# RCPCH MMC Cohort Study (Part3)

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# Executive summary

## Background and methodology

In light of key challenges faced by the paediatric workforce, the MMC cohort study aims to provide a better understanding of paediatric trainees' career intentions and progress in order to produce recommendations for how the College, NHS providers and commissioners can improve training programmes and ensure paediatric trainees are better prepared for their future career. This report will add evidence to the developing RCPCH workforce strategy.

The RCPCH sent a questionnaire to all trainees who began training in paediatrics in 2007 after approximately 1 year of training (part 1) and after 3 years of training (part 2). The 3rd part of this survey took place after their 5th year of training, and it is intended to repeat it after their 7th year.

A survey was sent using SurveyMonkey to the whole cohort, apart from those who stated they had left paediatric training to work in a different medical specialty or a different career in their response to part 2. This report presents the findings of part 3 of the study.

## Key findings and recommendations

**Response rate and cohort demographics**

- 57.6% of the original cohort responded to part 3 - 257 individual respondents. 47.5% (212) of the original cohort have responded to all three parts of the study.
- 241/257 (93.8%) are currently working in the UK, and 16/257 (6.2%) are not currently working in the UK.
- 222 (86.4%) stated that they are currently training in paediatrics, 212 of which are in the UK.
- 19 (7.4%) stated that they are working in paediatrics but not training, 16 of whom are in the UK.
- The attrition rate between part 2 and part 3 is 9.1%, or approximately 4.6% per annum.
- Trainees in the cohort vary considerably in the year of training that they have reached and some after 5 years in paediatric training have not yet completed ST2; 40.1% of the cohort (89/222) were in an ST5 post on 1st August 2012; 45% (100/222) were in a more junior position and a small percentage, 9.5% (21/222) had advanced to ST6.

***Recommendations***

- RCPCH to disseminate its findings on attrition rates widely, particularly to bodies responsible for workforce planning – HEE, CfWI, LETBs and Deaneries in England, Scottish, Welsh and Northern Irish assemblies with a request that these bodies formally liaise with the College on paediatric workforce modelling.
- RCPCH carry out further research to investigate the causes of attrition among trainees to establish whether it shows variance with other specialties or other fundamental reasons. The findings to be used to support trainees who are considering leaving training and to consider ways of reducing attrition rates where possible.

**Current post and preferences**

- 146 (64.0%) are working full time, 50 (21.9%) are working LTFT and 32 (14.0%) are currently OOP.
- Since part 2, there has been a statistically significant increase in part time working, from 13.1% (38/290) to 22.7%. 48.6% of respondents would like to work full time

and 51.4% LTFT on completion of training. The percentage wishing to work LTFT increases when looking at females only; 63.4% of whom would like to work LTFT.
- Considering their current work life balance, 68.9% were happy with their choice of paediatrics as a career.

***Recommendations***

- Disseminate the data in this report regarding demand for less than full time working to the College's LTFT officer for her comments and recommendations.
- Ensure each deanery has method of giving or signposting to advice for those considering LTFT working.

**Training progress**

- 43.7% of respondents had worked on a middle grade rota when they were ST3; 56.9% of whom stated they felt very or reasonably confident doing so.
- Over the 24 month period, respondents spent on average 11 months on a general/specialist rota, 3.3 months on community rotations and 5.5 months on neonatology rotations.
- There has been a decrease in confidence in obtaining their chosen post since part 1; after ST1 13.1% said they were not confident, in part 2 this rose to 31.3% and in part 3 it was 29.7%.
- When looking only at those who intended to be consultants, confidence is very slightly lower, with 31.5% stating they are not confident of obtaining a consultant post compared to 29.7% of all respondents.
- 78% of respondents felt that they were totally, very well or well supported by seniors in their training and development, and only 3.7% felt they were poorly supported.
- 45.1% of respondents had taken time out of training in the last 2 years.
- 43.3% (93/215) have no protected teaching time, 10.7% (23/215) have less than an hour per week, 19.5% (42/215) have an hour, and 26.5% (57/215) have more than an hour per week.

***Recommendations***

- Consultants and managers need to be cautious about conflating confidence with competence and ensure that when planning rota cover and presence on the ward, Facing the Future standards are adhered to.
- Deaneries/LETBs to increase available training slots to reflect the proportion of future consultants in their region where appropriate.
- At Deanery/LETB level more flexible rotations to be planned so that number of NTNs can be spread evenly throughout a region and individual units are not burdened by having to employ disproportionate amount of locums.
- Make members aware of the findings regarding confidence and support from seniors, and possibly amend paediatrician's handbook. Use findings to stress to employers' the importance of supervision, teaching and training time in consultant contracts and the need to allow for this time through SPAs.
- Explore ways of increasing access to career guidance and information during training.
- Work with colleagues responsible for education and training/college tutors to triangulate the findings around the amount of protected teaching time to ensure the response to the survey is not due to misunderstanding of the questions.
- If findings are corroborated, the College should work towards ensuring appropriate teaching time is promoted via the tutor network in trusts and deaneries, and consider developing a College standard or guideline and/or including this in the paediatric guidance checklist or the paediatricians' handbook.

**Geographic preferences**

- 10% of respondents would like to work abroad on completion of training; this is similar to the findings of our latest CCT holders follow up survey in which 10.2% stated they were currently working abroad.
- 74.1% of female respondents and 50.9% male respondents stated that their application for a consultant post would be limited due to geographical constraints.
- 70.5% of females and 58.6% of males stated their choice of training programme was limited due to geographical constraints.
- The most commonly cited geographic constraints to applying for a consultant post and choice of training programme were "My partner/spouse's job is fixed to this area" (83.2%), "I own a house" (66.5%) and "I like it here and my social network is in this area" (58.7%).
- 15.6% (40/257) had made an application for deanery transfer, and of these 80.0% (32/40) were successful.

**Career intentions**

- 93 (38.6%) intend to be general paediatricians, 78 (32.4%) intend to be subspecialty paediatricians, 20 (8.2%) intend to be paediatricians in community child health and 15 (6.2%) academic paediatricians. 25 doctors (10.4%) are undecided and five doctors do not intend to be paediatricians.
- The percentage of trainees intending to be subspecialty paediatricians has risen since part 1, up to 32.4% from 24.4%, although it peaked at 38.7% in part 2.
- Those intending to be general paediatricians fell between parts 1 and 2 of the study from over half to 25.7% in part 2, but rose again to 93 (38.6%), perhaps again reflecting the availability of grid positions.

## Subspecialty intentions

- The largest proportions of those intending to be subspecialists plan to go into community child health with 20 (21.7%) and neonatology with 19 (20.7%).
- There has been an increase between part 2 and part 3 in the proportion of the cohort intending to work in community child health on completion of training, but there is still a potential shortfall in the proportion intending to go into CCH when compared to the proportion of the current workforce working in that area.

***Recommendations***

- Ensure engagement occurs between the Community Child Health CSAC and the College (plus BACCH) to ensure adequate grid training opportunities are created to sustain the future workforce for non-acute care. This should go hand-in-hand in collaboration with BACCH on workforce modelling for CCH as part of the RCPCH workforce strategy.
- Improvements in more people wanting to do CCH as above, but College must work to increase numbers pursuing these careers. Consideration should be given to promoting these careers to men, otherwise there is a danger that this is seen as female only specialty.

**Resident shift working**

- 63.3% of trainees who have worked in a unit where consultants do resident shift work expect to do so, compared to 45.2% of those who have not worked in a unit where consultants work resident shift work.
- 41.1% of respondents felt that resident shift working provided better quality service, 37.9% were undecided, and 21.0% did not think it provided a better quality service.
- 58.9% of respondents do not think that resident shift working is sustainable in the long term.

***Recommendations***

- The College should continue to work collaboratively with trainees to examine the risks and benefits of RSW and to clarify why there is a need for this way of working given the workforce planning imperatives i.e. with fewer trainees in future and the need to protect training time; resident shift working will be part of the solution to sustain safe services. This should include further promotion of RSW models in practice.
- The College will continue to support the development of career portfolios and long term job planning for the individual doctor, and team job planning for the service. Resident shift working needs to be part of the overall service design with built in flexibility for doctors to change their job plans as they progress through their careers.
- To take forward recommendations in the College's workforce strategy to ensure there is the right workforce based on the right model of care, which truly engages children, young people and their parents and carers, from the point of design through implementation and with on-going evaluation.

# 1. Background

Career opportunities in paediatrics have, in the past, been relatively good for those completing their training with a considerable expansion in the number of consultant posts in recent years. However, the situation is now changing.

In the 1990s a unified registrar grade was introduced[i]. The "New Deal" was also introduced around this time, which created a financial disincentive for hospitals to have rotas where trainees worked excessively long shifts and hours. The full introduction of the European Working Time Directive (EWTD) by August 2009 further reduced the average number of hours which trainee doctors could be expected to work per week to 48.

The Modernising Medical Careers (MMC) programme was introduced in 2005. Successful completion of this programme enables the trainee to obtain the certificate of completion of training (CCT) and eligibility to apply for consultant posts. The introduction of MMC presented the RCPCH with the opportunity to track a cohort of paediatric trainees and to study their career pathways and intentions, providing valuable information to influence both the current training programme and workforce planners.

### Current challenges in the paediatric workforce

The paediatric workforce currently faces a number of challenges. There is a predicted oversupply of CCT holders based on current levels of consultant expansion; however there continues to be shortages in trainees to staff middle grade rotas, giving rise to concerns over safety and quality of training. There is a clear driver both from the public and key stakeholders, including the College, to provide a consultant delivered service to improve the quality and safety of care, and to provide a solution to middle grade shortages.

The College's Facing the Future document made 5 interlocking recommendations for the reconfiguration of services[ii]. In the recent past, reconfiguration of child health services have begun to be implemented, however this has not occurred to the extent set out in the standards document. At the same time, there is pressure to review the European Working Time Regulations, and the College continues to advocate for the protection of the Regulations in their current state.

Further changes to the training programme are expected in the near future, resulting from the publication of the Shape of Training final report[iii] in autumn 2013. Implementation of the recommendations made by Shape of Training could mean a reduction in the time spent in specialty training from the current 8 years to 4-6 years, with opportunity for credentialing in subspecialty areas after certification.

The College is currently implementing its workforce strategy and action plan[iv] which will aim to provide short and longer term solutions for the paediatric workforce. The strategy will be advising on the right balance of future training and consultant numbers and on the best models of care general paediatrics and for subspecialties including community child health and neonatology.

