

EDUCATION AND TRAINING

Should we teach and train in smaller hospitals?

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ABSTRACT

In the NHS, training occurs in nearly all our hospitals, and this is part of the NHS service model. As the shortage of doctors is increasingly recognised, so has the pull from remote, rural and smaller places to large urban centres. We discuss whether this is inevitable and what else could be done to ensure equitable access to healthcare for all, by making better use of the excellent clinical training the UK has in place in smaller as well as larger centres.

KEYWORDS: Medical training, remote, rural, smaller hospitals

The UK postgraduate medical training system is the envy of the world, or so we would like to believe! Training in the UK certainly has attracted doctors from all over the globe and continues to do so.

This may be in part due to the UK having one of the most structured postgraduate training programmes globally. The World Health Organization would like all clinical education to integrate with in-service training, continuing learning and professional development.¹ We do this very successfully in the UK with a multitude of workplace-based assessments, curricula set by our medical royal colleges and specialist societies, regulation of standards by the General Medical Council (GMC) and training delivered by senior doctors. The current funding model is based on a tariff acknowledging that service and education goes hand-in-hand for our doctors in training. Once recruitment, selection, assessment, remediation, revalidation and professional support components are added to this core functionality, then virtually all the requirements of a comprehensive postgraduate education programme are met.

The model in the NHS is that all hospitals train and nearly all doctors provide service. However clinical training occurs most frequently in acute care and less commonly in primary care and community settings. There is also an apprenticeship model of learning, particularly for junior doctors in training.

It could be argued that the fact that all general practitioner (GP) practices do not train has contributed to the shortage of GPs we now have in the UK.

Our hospitals are reliant on junior medical staff to provide service and this is recognised in the structure of education funding. This structure has worked successfully since the inception of the NHS but does mean that doctors need to go where our resident populations may need doctors to provide healthcare. Allocation of medical training posts have been allocated historically and often in response to previous reforms. They are not currently based on any weighted capitation basis and this may disproportionately disadvantage small hospitals and units.

In 2016, Health Education England (HEE) established a group, chaired by Namita Kumar, to consider training in such locations. The resulting report, *Training in smaller places* made various recommendations, summarised in Box 1.² They found that there are many good reasons to teach and train in smaller hospitals.

The location and distribution of universities undoubtedly impacts on student retention, as does the content of undergraduate rotations and postgraduate training, as well as placement location and duration. There is evidence that previous exposure improves retention, with increased exposure to smaller areas. Therefore, all training programmes at undergraduate and postgraduate level should include clinical placement periods in remote or smaller places. This could be additional to, or in place of, existing placements.

The choice of location of training programmes and healthcare delivery may not necessarily align with the life and location choices of our junior or indeed senior colleagues. The resulting shortfall has led to an explicit recognition that the NHS is short of doctors in these areas, with resulting impact on the quality and sustainability of services in remote areas and in some small healthcare economies. The longstanding belief that trainees will be 'exported' to continue their careers in these under-doctored areas from regions more replete of training posts is not borne out by the progression data for doctors' career destinations.³

For postgraduate medical placements, careful consideration is needed as to the timing of these placements within the training programme. While, in some respects, the undifferentiated nature of work in smaller hospitals is advantageous in terms of delivery, the need for autonomy and independence may require a higher level of experience.

Every unit has its strengths in terms of service and training. Specific elements of the curriculum that can be delivered appropriately within small settings should be identified, and particular attention given to issues, such as exposure to community settings, undifferentiated clinical case load, emerging models of care, systems thinking and the development of clinical judgement and decision making. Training programme directors often do this implicitly.

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Box 1. Recommendations from Health Education England *Training in smaller places* task and finish group 2016.² The full report sets out how the recommendations were reached, and the evidence.

Quality and transparency

As for all aspects of the NHS, change is on-going, as are the commissioning arrangements for education and training. However, a regional view in keeping with other local NHS structures must remain, allowing the geographical small place to deliver both regulatory educational requirements as well as serve the health needs of the local population.

