaching
- educational supervision
- research or academic activity included within a training programme.

Providers should record the reason for recurrent loss of educational activity and the action taken to restore access. Aggregated information should be reviewed through provider governance and should inform discussions with NHS England. Not every unavoidable cancellation should constitute a contractual failure. The concern is persistent displacement without acknowledgement, mitigation or improvement. Where loss of training is recurrent, providers should be required to examine workforce

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capacity, rota design and service arrangements rather than expecting individual resident doctors to recover missed experience independently.

The draft agreement already proposes stronger expectations concerning appropriate training, effective supervision and provider co-operation where concerns arise. Monitoring displaced training would help establish whether those contractual expectations are being realised in practice.

Quality improvement and consequences for persistent failure

The RCP welcomes the proposed requirement for providers to engage with NHS England where concerns exist and to act on recommendations arising from quality interventions or visits. We also welcome the shift from 'should' to 'must' in several of the agreement's quality provisions. The final agreement should set out a clearer graduated response where a provider persistently fails to deliver the required educational environment. Where improvement and support have not resolved persistent concerns, a graduated range of consequences could include:

- an agreed improvement plan with defined actions, ownership and timescales
- enhanced monitoring and support
- review of educational capacity, workforce and financial information
- targeted quality intervention
- conditions attached to future education funding
- recovery or ring-fencing of funding that cannot be shown to have supported eligible educational activity
- reduction, suspension or relocation of placements where safe and effective training cannot be assured.

The objective should be improvement wherever possible. Abrupt withdrawal of placements can disadvantage resident doctors and place further pressure on neighbouring providers, with a resulting impact on quality, outcomes and experience of patient care. Any intervention should therefore consider learner continuity, local workforce effects and the availability of alternative placements. Nevertheless, an agreement is unlikely to change behaviour if persistent failure has no meaningful consequence.

The RCP has previously proposed routine educational funding audits of a proportion of organisations and clearer action where funding cannot be shown to support agreed training outcomes. NHS England should also set out how it will use and enforce the financial transparency provisions in the agreement. The ability to request an itemised financial report is valuable, but it will provide limited assurance if information is sought only once serious concerns have arisen. Routine sample audits should test whether providers can account for funding to demonstrate its contribution to education and training.

Review meetings and annual assurance

The draft proposes that formal review meetings need not take place where NHS England is assured about delivery, contractual compliance and regular communication, and where a satisfactory annual return has been submitted. It retains annual review meetings where these conditions are not met and permits NHS England to arrange a meeting as part of good governance and accountability. The RCP supports a proportionate, risk-based approach but recommends safeguards against assurance becoming overly dependent on organisational self-assessment.

Decisions not to hold a formal review meeting should take account of:

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- resident doctor and educator feedback
- available survey and quality data
- unresolved concerns or whistleblowing information
- evidence about supervision and training delivery
- previous improvement requirements
- information about educational funding and capacity
- evidence that the provider can comply with financial transparency requirements.

NHS England should retain a programme of sample review meetings and audits even among providers regarded as compliant. This would provide independent assurance, test the reliability of annual returns and help identify good practice. A written record should explain why a review meeting was or was not required and identify any matters to be monitored over the following year.

Given the scale of reform now underway through the Medical Education and Training Review, the RCP does not believe that NHS England should wait until the end of the 2027–30 agreement to assess whether these strengthened provisions are having the intended effect. We recommend an interim review of the operation of the agreement, informed by provider reporting, resident doctor and educator experience, and the implementation of relevant Medical Education and Training Review recommendations. This should provide an opportunity to strengthen or amend the agreement during its lifetime where evidence shows that requirements are not delivering meaningful improvements in training.

Resident doctor and educator voice

The draft agreement rightly emphasises learner and educator safety, wellbeing and systems for raising concerns. These provisions will be most effective if learners and educators are actively involved in evaluating delivery rather than treated solely as sources of survey data.

Providers should be required to demonstrate how they:

- involve resident doctors and educators in educational governance
- respond to themes from national and local surveys
- close the feedback loop by explaining what action has been taken
- protect those raising concerns from adverse consequences
- include doctors working less than full time and those with protected characteristics
- obtain insight from doctors across different specialties, sites and career stages
- involve resident doctor representatives in improvement planning.

The draft's recognition that learners must feel safe and empowered to raise concerns is welcome. The agreement should similarly recognise that educators need safe routes to report when workload, staffing or organisational pressures prevent them from providing adequate supervision.