### MMC cohort study (part 3 after 5th year in training)

To obtain a better understanding of paediatric trainees career intentions and progress the RCPCH sent a questionnaire to all trainees who began training in paediatrics in 2007. The 3rd part of this survey took place after their 5th year of training, and it is intended to repeat it after their 7th year.

The specific aims of the third part of this study were to:

- Make factual comparisons of the cohort's career intentions in terms of the paediatrician they wish to become, their specialty and subspecialty interests, their expectations regarding less than full time and full time working and any geographical restrictions they have in their career.
- Assess the level of confidence the cohort have about their career choices and any reasons for changes since ST1 and ST3.
- Establish the current status of training careers in terms of examination passes, out of programme experience and working on middle grade rotas.
- To identify those who are no longer in paediatrics and assess the attrition rate and to carry out further investigations as to why they have left paediatrics.
- To look at changes in career intentions throughout the period of the study and to identify work-life balance issues.
- To inform the NHS workforce planning process.
- To produce recommendations for how the College, NHS providers and commissioners can improve training programmes and ensure paediatric trainees are better prepared for their future career.

Results from parts 1 and 2 of this study are available to download from the College website: www.rcpch.ac.uk/mmc.

# 2. Methodology

All trainees who began training in paediatrics in 2007 were selected to be members of the cohort. The initial survey (part 1) was sent out shortly after the cohort had completed 1 year of training by using a questionnaire on SurveyMonkey. Email addresses were gathered from the College membership and training records.

Part 2 included all respondents and non-respondents to part 1 and was sent using a further SurveyMonkey questionnaire following the cohort's 3rd year of training in October 2010. Data collection was closed in Spring 2011.

For those doctors who had left paediatrics and were willing to be contacted, an in-depth telephone interview survey was carried out between November 2011 and January 2012 to ascertain the reasons for leaving paediatrics and the results of this survey can be found within the discussion section.

Part 3 was conducted after the cohort's 5th year of training. Again, a survey was sent using SurveyMonkey to the whole cohort, apart from those who stated they had left paediatric training to work in a different medical specialty or a different career in their response to part 2.

Those that had left in part 2 were separately asked two questions;

1. Are you happy with your decision to leave paediatric training? If yes, why?
2. Would you ever consider returning to paediatrics? If not why not?

The data from Survey Monkey was downloaded into an Access database and analysed using Access and Excel.

The table below summarises the stages in the cohort study and links to the results of each part:

| Survey | Time in training | Reference |
|---|---|---|
| Part 1 | After 1 year | http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/MMC%20Cohort%20Study_main%20findings%20link.pdf |
| Part 2 | After 3 years | www.rcpch.ac.uk/system/files/protected/page/MMC%20part%202%20Report.pdf |
| Part 3 | After 5 years | http://www.rcpch.ac.uk/mmc |

Individual data has been kept confidential and no data will be presented which identifies individual doctors.

# 3. Full findings

## 3.1 Response rate and cohort demographics

The questionnaire for part 3 of the cohort study was sent to all members of the cohort including those who did not respond to part 1 or part 2 of the cohort. Those that were known to have left at part 2 of the survey were not included in the Survey Monkey survey but sent a separate set of questions. Figure 1 shows the response rate at each stage of the cohort study.

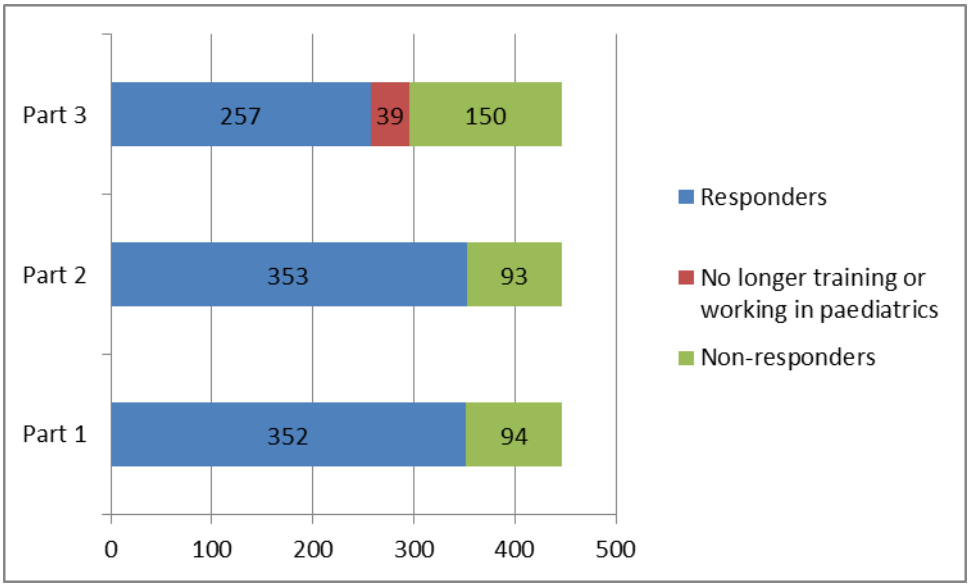



**Figure 1: Comparison between part 1, part 2 and part 3 responders and non-responders**

Overall 57.6% of the original cohort responded to part 3, which represents 257 individual respondents. When those who were no longer training or working in paediatrics at part 2 are discounted, the response rate for part 3 was 63.1%. 47.5% (212) of the original cohort have responded to all three parts of the study.

The 39 who had left paediatric training at part 2 were asked whether they were happy with their decision to leave paediatric training, whether they would ever consider returning to paediatrics, and the reasons for their answers. 13 responses were received and 11 of those were happy with their decision to leave paediatric training. The majority of reasons provided for being happy not doing paediatric training were either connected to their improved work life balance or due to the fact that paediatrics wasn't their first choice. However, if they had no choice they would consider paediatric training again. 3/13 said that they would return to paediatrics at some point in one capacity or another. 6/13 are still involved in paediatric work in their new choices. The main reason for not returning to paediatric training was that they did not want to start training from the beginning again.

### Current training status and location

Survey respondents were asked whether they were still training in paediatrics, still working in paediatrics (but not in training), training in another specialty or working in a different career. The response to these questions is broken down in Table 1 according to whether the respondent works in the UK or not.

Of the 257 respondents, 241 (93.8%) stated that they are currently working in the UK, and 16 stated that are not currently working in the UK. A total of 222 (86.4%) stated that they are currently training in paediatrics, 212 of which are in the UK. A total of 19 (7.4%) stated that they are working in paediatrics but not training, 16 of whom are in the UK. A total of 16 (6.2%) stated that they are training in other specialties or working in another career, 13 of whom are in the UK.

**Table 1: Training status and working location**

| | Training in paediatrics | Working in paediatrics but not training | Training in other specialities/working in different career | Total |
|---|---|---|---|---|
| Working in UK | 212 | 16 | 13 | 241 |
| | 95.6% | 84.2% | 81.3% | 93.8% |
| Not currently working in UK | 10 | 3 | 3 | 16 |
| | 4.5% | 15.8% | 18.8% | 6.2% |
| Total | 222 | 19 | 16 | 257 |
| | 86.4% | 7.4% | 6.2% | |

It is important to assess how many trainees leave training each year to be able to help predict the number of CCTs which will be achieved by a given starting group of trainees. This is vital for assessing future training numbers. 301 members of the cohort reported that they were in training when we undertook part 2 of the study, 220 of those responded to part 3, 20 of whom have left training in the last 2 years. This equates to 9.1% or approximately 4.6% attrition per annum.

Of the 20 that have left paediatric training, 4 are working in paediatrics, leaving 241 respondents who are either training or working in paediatrics in the UK or abroad. The remaining 16 respondents who are no longer in paediatrics were asked which specialty or career they are now in and the findings are shown in Table 2.

**Table 2: Those no longer in paediatrics – other career by gender**

| | Totals |
|---|---|
| General practice training | 7 |
| Not training in other specialty | 6 |
| Clinical genetics training | 2 |
| Public health training | 1 |
| Totals | 16 |

Of the 16 who are no longer training or working in paediatrics, the largest proportion (7/16) are now training in general practice, and six are not training in another specialty i.e. they are in a career outside medicine or not in a career at present. By part 2, 39 had left paediatrics (11.0%) and 14 (4.0%) were working but not training in paediatrics. The majority of those training in another specialty were in GP training (20/39).

## Current training grade

Although the survey was conducted shortly after the 5 year point from when respondents commenced training, progress through training varies greatly and Figure 2 shows the grade breakdown of the 210 respondents who provided the grade they were working in on 1st August 2012.

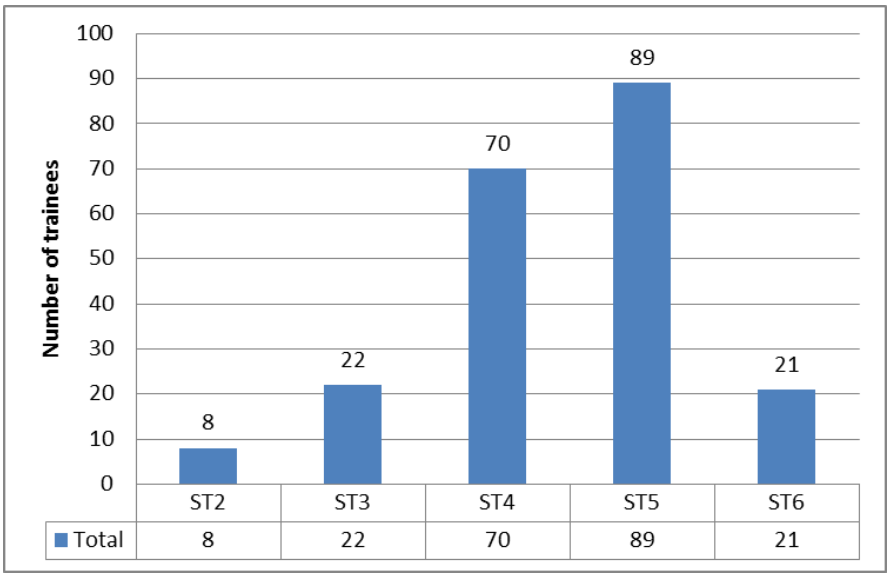



**Figure 2: Training grade of respondents on 1st August 2012***
*7 respondents were SAS grades
**16 were not eligible to answer this question and 24 did not provide a grade (12 in training and 12 not in training).

Figure 2 indicates that 40.1% of the cohort (89/222) still in paediatric training was in an ST5 post on 1st August 2012; 45% (100/222) were in a more junior position and a small percentage, 9.5% (21/222) reported having advanced to ST6. 7 respondents were not in training but working as SAS grade doctors. Trainees in the cohort vary considerably in the year of training that they have reached after 5 years in paediatric training, which represents a significant challenge to workforce planners.