Workforce planning

Health Education England should commission a piece of work looking at the current distribution of current funded training posts and opportunities across England to establish if the current arrangements are appropriate to serve the needs of communities now and in the future. Part of this work must address how to strengthen links between those planning clinical training programmes and those developing clinical services.

Active monitoring of the impact of the abolition of nursing, midwifery and allied healthcare professional bursaries on the uptake and distribution of placements by geography and size of institution should be performed by the wider NHS so that any potential effect as a result of this policy can be managed, be it positive or negative. Any work should reference the Department of Health and Social Care led work in this area.

Curricula and training programme design

Rotations for all undergraduate nurses and allied healthcare professionals to an adequate primary and community care placement should be increased and, where appropriate, all professions should have rotations at a provider in a small place. For smaller places this should be done for the next academic year.

Royal colleges and national NHS organisations, alongside employers and appropriate organisations, should ensure that they work together to communicate the curricular benefits to trainees of working in smaller places.

The curriculum must reflect bespoke local healthcare requirements and local healthcare systems should work together to establish their local priorities. Royal colleges should recognise the value of smaller units as training environments within their curricula, and support trainees to undertake training with providers in smaller places.

Programme directors should consider the opportunities for gaining in non-clinical skills, such as resilience and decision making – when allocating placements.

Recruitment and retention

Health Education England should consider commissioning a comprehensive study looking at how best to improve recruitment and retention in rural areas, and the factors that tie into fostering this improvement.

Coordinated local and national attention and action needs to be given to social needs of trainees in remote or smaller locations in order to foster a sense of belonging and shared culture in local health economies. This includes acknowledgement of, and actions to support, the 'hidden' curriculum which forms an important part of trainees' lives. There must also be actions to mitigate potential advantages for career progression and work life balance that arise from being located in an urban centre, which discriminate against smaller places. Throughout this, cultural requirements of minority groups must be considered.

Appropriate careers advice should be available to those considering employment in the health service, as well as current learners as part of the planned programme of study on entry to both undergraduate and specialist training programmes. This should have a particular emphasis on making health professionals aware of the needs of the health service, on both a local and national level.

Continued professional development

Continued professional development must be provided using the advances in technology available. There should be better use of technology enhanced learning, webinars, video links and online modules need to be used. However, the value of face-to-face contact for both role-modelling and inspiration should not be forgotten. Development of communities of practice may help avoid isolation.

In order to keep skills and knowledge up to date, there should be access to local simulation learning integrated with the clinical services, and true team-based multiprofessional learning should be fostered to increase efficiency and improve patient outcomes.

Financial

Those communities with one provider and one commissioner should consider the value of business processes on limited resource. If there is no realistic alternative provider, business processes and structures should be streamlined to increase efficiency.

The system should consider the use of preferential fees and placement rates to encourage training in smaller places, including a re-evaluation of the propriety of the market forces factor. There should be long-term evaluations for all financial incentives, both current and future.

Developing training rotations and programmes that develop an understanding of the different elements within healthcare systems and clinical networks, which would include exposure to community, primary care and remote settings as well as more specialist services can give a more comprehensive view of health economies and can help support trainees in all professions in non-clinical curricula and leadership skills.

Benefits to doctors in training range from more hands-on tutelage from consultants, leadership and management challenges that present themselves more regularly due to fewer trainees, greater responsibilities and challenges earlier in career than would be seen in an urban centre, among others. Trainees benefit from having this exposure earlier in their career than they would have otherwise; benefits that are not currently being articulated strongly enough.

The variety of case mix that trainees will see will vary according to location of training, but core UK standards and curriculum requirements are the same. Deprivation and poverty, exposure to industry related health problems, and caring for health problems in different ethnic groups are more a feature of a geography as opposed to the size of training unit.

It is often thought that those undertaking training in smaller centres develop better non-clinical skills such as resilience, autonomy and decision making.