Doctors outside formal training programmes

The proposed definition of 'resident doctors' is limited to doctors in formal medical training programmes. The RCP is concerned that this may reinforce a divide between doctors in formal training programmes and locally employed doctors, clinical fellows and others who are contributing to NHS care while seeking to develop their capabilities. The education funding agreement cannot by itself resolve

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the different funding arrangements affecting these doctors. However, it should not prevent providers from adopting an inclusive approach to educational infrastructure and workforce development.

The RCP recommends that the final agreement require providers to explain how their wider educational environment supports doctors outside formal training programmes, including access to:

- induction
- educational or career supervision
- protected professional development
- relevant learning opportunities
- appraisal and constructive feedback
- support to evidence capabilities and enter formal training where desired
- appropriate library, digital and educational resources.

Where tariff funding is restricted to recognised placements, the accounting arrangements should remain clear. However, providers should be encouraged to use the educational capacity and infrastructure created through NHS education investment to support a learning culture across the medical workforce, without reducing the provision owed to funded learners.

Workforce planning and educational capacity

The final agreement should make clear that workforce plans must assess educational capacity, not simply the number of learners or posts commissioned. Expansion in training numbers without expansion in supervisory capacity, clinical exposure and supporting infrastructure risks increasing competition for limited learning opportunities. Providers should therefore be expected to assess:

- the number and availability of suitably trained educators
- job planned educational time
- clinical environments and activity available for learning
- access to clinics and procedures
- rota and staffing capacity to release learners and educators
- facilities, simulation, library and digital support
- the effect of service reconfiguration on training
- the educational implications of new workforce models.

Where material gaps are identified, providers and NHS England should agree how they will be addressed before additional placements are commissioned. The RCP supports closer alignment between education commissioning, workforce planning and population need. Educational capacity should be recognised as an essential component of workforce infrastructure rather than an assumption made after workforce numbers have been set.

Equality, diversity, inclusion and learner safety

The RCP welcomes the proposed provisions on harassment, discrimination, bullying, intimidation and victimisation, including requirements for providers to maintain effective policies, reporting routes and timely investigation. We also welcome the requirement to notify NHS England of serious or systemic concerns that may affect learner safety, workforce wellbeing, service delivery or contractual

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compliance. The final agreement should ensure that providers assess whether different groups of learners experience unequal access to:

- supervision
- procedures and clinics
- study leave
- leadership and research opportunities
- supportive feedback
- career development
- flexible training
- routes for raising concerns.

Aggregated data should be reviewed across relevant characteristics and working patterns where it is lawful, proportionate and methodologically sound to do so. Providers should act where material disparities are identified. Quality assurance should consider inclusion not only through policies and processes, but through learners' actual access to training and progression.

Data, proportionality and administrative burden

The RCP recognises that stronger accountability will require better information. However, new reporting should be carefully designed so that it improves training rather than generating administrative work with little educational value. Data requirements should be:

- nationally consistent
- proportionate to the funding received and activity delivered
- aligned with existing systems wherever possible
- designed with providers, educators and learners
- focused on decisions and improvement
- accompanied by clear definitions and guidance
- reviewed periodically to remove low-value requirements.

The introduction of an annual education funding statement should build on information that providers must already be capable of supplying. NHS England should avoid creating parallel reporting systems and should instead establish a consistent national format through which providers can meet both their existing financial transparency duties and the strengthened assurance requirements proposed by the RCP. NHS England should publish an annual national overview drawing together the main findings from provider returns, learner and educator feedback, quality interventions and education funding information. This would make variation visible, support shared learning and allow national bodies to assess whether the agreement is improving educational quality.

Conclusion

The NHS England education funding agreement provides an important opportunity to make education funding, educational capacity and training quality more visible and accountable.

The RCP supports much of the proposed direction, particularly the stronger mandatory language, clearer quality expectations and emphasis on effective supervision, learner safety and protected learning. We

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also welcome the existing requirement for providers to ensure financial transparency and make itemised information available to NHS England. However, contractual expectations and powers will not be sufficient unless providers are required to demonstrate routinely how education is funded, governed and delivered in practice, and NHS England consistently tests and enforces those requirements.

The principle should be straightforward: organisations receiving public funding for education should be able to show how that funding improves education. The final agreement should establish a clear line from funding to educator capacity, from educator capacity to training opportunities, and from training opportunities to educational quality. It should place responsibility at provider board level, use learner and educator experience as central evidence, and provide meaningful routes for intervention where training is repeatedly displaced or standards are not met.

It should also make clear what postgraduate medical education funding may and may not support, introduce routine and proportionate financial reporting, and ensure that existing transparency provisions are actively applied rather than used only after concerns have arisen. Embedding these requirements would help ensure that postgraduate medical education is recognised as a core NHS function and protected as an investment in the quality, safety and sustainability of future patient care.

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