## 3.2 Current post and preferences

### Full time/Less than full time working

Respondents were asked how they currently work in terms of full time (FT), less than full time (LTFT) or out of programme (OOP). The out of programme options have been grouped in Table 3 due to small numbers.

**Table 3: How currently work by current status**

| | Full time | Less than full time | OOP | Total |
|---|---|---|---|---|
| Currently training in paediatrics | 134 | 49 | 29 | 212 |
| | 63.2% | 23.1% | 13.7% | |
| Currently working in paediatrics | 12 | 1 | 3 | 16 |
| | 75.0% | 6.3% | 18.8% | |
| Total | 146 | 50 | 32 | 228* |
| | 64.0% | 21.9% | 14.0% | |

*16 respondents were not eligible to answer this question and a further 13 did not respond.

Overall, 146 (64.0%) are working full time whilst 50 (21.9%) are working LTFT and 32 (14.0%) are currently OOP. Since part 2, there has been a statistically significant increase in part time working, from 13.1% (38/290). Less than full time working and OOP is more common among those in the lower grades, as might be expected.

Respondents were asked how they would like to work as a trained paediatrician in terms of full time and less than full time working. Overall, 48.6% would like to work full time and 51.4% less than full time on completion of training (see Table 4). This is largely unchanged since part 2, when 52.0% said they would prefer to work full time as trained paediatricians. In the current consultant workforce, as reported in the RCPCH 2011 census[v], 80.0% currently work full time (10 or more PAs).

**Table 4: How would like to work as a trained paediatrician by gender**

| | Full time | Less than full time | Totals |
|---|---|---|---|
| Female | 59 | 102 | 161 |
| | 36.6% | 63.4% | |
| Male | 44 | 7 | 51 |
| | 86.3% | 13.7% | |
| Totals | 103 | 109 | 212* |
| | 48.6% | 51.4% | |

*10 of the 222 in training did not respond to this question.

Table 4 also shows future intentions in regard to full time/less than full time working according to gender. Once qualified, 63.4% of females and 13.7% of males would like to work less than full time. In part 2, 58.8% of females and 14.9% of males wanted to work less than full time when trained, and in part 1, 56.9% of females and 9.1% of males wanted to work less than full time or flexibly.

Table 5 shows that overall, 78.8% of those in training are currently working as a trainee in the way that they prefer. A larger proportion of those working less than full time (87.8%) than those working full time (76.1%) are working in their preferred way.

**Table 5: How currently working as a trainee by preferred way of working**

| | Preferred way of working as a trainee | | |
|---|---|---|---|
| Currently working | Yes | No | Total |
| Full time | 102 | 32 | 134 |
| | 76.1% | 23.9% | |
| Less than full time | 43 | 6 | 49 |
| | 87.8% | 12.2% | |
| Out of programme | 22 | 7 | 29 |
| | 75.9% | 24.1% | |
| Totals | 167 | 45 | 212* |
| | 78.8% | 21.2% | |

*10 of the 222 in training did not respond to this question.

## Work life balance

Respondents were asked if they were happy choosing paediatrics as a career considering their current work life balance, shown in Table 6 according to how they are currently working.

**Table 6: Considering work life balance, happy with choosing paediatrics as a career by gender**

| Happy with choosing paediatrics as a career | Female | Male | Total |
|---|---|---|---|
| Yes | 114 | 43 | 157 |
| | 66.7% | 75.4% | 68.9% |
| No | 57 | 14 | 71 |
| | 33.3% | 24.6% | 31.1% |
| Total | 171 | 57 | 228* |

*13 did not respond and a further 16 were not eligible for this question.

Overall, 68.9% are happy with choosing paediatrics as a career. Males appear to be happier, with 75.4% (43) happy choosing paediatrics as a career compared to 66.7% (114) of females. Although a chi square test on this data shows that there is no relationship between gender and happiness and that we cannot infer males are happier with choosing paediatrics as a career.

## 3.3 Training progress

This section considers the progress of trainees in terms of passing exams, how much time they have spent on various rotations, whether they have worked on middle grade rotas at ST3, their levels of confidence about obtaining intended posts, support from seniors and protected teaching time available.

In part 3, of the 241 who were eligible to answer the question, 207 (85.9%) had passed their MRCPCH exams, 19 (7.9%) had not, and 15 (6.2%) did not answer.

### Working on middle grade rota at ST3

The cohort was asked if they worked on the middle grade rota when they were an ST3. Of the 241 who were eligible to answer this question, 109 (45.2%) had acted as a middle grade at ST3, 107 (44.4%) had not, and 25 (10.4%) did not answer.

Those who had worked on the middle grade rota when they were an ST3 were asked how confident they felt working at that level and the results are shown in Figure 3.

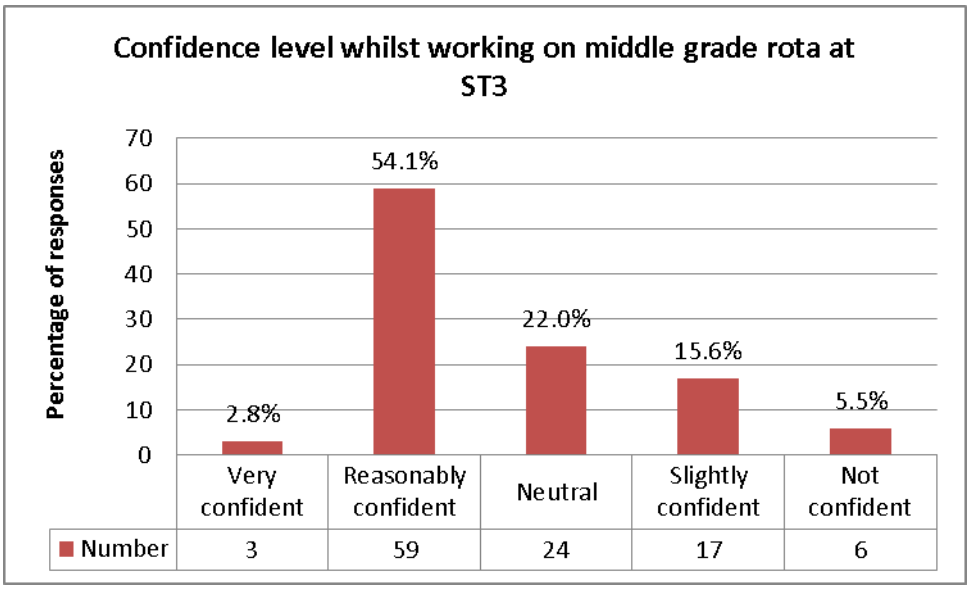



**Figure 3: Confidence level whilst working on middle grade rota at ST3**

56.9% (62) of respondents were very or reasonably confident whilst working on the middle grade rota at ST3 with only 5.5% (6) of respondents stating they were not confident (see Figure 3). Although it is encouraging that the majority were confident, there is still a proportion who reported lacking confidence. It is also important to note that confidence does not necessarily equate to quality and safety.

### Training rotations

Each respondent was asked how many months they had spent on general/acute, subspecialty, community and neonatal rotations in the 24 months of their training programme between the 3rd and 5th year of training, and Table 7 shows the average for each type of rotation.

**Table 7: Average months spent on specialty rotation in 2 years prior to 31st July 2012.**

| Rotation | Average no. of months | % of time |
|---|---|---|
| Community | 3.3 | 13.7% |
| General/Specialist | 11.0 | 45.6% |
| Neonatology | 5.5 | 22.8% |
| OOP | 3.2 | 13.3% |
| Other | 1.1 | 4.6% |
| All rotations | 24.1 | |

Time spent by the cohort is heavily geared towards time spent on the general/specialist rota: 11.0 months (or 45.6% of 24 month period). This is compared to 15.1 months and 44% of the 36 month period to part 2. In contrast, members of the cohort spent on average 3.3 months (13.7% of the 24 month period) on community rotations compared to 1.6 months (4.7% of the 36 months to part 2). This indicates that the proportion of time spent on community rotations has increased approximately 3 fold for the cohort.

## Confidence in obtaining chosen post

Cohort respondents were asked a series of questions about the confidence they have in obtaining their chosen post when they complete training, the change in their confidence level since they were surveyed after their first year in training, the reasons for not being confident and if they are considering other career options. The following section sets out the findings in further detail.

All participants in the cohort who are still training or working in paediatrics were asked to select their level of confidence about obtaining their chosen post at the end of training and the response is shown in Table 8 for males, females and the total cohort.

**Table 8: Confidence in obtaining chosen post by gender**

| | Female | | Male | | Totals | | Intending to be consultants only | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| Confident | 18 | 10.3% | 12 | 20.7% | 30 | 12.9% | 24 | 11.3% |
| Reasonably confident | 102 | 58.6% | 31 | 53.4% | 133 | 57.3% | 122 | 57.3% |
| Not confident | 54 | 31.0% | 15 | 25.9% | 69 | 29.7% | 67 | 31.5% |
| Totals | 174 | | 58 | | 232* | | 213 | |

*16 were not eligible to answer this question and a further 9 did not answer.

Overall 12.9% (30) were confident of obtaining their chosen post, 57.3% (133) were reasonably confident and 29.7% (69) were not confident. Males showed higher levels of confidence overall with 20.7% confident compared to only 10.3% of females. Only 25.9% of men were not confident compared to 31.0% of females.

When looking at those intending to be consultants only, confidence levels are broadly similar to the total cohort; however there appears to be a very slight fall in confidence. It is

of concern to the College that 67 (31.5%) of those intending to be consultants are not confident about obtaining that post.

Table 9 compares the cohort's confidence of obtaining their chosen post on completion of training at each stage of the cohort study. Table 10 shows the same information for those intending to be consultants only.

**Table 9: Confidence of obtaining chosen post compared with parts 1 and 2**

| | Part 1 (after 1 year) | | Part 2 (after 3 years) | | Part 3 (after 5 years) | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| Confident | 90 | 26.9% | 36 | 11.7% | 30 | 12.9% |
| Reasonably confident | 201 | 60.0% | 175 | 57.0% | 133 | 57.3% |
| Not confident | 44 | 13.1% | 96 | 31.3% | 69 | 29.7% |
| Totals | 335 | | 307 | | 232 | |

When looking at all respondents (Table 9), there has been a decrease in confidence in obtaining their chosen post since part 1; after part 1, 13.1% said they were not confident, in part 2 this rose to 31.3% and in part 3 it was 29.7%.