Doctors in rural areas may receive patient cases they might not normally encounter in medical school or during early years training. A rural physician has a reputation for being more of a generalist, as the physician will see a broader scope of illnesses than a physician not operating in this environment. Since a specialty hospital or clinic might be inaccessible to the patient for geographic reasons, a rural physician needs to be proficient in providing a wider variety of services that, in an urban, area might be referred to a specialist. Being proactive and having many skills is an advantage that many see as providing increased job satisfaction.

The American Academy of Family Physicians found that the more rural the location, the more likely the patient saw a family physician. In the most rural communities, the likelihood of seeing an emergency physician drops five-fold, while the odds of seeing a family physician increases seven-fold. They have also commented that rural education is by nature more interprofessional, with physicians, pharmacists, mental health providers, dentists, nurse practitioners, physician assistants, social workers, dietitians and other healthcare professionals learning side by side. Again, there is an increasing recognition of the value of context in training, career satisfaction and retention, and so possibly addressing burnout. These areas are defined as security, freedom and identity.⁴

Those of us involved in postgraduate medical and dental education (PGMDE) have recognised the imbalance between training in larger and smaller centres for some time. This imbalance is further pressurised by the intermittent pulls to create larger hospitals in order to support streamlining of rotas, due to the lack of workforce. The system has repeatedly asked for greater generalism in education, training and practice, exemplified best by high-level policy documents such as the Shape of Training review which enjoyed UK-wide support from devolved health departments and their respective medical training authorities.⁵ This ambition was further supported in *Five year forward view of the NHS in England*.⁶

In 2017, as a result of fitness to practice data and the Shape of Training review, the GMC produced its *Generic professional capabilities framework* which recommends both the importance

of and need for specific training to address individual, team and organisational deficiencies as well as addressing wider systemic failures.⁷ These skills and this training are often better delivered by smaller providers.

Last year, the NHS in England produced *The NHS Long Term Plan* and, within it, the specific recognition that training and education supports recruitment, things we have known to be self-evident in PGMDE.⁸

Quality might be argued to be lessened by training in smaller hospitals, but this is not necessarily so; the GMC data suggests that the quality of training depends on many factors. In north-east England and north Cumbria, a high-quality learning environment is widely reported by trainees, and this is despite the areas having many training locations defined as a 'smaller place'.

The key to offering high-quality learning environments is having someone who understands the unique requirements of doctors in training in the NHS and judicious use of the traditional apprenticeship model. Junior doctors need training organised by a professional who understands that learning must align with patient flow. This underpins how programmes and rotations, and their oversight and management, are currently organised in the UK. It is also the reason why specialties may need to train differently.

Accountability at board level by a medical director is also key, as well as role-modelling by dedicated doctors and clinicians who constitute the faculty and fabric of the trainee's learning environment. We are fortunate that we have no shortage of this vital part of the training infrastructure.

Of increasing concern is the lack of understanding of educational needs in some pressured providers leading to bundling of human resource, organisational development and education into the same compressed resource envelope, in the absence of appropriate medical leadership. This is a common reason of the failure of training, regardless of the size of the hospital.

HEE is now not only determined to support training in smaller places but is actively encouraging geographical (re)distribution. In *The NHS Long Term Plan* and the *Interim NHS People Plan*, the need for distribution of postgraduate training to address geographic and specialty inequalities was explicitly articulated.⁹ This has led, in England, to HEE establishing a distribution of training programme board which will seek to address this inequality and, in doing so, will specifically look at the particular requirements of smaller hospitals and how the success of high-quality training in smaller units can be harnessed to match the distribution of the junior doctor workforce to the populations needing care.



Training in smaller places and hospitals not only provides learners with most of the clinical skills needed, but more often the generic professional and leadership skills needed. All of this is required, in addition to the vast clinical knowledge we need, to allow us to be the doctors that the NHS wants and our patients need, in the places where we are needed. ■

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