**Table 10: Change in confidence in obtaining a consultant post since part 1 (those intending to be consultants only)**

| | Part 1 (after 1 year) | | Part 2 (after 3 years) | | Part 3 (after 5 years) | |
|---|---|---|---|---|---|---|
| | No | % | No | % | No | % |
| Confident | 36 | 12.3% | 33 | 11.5% | 24 | 11.3% |
| Reasonably confident | 188 | 64.4% | 167 | 58.2% | 122 | 57.3% |
| Not confident | 68 | 23.3% | 87 | 30.3% | 67 | 31.5% |
| Total wishing to become consultant | 292 | | 287 | | 213 | |

There has been a statistically significant decrease in trainees' confidence of obtaining a consultant post between part 1 and part 3; after part 1, 23.3% said they were not confident of obtaining a consultant post, in part 2 this rose to 30.3% and was 31.5% in part 3 (Table 10).

Respondents were asked why they are not confident and were given choices as well as being able to provide other reasons. Of the 67 who stated they were not confident of obtaining a consultant post, 52 (77.6%) stated that there weren't enough consultant posts available or competition for posts was high. The remaining respondents cited a number of reasons, including needing further guidance on choice, the interview process, lack of exposure to interest, work life balance and that they wouldn't complete training.

Those who were not confident of obtaining their chosen post were asked whether they were looking for other options; 47 (68.1%) said they were, 21 (30.4%) said they were not, and one did not answer.

Figure 4 analyses confidence levels according to respondents' intended consultant job type.

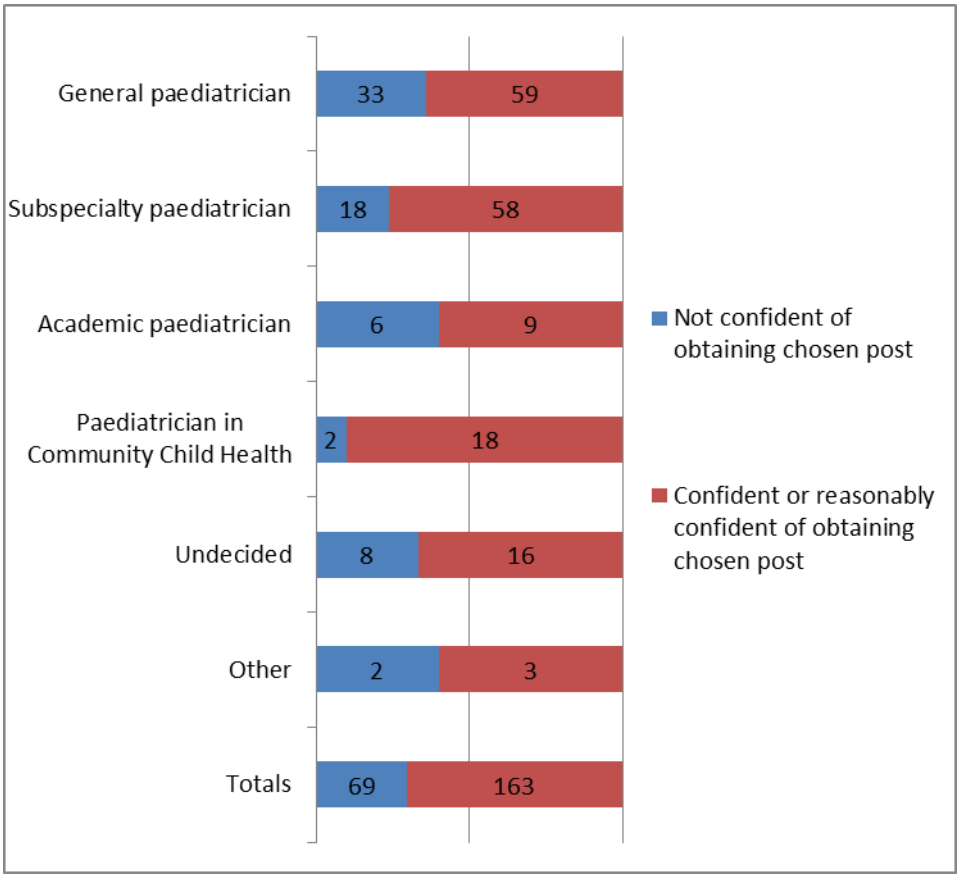



**Figure 4: Confidence of getting chosen post by type of consultant post intended**
*16 respondents were not eligible to answer this question and 9 did not respond.

Overall, 28.6% (69/232) were not confident of obtaining their chosen post (see Figure 4). Trainees intending to become academic paediatricians were least confident of obtaining their chosen post; 40.0% (6/15) stated they were not confident, followed by those intending to become general paediatricians (35.9% or 33/92). In comparison only 10.0% (2/20) of those intending to be paediatricians in community child health were not confident.

Table 11 shows that those who stated that they are not happy with their choice of paediatrics as a career considering work life balance were less likely to be confident of obtaining their chosen post (46.5% or 33/71 not confident) compared to those who are happy with their choice (22.3% or 35/157).

**Table 11: Confidence of obtaining chosen post by happiness with choosing paediatrics as a career**

| | Happy with choosing paediatrics as a career | | | | | |
|---|---|---|---|---|---|---|
| | Yes | | No | | Total | |
| | No. | % | No. | % | No. | % |
| Confident | 22 | 14.0% | 6 | 8.5% | 28 | 12.3% |
| Reasonably confident | 100 | 63.7% | 32 | 45.1% | 132 | 57.9% |
| Not confident | 35 | 22.3% | 33 | 46.5% | 68 | 29.8% |
| Total | 157 | 100.0% | 71 | 100.0% | 228 | 100.0% |

*16 respondents were not eligible to answer this question and a further 13 did not respond.

## Support and training time

Respondents who were training or working in paediatrics were asked how well they felt supported by seniors, whether they had protected teaching time and how much protected teaching time they had.

A five point scale ranging from totally to poorly supported was used to ask how well supported respondents felt from seniors and the response is shown in Figure 5.

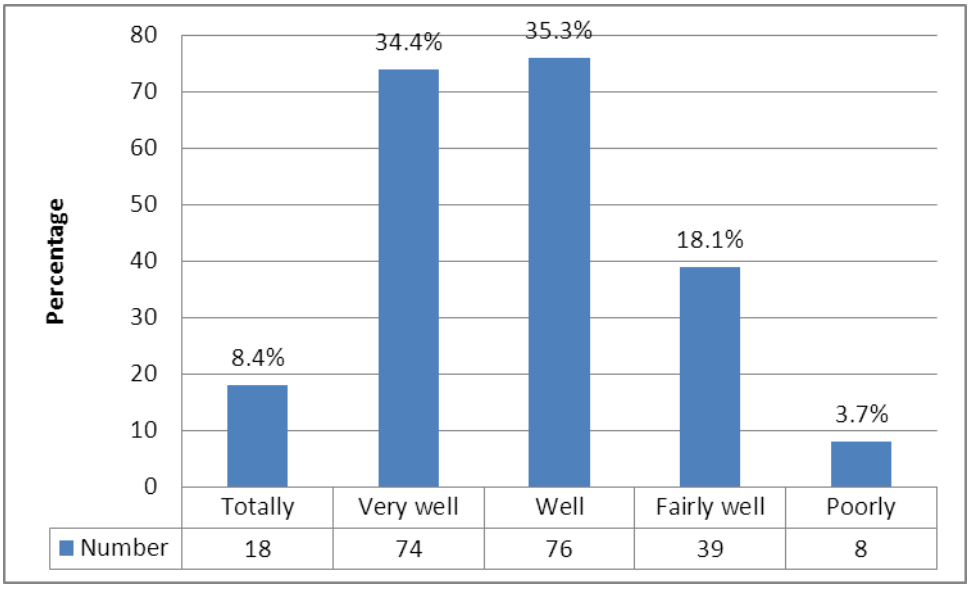



**Figure 5: How supported trainees felt by seniors in their training and development**
*26 did not answer question

It is reassuring to see that 78% of respondents felt that they were totally, very well or well supported in their training and development, and only 3.7% felt they were poorly supported (Figure 5).

It is useful to consider whether there is a relationship between support and confidence in obtaining a post and Table 12 provides that analysis.

**Table 12: How supported trainees felt by their seniors by how confident they were of obtaining their chosen post in paediatrics**

| | Confidence of obtaining chosen post | | | |
|---|---|---|---|---|
| How supported trainees felt by seniors | Confident | Reasonably confident | Not confident | Total |
| Totally (5) | 10 | 70 | 10 | 90 |
| Very well (4) | 36 | 192 | 68 | 296 |
| Well (3) | 36 | 129 | 63 | 228 |
| Fairly well (2) | 2 | 34 | 42 | 78 |
| Poorly (1) | 2 | 1 | 5 | 8 |
| Total | 86 | 426 | 188 | 700 |
| Average score | 3.31 | 3.46 | 2.85 | 3.26 |

*16 respondents were not required to answer this question and 26 did not answer.

A rank was given from 1 to 5 to each of the answer options to the question of support from seniors. This was multiplied by the number of respondents who were confident, reasonably or not confident, and averaged to see if support made a difference to confidence of obtaining their chosen post. The results suggest that respondents are more likely to be reasonably confident (3.46) or confident (3.31) than not confident (2.85) if they feel more supported by their seniors.

In consideration of trainees career development we asked a question to find out how many trainees have protected teaching time allocated in their job plans.

**Table 13: How much protected teaching time do you have?**

| Protected teaching time | No. | % |
|---|---|---|
| No protected teaching time | 93 | 43.3% |
| Less than an hour per week | 23 | 10.7% |
| An hour per week | 42 | 19.5% |
| More than an hour per week | 57 | 26.5% |
| Totals | 215* | |

*7 of those currently in training did not respond.

Table 13 shows that 43.3% (93/215) have no protected teaching time, 10.7% (23/215) have less than an hour per week, 19.5% (42/215) have an hour, and 26.5% (57/215) have more than an hour per week.

The number of respondents with little or no protected teaching time is of concern. . An average of 3 hours protected teaching time has historically been regarded as a "norm" for trainees and further work is required to assess the implications of this data.

Analysis was carried out on the question "Do you have protected teaching time?" by training deanery. In those deaneries with more than 10 respondents, the percentage who said they had protected teaching time varied from approximately 50% to almost 85%.

Table 14 looks at the relationship between the amount of protected teaching time per week and whether respondents are happy having chosen paediatrics as a career.

**Table 14: Happy with choosing paediatrics as a career by how much protected teaching time**

| | Considering current work life balance, happy with choosing paediatrics | | |
|---|---|---|---|
| Protected teaching time | Yes | No | Total |
| No protected teaching time | 56 | 37 | 93 |
| | 60.2% | 39.8% | |
| Less than an hour per week | 15 | 8 | 23 |
| | 65.2% | 34.8% | |
| An hour per week | 30 | 12 | 42 |
| | 71.4% | 28.6% | |
| More than an hour per week | 49 | 8 | 57 |
| | 86.0% | 14.0% | |
| Totals | 150 | 65 | 215* |
| | 69.8% | 30.2% | |

*7 of those currently in training did not respond.

There appears to be a relationship between the amount of protected teaching time and a trainee's happiness choosing paediatrics as a career. 86% of those that have more than an hour a week are happy with their career choice, compared to 60.2% of those who have no protected teaching time.

**Table 15: Protected teaching time by confidence in obtaining chosen post in paediatrics**

| | Confidence in obtaining chosen post in paediatrics | | | |
|---|---|---|---|---|
| Protected teaching time | Confident | Reasonably confident | Not confident | Total |
| No protected teaching time | 4 | 56 | 33 | 93 |
| | 4.3% | 60.2% | 35.5% | |
| Less than an hour per week | 2 | 11 | 10 | 23 |
| | 8.7% | 47.8% | 43.5% | |
| An hour per week | 6 | 27 | 9 | 42 |
| | 14.3% | 64.3% | 21.4% | |
| More than an hour per week | 14 | 29 | 14 | 57 |
| | 24.6% | 50.9% | 24.6% | |
| Totals | 26 | 123 | 66 | 215* |
| | 12.1% | 57.2% | 30.7% | |

*7 of those currently in training did not respond.

There is a relationship between protected teaching time and confidence in obtaining their chosen post in paediatrics; 64.5% of those with no protected teaching time are confident or reasonably confident, compared to 75.5% of those with more than an hour per week.

## Time taken out of training

Managing rotas in paediatrics has been reported as difficult by clinical directors in other RCPCH surveys, and trainees themselves often raise with the College that they have to provide cover for vacancies and absences. A further concern is time spent out of programme. As part of this study we asked the cohort if they have taken time out of training for any reason in the last 2 years.

**Table 16: Time taken out of training by gender**

| | Yes | No | Total |
|---|---|---|---|
| Female | 83 | 87 | 170 |
| | 48.8% | 51.2% | |
| Male | 19 | 37 | 56 |
| | 33.9% | 66.1% | |
| Total | 102 | 124 | 226* |
| | 45.1% | 54.9% | |

*16 respondents were not required to answer this question and 15 did not answer.

In total 102 (45.1%) respondents said that they had taken time out of training and 124 (54.9%) said they had not (Table 16). Females appear to be more likely to take time out of training; 48.8% compared to 33.9% of males.

37.3% (38/102) of those who said they had taken time out had done so for academic related activities and 60.8% (62/102) had done so for a career break, including maternity or sickness. Respondents could provide more than one answer or leave this question blank.

## 3.4 Geographic preferences

It is important for future workforce planning and in assessing the attractiveness of paediatrics as a career to consider trainees' geographic preferences when they complete their training. Respondents were therefore asked where they would like to work on completion of training and the results are analysed in Table 17.

**Table 17: Where would like to work on completion of training**

| Location preference | Females | Males | Total |
|---|---|---|---|
| UK | 162 | 46 | 208 |
| | 93.6% | 79.3% | 90.0% |
| Abroad | 11 | 12 | 23 |
| | 6.4% | 20.7% | 10.0% |
| Total | 173 | 58 | 231* |

*16 respondents were not eligible to answer this question and a further 10 did not respond.

The findings show that 208 (90.0%) of trainee doctors would prefer to stay in the UK and 23 (10.0%) would like to work abroad. The most favoured area abroad was Australasia, with 7/23 doctors wishing to work there on completion of training. 93.6% of females preferred to stay in the UK compared to 79.3% males. The overall proportion stating that they would like to work abroad on completion of training is roughly similar to the rate of attrition overseas observed in our post CCT surveys; 7.2% of the CCT class of 2010 and 10.2% of the CCT class of 2011/2012 were working abroad[vi],[vii].

The respondents who would prefer to work abroad were asked how long they intend to stay abroad i.e. whether this was a permanent or temporary, the data shows that 12 respondents who would like to work abroad intended to do so permanently and 11 would prefer to work abroad temporarily. Female doctors showed more of a preference for working abroad permanently (8/11) than males (4/12). In part 2, 18/35 wanted to work abroad permanently and 17/35 temporarily.

## Geographical constraints to obtaining consultant post

The cohort was asked whether their application for a consultant post will be limited due to geographical constraints and the findings by gender are shown in Figure 6.

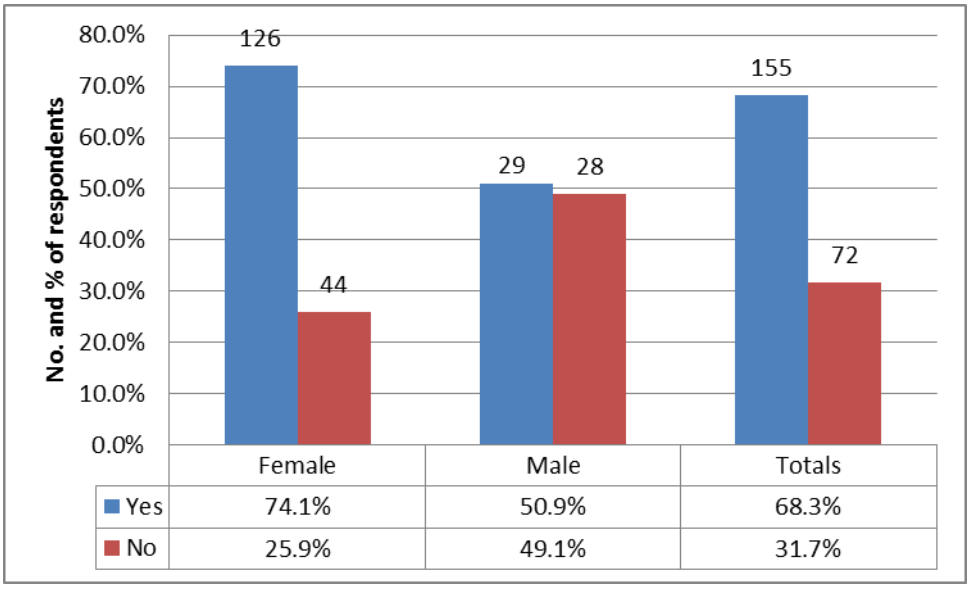



**Figure 6: Will your application for a consultant post be limited due to geographical constraints?**
*16 respondents were not eligible to answer this question and a further 14 did not respond.

Overall, similar numbers and proportions of doctors who have constraints in their training location have constraints when applying for consultant positions. 68.3% of the cohort says their application will be limited suggesting a certain lack of mobility for the future workforce. A higher proportion of females (74.1%) have constraints compared to 50.9% of males.

Those who stated their application for a consultant post will be limited were asked to select reasons why. They could provide more than one answer and also specify other reasons. The reasons provided are set out in Table 18.

**Table 18: Geographic constraints in applying for consultant post**

| | Total | % |
|---|---|---|
| My partner/spouse job is fixed to this area | 129 | 83.2% |
| I own a house | 103 | 66.5% |
| I like it here and my social network is in this area | 91 | 58.7% |
| My childcare is fixed to this area | 63 | 40.6% |
| I like my work place | 21 | 13.5% |
| My subspecialty position in different region | 10 | 6.5% |
| Other | 17 | 11.0% |

The breakdown of reasons provided are broadly similar to the constraints which restricted mobility in training with spouse's job, home ownership and the doctor's social network being the most common reasons. There doesn't appear to be a difference in perceived geographic constraints in applying for consultants posts in the future when broken down by gender.

## Geographical constraints to training programme

The cohort was asked whether their choice of training programme is limited due to geographical constraints and the findings by gender are shown in Figure 7.

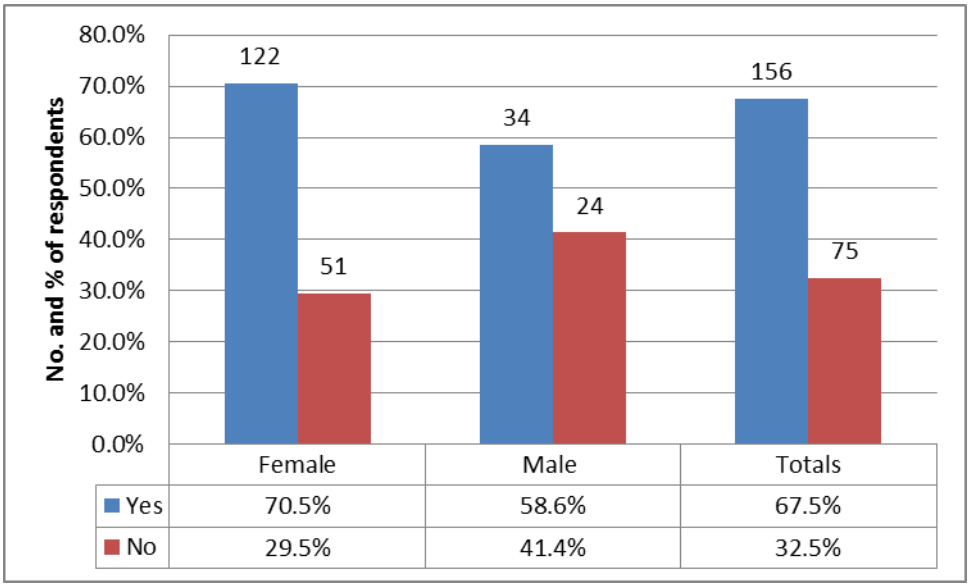



**Figure 7: Is choice of training programme limited due to geographical constraints?**
*16 respondents were not eligible to answer this question and a further 10 did not respond.

Figure 7 shows that 70.5% of females' choice was limited by geographical constraints while 58.6% of men were limited in the same way.

Those who stated their choice was limited were asked to select reasons why this was. They could provide more than one answer and also specify other reasons. The reasons provided are set out in Table 19.

**Table 19: Geographic constraints in regards to training programme**

| | Total | % |
|---|---|---|
| My partner/spouse job is fixed to this area | 120 | 76.9% |
| I own a house | 115 | 73.7% |
| I like it here and my social network is in this area | 88 | 56.4% |
| My childcare is fixed to this area | 70 | 44.9% |
| I like my work place | 23 | 14.7% |
| My subspecialty position in different region | 12 | 7.7% |
| Other | 14 | 9.0% |

The most common reasons relate to the jobs of the doctors' spouses and home ownership in a particular area. There doesn't appear to be a difference in geographic constraints to training programme when broken down by gender.

## Application for deanery transfer

Respondents were asked whether they had made an application for deanery transfer since starting their training (Table 20). 15.6% (40/257) had made an application for transfer, and of these 80.0% (32/40) were successful. When they were asked this question in part 2, 9% (29/315) had made an application, and 76% (22) were successful.

**Table 20: Application for deanery transfer**

**Made an application for inter-deanery transfer**

| | Number | % |
|---|---|---|
| Yes | 40 | 15.6% |
| No | 181 | 70.4% |
| No answer | 36 | 14.0% |

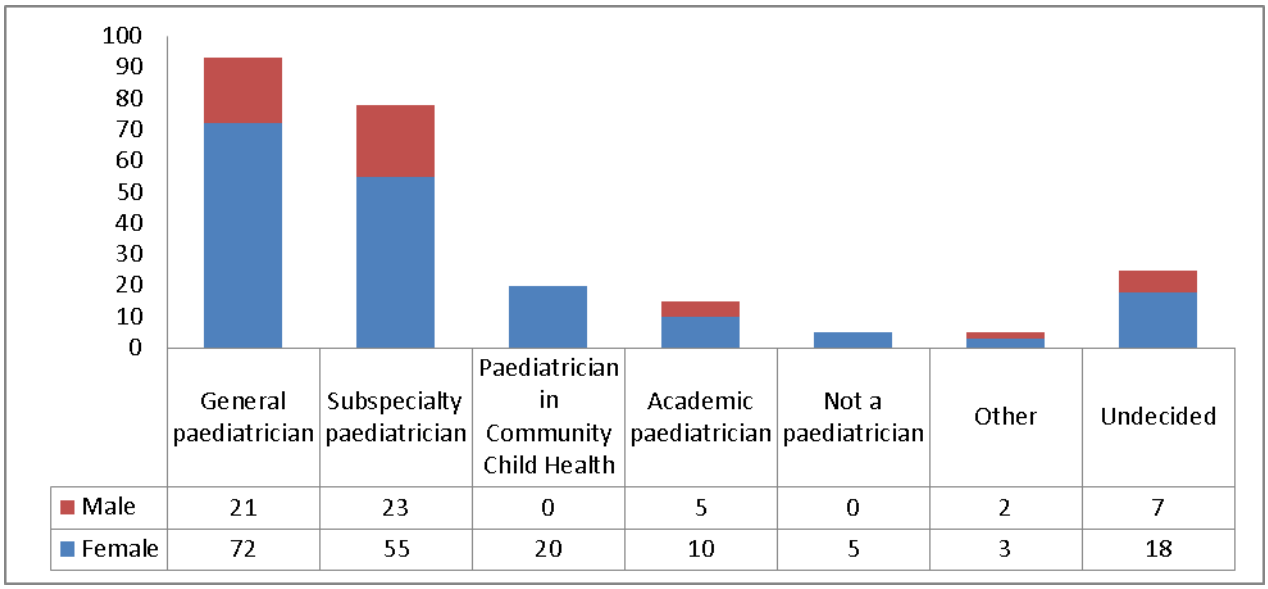
**If yes, was application for inter deanery transfer successful**

| | Number | % |
|---|---|---|
| Yes | 32 | 80% |
| No | 8 | 20% |
| Total | 40 | |

The number of unsuccessful applications was small at 8. These were spread across trainees working in 7 separate deaneries indicating that there are not any regional problems in regard to inter deanery transfer applications. It is reassuring that this is the case, and the national inter deanery transfer process, launched in April 2013, should make this process simpler for trainees.

## 3.5 Career intentions

The study asked respondents a series of questions about career intentions; the type of paediatrician they intended to be, subspecialty intentions and if they intend to be a consultant or a specialty doctor Figure 8 shows the response regarding the sort of paediatrician respondents intend to be by gender.




| | General paediatrician | Subspecialty paediatrician | Paediatrician in Community Child Health | Academic paediatrician | Not a paediatrician | Other | Undecided |
|---|---|---|---|---|---|---|---|
| Male | 21 | 23 | 0 | 5 | 0 | 2 | 7 |
| Female | 72 | 55 | 20 | 10 | 5 | 3 | 18 |

**Figure 8: Type of paediatrician intention by gender**

The largest proportion of respondents, 93 (38.6%) intend to be general paediatricians, 78 (32.4%) intend to be subspecialty paediatricians, 20 (8.2%) intend to be paediatricians in community child health and 15 (6.2%) academic paediatricians. 25 doctors (10.4%) are undecided and five do not intend to be paediatricians.

The graph shows that there were no males intending to be paediatricians in community child health, but that almost half of male respondents 28/58 (48.3%) intend to be subspecialty or academic paediatricians.

We asked about specialty intentions in both part 1 and part 2 of the study and the comparison with part 3 is shown in Table 21 to ascertain whether trainees' intentions have changed during the period of the study.

**Table 21: Type of paediatrician intention compared with parts 1 and 2**

| | Part 1 | % of cohort | Part 2 | % of cohort | Part 3 | % of cohort |
|---|---|---|---|---|---|---|
| Subspecialty paediatrician | 82 | 24.4% | 122 | 38.7% | 78 | 32.4% |
| General paediatrician | 169 | 50.3% | 81 | 25.7% | 93 | 38.6% |
| Paediatrician in community child health | 14 | 4.2% | 17 | 5.4% | 20 | 8.3% |
| Academic paediatrician | 17 | 5.0% | 11 | 3.5% | 15 | 6.2% |
| Combined - acute and community paediatrician | 18 | 5.4% | Not an option | | Not an option | |
| Other | 4 | 1.2% | Not an option | | 5 | 2.1% |
| Not a paediatrician | 6 | 1.8% | 2 | 0.6% | 5 | 2.1% |
| Undecided | 26 | 7.7% | 82 | 26.0% | 25 | 10.4% |
| Totals | 336 | | 315 | | 241* | |

*16 were not eligible to answer this question in part 3.

The data shows that trainees career intentions over the period of study have been far from consistent with the high number of respondents who were undecided at the end of ST3 having an impact on the figures. The percentage of trainees intending to be subspecialty paediatricians has risen since part 1, up to 32.4% from 24.4%, although it peaked at 38.7% in part 2. This may reflect the realities of the number of grid (subspecialty) training vacancies at the end of ST5. Those intending to be general paediatricians between parts 1 and 2 of the study from over half to 25.7% in part 2, but rose again to 93 (38.6%), perhaps again reflecting the availability of grid positions.

It is reassuring to note that the proportion intending to be community paediatricians has almost doubled since the cohort began from 4.2% to 8.3% in part 3. There has been a statistically significant decrease in the percentage of trainees who were undecided since part 2, from 26.0% to 10.4% in part 3. Of the 25 trainees who were undecided however, 24 did state a subspecialty that they had an interest in. Those preferences are listed in Table 22 and show a range of specialties which the undecided group are interested in

**Table 22: Special interest of those who were undecided on training subspecialty**

| Specialty | Number | % |
|---|---|---|
| Neonatology | 4 | 16.7% |
| Paediatric Emergency Medicine | 4 | 16.7% |
| Community Child Health | 2 | 8.3% |
| Paediatric Respiratory Medicine | 2 | 8.3% |
| Paediatric Infectious disease, allergy & immunology | 1 | 4.2% |
| Paediatric Intensive care Medicine | 1 | 4.2% |
| Paediatric Nephrology | 1 | 4.2% |
| Paediatric Neurology | 1 | 4.2% |
| Paediatric Oncology | 1 | 4.2% |
| Other | 1 | 4.2% |
| None | 6 | 25.0% |
| Total | 24* | 100% |

*1 person did not respond to this question.

## 3.6 Subspecialty intentions

Each of the 78 respondents who intend to be a subspecialist indicated which subspecialty they would like to work in and the breakdown according to gender is shown in Figure 9.

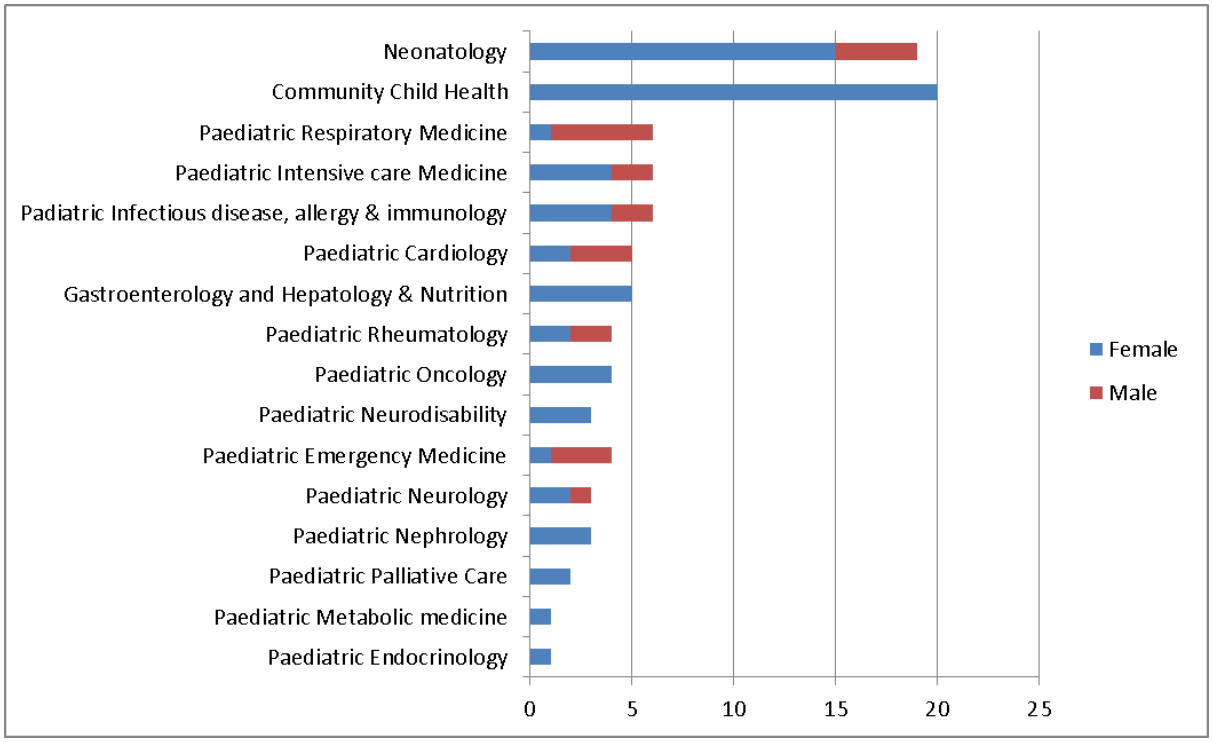



**Figure 9: Subspecialty intentions of those who intend to be paediatric subspecialists**

*6 respondents not included as they did not specify a subspecialty.

The largest proportions of those intending to be subspecialists plan to go into community child health with 20 (21.7%) and neonatology with 19 (20.7%). These are followed by 6.5% in paediatric respiratory medicine, paediatric intensive care medicine and paediatric infectious disease, allergy and immunology.

It is interesting to note that 5 members of the cohort wish to sub-specialise paediatric cardiology for which the training is under the auspices of the RCP.

As mentioned above, there are no male respondents who intend to specialise in community child health, and despite lower numbers overall, the majority of those intending to enter respiratory medicine, emergency medicine and cardiology are male.

A similar question was asked in the earlier parts of the study and a comparison of the response with parts 2 and 3 is shown in Table 23.

**Table 23: Subspecialty intentions compared with part 1, part 2 and part 3**

| | Type of Paediatrician Intended | | | | | |
|---|---|---|---|---|---|---|
| Subspecialty Intention | Subspecialty Intention (after part 1) | | Subspecialty Intention (after part 2) | | Subspecialty Intention (after part 3) | |
| | No. | % | No. | % | No. | % |
| Community Child Health | 14 | 4.0% | 17 | 4.8% | 20 | 7.8% |
| Neonatology | 29 | 8.2% | 36 | 10.2% | 19 | 7.4% |
| Oncology | 8 | 2.3% | 12 | 3.4% | 4 | 1.6% |
| Paediatric Cardiology | 12 | 3.4% | 11 | 3.1% | 5 | 1.9% |
| Gastroenterology, Hepatology & Nutrition | 6 | 1.7% | 10 | 2.8% | 5 | 1.9% |
| Infectious Disease, Allergy & Immunology | 4 | 1.1% | 8 | 2.3% | 6 | 2.3% |
| Intensive Care Medicine | 2 | 0.6% | 8 | 2.3% | 6 | 2.3% |
| Nephrology | 1 | 0.3% | 7 | 2.0% | 3 | 1.2% |
| Respiratory Medicine | 0 | 0.0% | 5 | 1.4% | 6 | 2.3% |
| Endocrinology | 5 | 1.4% | 5 | 1.4% | 1 | 0.4% |
| Accident and Emergency | 2 | 0.6% | 4 | 1.1% | 4 | 1.6% |
| Neurology | 0 | 0.0% | 3 | 0.8% | 3 | 1.2% |
| Rheumatology | 2 | 0.6% | 3 | 0.8% | 4 | 1.6% |
| Neurodisability | 0 | 0.0% | 3 | 0.8% | 3 | 1.2% |
| Palliative Care | 0 | 0.0% | 1 | 0.3% | 2 | 0.8% |
| Haematology | 1 | 0.3% | 0 | 0.0% | 0 | 0.0% |
| Dermatology | 2 | 0.6% | 0 | 0.0% | 0 | 0.0% |
| Child Mental Health | 1 | 0.3% | 0 | 0.0% | 0 | 0.0% |
| Metabolic Medicine | 0 | 0.0% | 0 | 0.0% | 1 | 0.4% |
| Other | 6 | 1.7% | 3 | 0.8% | 4 | 1.6% |
| Not Known | 1 | 0.3% | 3 | 0.8% | 2 | 0.8% |
| Total | 96 | 28.6% | 139 | 44.1% | 98 | 40.7% |
| Total training or working in paediatrics | 336 | | 315 | | 241 | |

The number of trainees specifying a subspecialty intention was 97 (37.7%) in part 3; a small fall since part 2 when 139 (39.4%) stated a subspecialty intention, but an increase on part 1 when the figure was 96 (27.3%). The number of trainees with subspecialty intentions for community child health has increased from 17 (4.8%) in part 2 to 20 (7.8%) in part 3 whilst those intending to have neonatology as a subspecialty has decreased from 36 (10.2%) in part 2 to 19 (7.4%) in part 3.

In Table 24 the broad career intentions of the cohort i.e. whether they intend to work in general, community, academic or subspecialty paediatrics is compared with the breakdown of the consultant workforce recorded in the 2011 RCPCH Census. Cohort study respondents who were undecided (66) or stated "Not a Paediatrician" have been omitted.

**Table 24: How career intentions match job availability**

| | ST5 cohort | Consultants 2011 |
|---|---|---|
| Academic paediatrician | 15 | 156 |
| | 7.3% | 4.6% |
| General paediatrician | 93 | 1381 |
| | 45.1% | 40.4% |
| Paediatrician in Community Child Health | 20 | 675 |
| | 9.7% | 19.7% |
| Subspecialty paediatrician | 78 | 1206 |
| | 37.9% | 35.3% |
| Totals | 206 | 3418 |

There appears to be a mismatch between the cohort and the current breakdown of consultant positions in terms of proportions intending to be different sorts of paediatricians. There is for example a potential oversupply in those intending to be general paediatricians (4.7%) and a potential shortfall in community paediatricians (-10%).

The proportion intending to be subspecialty paediatricians is roughly similar to that of the overall consultant workforce. There has been an increase in the proportion intending to be community paediatricians since part 2 when 7.4% (17/231) intended to take this route.

The study has continued to ask if the cohort intend to be consultants or specialty doctors in the future and Table 25 provides a breakdown of the responses received which shows most but not all doctors in the cohort intend to be consultants.

**Table 25: Percentage intending to be paediatric consultants and specialty doctors in future**

| | Part1 | | Part 2 | | Part 3 | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| Consultant | 302 | 85.8% | 287 | 91.1% | 213 | 85.9% |
| Specialty Doctor | 4 | 1.2% | 9 | 2.9% | 10 | 4.0% |
| Other | 30 | 8.5% | 0 | 0.0% | 0 | 0.0% |
| Not stated | 16 | 4.5% | 7 | 2.2% | 25 | 10.1% |
| Unsure | 0 | 0.0% | 12 | 3.8% | 0 | 0.0% |
| Totals | 352 | | 315 | | 257 | |

Of those still in paediatrics, 85.9% intend to be consultants, 4.0% intend to be specialty doctors and a large amount - 10.1% are unsure or did not state an intention.

## 3.7 Resident shift working

Paediatrics is, by its nature, a 24/7 service and the RCPCH advocates a consultant delivered care (CDC) model defined as a service where the consultant is clinically responsible for the care received by the patient throughout the treatment course, either through hands on care or close supervision in the clinical setting of all aspects of care. This may involve consultant working resident shifts outside of the normal working day, i.e. at night, during the evenings and at weekends.

The College's report Consultant Delivered Care: An evaluation of new ways of working in paediatrics[viii], which looks in detail at the application of this model in various guises in a number of trusts, the reports by the Academy of Medical Royal Colleges[ix,x], Sir Bruce Keogh's review of urgent and emergency services[xi] and the outcomes from the Francis inquiry are key drivers for ensuring high quality care.

We know from our follow-ups of paediatric CCT holders from 2011 and 2012 that over a fifth are in consultant posts where they work resident shifts (average 2.86 PAs). Against this backdrop members of the cohort were asked a series of questions about their views on resident shift working for consultants. Table 26 considers respondents' expectation of working resident shifts following training according to whether they have worked in a unit where consultants do resident shifts.

**Table 26: Expectations of resident shift working against experience of working in a unit with resident shift working consultants**

| Expect to work resident shifts after completing training | Worked in a unit where consultants do resident shift work | | Total |
|---|---|---|---|
| | Yes | No | |
| Yes | 38 | 75 | 113 |
| | 63.3% | 45.2% | 50.0% |
| No | 22 | 91 | 113 |
| | 36.7% | 54.8% | 50.0% |
| Total | 60 | 166 | 226* |

*15 did not respond and a further 16 were not eligible for this question

Table 26 shows 50.0% expect to be working resident shifts after they have completed training and 63.3% of trainees who have worked in a unit where consultants do resident shift work expect to do so, compared to 45.2% of those who have not worked in a unit where consultants work resident shift work. Trainees' expectations appear to be determined by their experience of service delivery models.

Respondents were asked to rank a series of options for resident shift working in their consultant post; the results are shown in Table 27.

**Table 27: Ranking of options for consultant resident shift working**

| Resident shift working option* | Accept consultant post on this basis | | | | | | | | | | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Very happy to accept | | Reasonably happy to accept | | Unsure about accepting | | Reluctantly accept | | Would not accept under any circumstances | | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Option 1 | 182 | 82.0% | 20 | 9.0% | 10 | 4.5% | 1 | 0.5% | 9 | 4.1% | 222 |
| Option 2 | 74 | 33.6% | 79 | 35.9% | 29 | 13.2% | 25 | 11.4% | 13 | 5.9% | 220 |
| Option 3 | 11 | 5.0% | 68 | 30.6% | 59 | 26.6% | 48 | 21.6% | 36 | 16.2% | 222 |
| Option 4 | 18 | 8.1% | 71 | 32.1% | 49 | 22.2% | 53 | 24.0% | 30 | 13.6% | 221 |
| Option 5 | 5 | 2.2% | 10 | 4.5% | 36 | 16.1% | 70 | 31.4% | 102 | 45.7% | 223 |

Option 1: No resident shifts in contract.
Option 2: RSW involves twilight (up to 10 pm) shifts and/or some weekend working (no nights) with a move to a phased career option to be non-resident in later career.
Option 3: RSW involves twilight (up to 10 pm) shifts and/or some weekend working (no nights) with no phased career options.
Option 4: RSW involves working day, twilight and some night resident shifts with a move to a phased career option to be non-resident in later career.
Option 5: RSW involves working day, twilight and some night resident shifts with no phased career options.

Apart from an option which involves no resident shifts in their contracts (82.0% would be very happy to accept), a scenario where consultants do twilight shifts and weekend working with a move to a phased career later on is most popular with respondents – 69.5% of respondents would be very or reasonably happy to accept this way of working. The least popular way of working was day, twilight and some night resident shifts with no phased career options; 45.7% of respondents would not accept this option under any circumstances.

In addition to respondents' views about personally working resident shifts, we also asked whether they believe that resident shift working provides a better quality service. The results are analysed in Table 28 according to whether trainees have worked in a unit where consultants do resident shifts.

**Table 28: Does resident shift working provide better quality service by experience of working with resident shift working consultants.**

| Worked in a unit where consultants do resident shift work | Does resident shift working provide better quality service? | | | Total |
|---|---|---|---|---|
| | Yes | No | Don't know | |
| Yes | 31 | 12 | 16 | 59 |
| | 52.5% | 20.3% | 27.1% | |
| No | 61 | 35 | 69 | 165 |
| | 37.0% | 21.2% | 41.8% | |
| Total | 92 | 47 | 85 | 224* |
| | 41.1% | 21.0% | 37.9% | |

*17 did not respond and a further 16 were not eligible for this question.

Overall 41.1% of respondents agreed that resident shift working provided better quality service, rising to 52.5% when respondents could see the effect first hand in units where consultants are doing resident shift work. A significant proportion, 37.9% (85/224) are undecided as to whether resident shift working provides a better quality service. This

indicates that more work is required to inform trainees and advocate for consultant delivered care amongst the future consultant population.

Respondents were asked whether they thought resident shift working is sustainable in the long term (Table 29).

**Table 29: Is resident shift working sustainable in the long term?**

| | Number | % |
|---|---|---|
| Yes | 32 | 14.3% |
| No | 132 | 58.9% |
| Don't know | 60 | 26.8% |
| Totals | 224* | 100% |

*17 did not respond and a further 16 were not eligible for this question.

58.9% of respondents do not think that resident shift working is sustainable in the long term. This could be interpreted as sustainability on a personal level as a consultant moves through their career, or at a service level. The sustainability of the model is clearly dependent on the option that is adopted, and the College is in agreement that full resident shifts throughout a consultant's career are not sustainable. The sustainability of resident shift working also depends on the whole system of care being adapted to this way of working to ensure that training is maintained to a high level.

# 4. Discussion

After part two of the study, we raised several issues arising from the data including:-

- The College's concern that the 15% attrition rate for specialty trainees (STs) over the first three years of the cohort's training had significant implications for workforce planning in paediatrics.
- That 28% of STs had reservations about choosing paediatrics with the two most common reasons stated as a poor work life balance and the intense on-call commitments.
- The apparent mismatch between the type of post trainees aspire to and the roles that exist within the consultant workforce. The survey revealed the limited exposure that trainees have to community paediatrics early in their training career– only 4.7% of their rotations in ST1-3. This may be a factor influencing future choice of subspecialty.
- That over the first two years of this survey there has been a marked decrease in the trainees confidence in obtaining a consultant post with 11.5% stating that they were confident (fallen 0.8% since ST1) and 30.3% stating that they were not confident (an increase of 7% since ST1).

Many of these themes continue in the findings and implication from part 3 of the study. The following brief summary looks at these topics and where possible draws some recommendations for action either by the College or by the wider stakeholder group of those involved in and responsible for commissioning and delivery of paediatric training and paediatric services.

### Attrition from training

Movement of paediatric trainees outside of the UK is fairly small (about 6.2% of this cohort now works abroad) but overall the study shows that attrition from training is estimated at 4.6% per year between ST3 and ST5. This is in addition to the 5% rate recorded between ST1 and ST3 in part 2 of this study. Applying these attrition rates to the original starting cohort of 440 trainees implies that around 100 are no longer in training. It is difficult to project forward for the final 3 years of training when it would be expected that attrition rates will fall, but it is clear that workforce planning must take account of the substantial numbers who leave training or who have not completed training within 8 years.

This finding has implications for workforce planning; The Centre for Workforce Intelligence (CfWI) uses a 1% per annum assumption for attrition in its workforce models to calculate demand for consultant posts in England. The College's data infers that this may give an overestimate of completed CCTs.

The majority of those leaving paediatrics to train in another specialty continue to move into general practice. The College is keen to increase the level of paediatric expertise in the general practice workforce, and retaining the skills and interest in paediatrics of these doctors is important.

Recommendations

- RCPCH to disseminate its findings on attrition rates widely, particularly to bodies responsible for workforce planning – HEE, CfWI, LETBs and Deaneries in England, Scottish, Welsh and Northern Irish assemblies with a request that these bodies formally liaise with the College on paediatric workforce modelling.
- RCPCH carry out further research to investigate the causes of attrition among trainees to establish whether it shows variance with other specialties or other fundamental reasons. The findings to be used to support trainees who are

considering leaving training and to consider ways of reducing attrition rates where possible.

### Time out of training.

In part 3 we looked at the whether trainees had taken time out and 45.1% of the cohort has done so in the last 2 years. It is clear that such an "absentee" rate will have a large impact on rota managers to design safe service. Career breaks including maternity are a large part of this absence. The cohort in this study has fewer women than those currently entering paediatric training where the proportion of trainees is around 70% female. It is a reasonable assumption, given the gender and age of paediatric trainees, that maternity leave will continue to have a significant impact on maintenance of paediatric rotas alongside other career breaks.

Recommendations

- Deaneries/LETBs to increase available training slots to reflect the proportion of future consultants in their region where appropriate.
- At Deanery/LETB level more flexible rotations to be planned so that number of NTNs can be spread evenly throughout a region and individual units are not burdened by having to employ disproportionate amount of locums.

### Less than full time working

Although 50% of this cohort state that they wish to work less than full time (LTFT) when they complete their training, a similar position to when they were surveyed at the end of part 2, the proportion of the trainees in the cohort who work LTFT is similar to the overall consultant workforce. It is clear that LTFT roles are becoming more sought after, but it is arguable that trusts/employers need to create more LTFT opportunities to meet expected demand. We did receive comments from some of those who had left paediatrics at the end of ST3 that paediatrics was not particular family friendly and that career options for women were being limited.

Recommendations

- Disseminate the data in this report regarding demand for less than full time working to the College's LTFT officer for her comments and recommendations.
- Ensure each deanery has method of giving or signposting to advice for those considering LTFT working.

### Intentions to work in Community Child Health

It is encouraging that more time is spent on community rotations at this stage of the study; this is reflected in an increase in those who intend to be community paediatricians. However, we know that there are still not currently enough CCT holders with CCH to sustain this part of the workforce.

Recommendation

- Ensure engagement occurs between the Community Child Health CSAC and the College (plus BACCH) to ensure adequate grid training opportunities are created to sustain the future workforce for non-acute care, which should go hand-in-hand with collaborating with BACCH on workforce modelling for CCH.

### Subspecialty intentions of the cohort

Overall, it is clear that the percentage wanting to be subspecialists is becoming more realistic, given the numbers of specialists who obtain CCT each year which in itself is a function of those being accepted for grid training. 32.4% want to be subspecialist and 8.3% community paediatricians. This compares with our knowledge from the RCPCH CCT follow up survey that around 36.3% of new holders in 2011 and 2012 had a subspecialty registration.

Recommendation

- Improvements in more people wanting to do CCH as above, but College must work to increase numbers pursuing these careers. Consideration should be given to promoting these careers to men, otherwise there is a danger that this is seen as female only specialty.

### Confidence of cohort when working at ST3

When asked whether they were confident of working at middle grade level when working at ST3, there is a high response with very few trainees saying they were not confident. It is important to note that confidence does not necessarily equal quality and safety, and the College recognise through its Facing the Future standards that where the highest grade on a middle grade rota is ST3, there needs to be more regular review. Back to Facing the Future, the College's audit of Facing the Future standards, found that if a child was first seen by an ST3 rather than ST4 or above, there was no difference to how soon the child was subsequently seen by a consultant[xii].

Recommendation

- Consultants and managers need to be cautious about conflating confidence with competence and ensure that when planning rota cover and presence on the ward, Facing the Future standards are adhered to.

### Confidence of obtaining a consultant post

The proportion of the cohort which was not confident of obtaining a consultant post rose slightly between parts 2 and 3. We also asked how well trainees felt they were supported by their seniors and very few responded that they were poorly supported. We did find however that those who were more confident felt more supported by their seniors and vice versa those lacking in confidence about obtaining a consultant post on average felt less supported. We also found that confidence was higher for those who want to do CCH or subspecialties as against general or academic paediatrics.

Recommendations

- Make members aware of the findings regarding confidence and support from seniors, and possibly amend paediatrician's handbook. Use findings to stress to employers' the importance of supervision, teaching and training time in consultant contracts and the need to allow for this time through SPAs.
- Explore ways of increasing access to career guidance and information during training.

### Protected teaching time

The study shows that 43.3% of the cohort has reported that they do not have protected teaching time, and that only 26.5% report having more than one hour. There are no absolute standards for protected teaching time, although there has been consensus that 3 hours per week is good practice and many paediatric regions aim for this. The data also

indicates that more protected teaching time maps onto higher levels of happiness and confidence amongst trainees.

Recommendations

- Work with colleagues responsible for education and training/college tutors to triangulate the findings around the amount of protected teaching time to ensure the response to the survey is not due to misunderstanding of the questions.
- If findings are corroborated, the College should work towards ensuring appropriate teaching time is promoted via the tutor network in trusts and deaneries, and consider developing a College standard or guideline and/or including this in the paediatric guidance checklist or the paediatricians' handbook.

### Resident shift working

There is growing acceptance from trainees that resident shift working (RSW) is to be expected once training is complete and there is a majority view that it provides a better quality service. However, respondents displayed some ambiguity about whether RSW is sustainable in the long term. Almost 59% said it was unsustainable, but it could be interpreted that trainees were thinking about this in terms of their own career i.e. it would be unsustainable to work regular RSW throughout their career, rather than the sustainability of the model of care.

Recommendations

- The College should continue to work collaboratively with trainees to examine the risks and benefits of RSW and to clarify why there is a need for this way of working given the workforce planning imperatives i.e. with fewer trainees in future and the need to protect training time; resident shift working will be part of the solution to sustain safe services. This should include further promotion of RSW models in practice.
- The College will continue to support the development of career portfolios and long term job planning for the individual doctor, and team job planning for the service. Resident shift working needs to be part of the overall service design with built in flexibility for doctors to change their job plans as they progress through their careers.
- To take forward recommendations in the College's workforce strategy to ensure there is the right workforce based on the right model of care, which truly engages children, young people and their parents and carers, from the point of design through implementation, and with on-going evaluation.

### Geography

10% of trainees wish to go abroad. This is close to reality for CCT holders as we have found in our CCT follow up survey. This factor needs to be used for calculating demand in workforce planning models. There are several constraints particularly for women in looking for consultant posts and as the workforce becomes increasingly feminised, training places should more closely match expected consultant posts in each area.

Recommendations

- That data about attrition and movement is highlighted to HEE, CfWI and other national workforce planners when we disseminate. It is also important for CCGs to know the level of attrition overseas.
- RCPCH to continue to monitor levels of attrition and movement in future surveys.

# 5. References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