NHS England postgraduate medical training review 2025

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

1. Introduction

The College

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians, raising professional standards and informing research and policy. RCPCH has over 24,000 members in the UK and internationally. We work to transform child health through knowledge, research, advocacy and expertise, to improve the health and wellbeing of infants, children and young people across the world.

Within training we are responsible for:

- Developing the curriculum and related assessments for paediatricians in consultation with our members and stakeholders.
- Developing, delivering and standard setting the globally respected national paediatric examinations.
- Advising national recruitment standards and running subspecialty recruitment.
- Managing networks and ongoing support for our Postgraduate Doctors in Training (PGDiT), trainers, SAS doctors, subspecialty areas, and for Heads of the Schools of Paediatrics.
- helping to quality assure aspects of training through certification, portfolio pathway, and arranging external input to ARCPs.
- Running the assessment ePortfolio.
- Developing high quality evidence based educational resources (courses, e-learning, podcasts) to support wider learning.
- Developing curricula and capability frameworks for related areas of training, including medical schools and Advanced Practitioners.

Paediatrics

Whilst defined as a specialty, paediatrics in reality is a population group with the need to train doctors in generalist skills across all of medicine for children and young people (CYP). Defined as subspecialties, we are also responsible for 18 areas of specialist practice, including areas as diverse as Paediatric Intensive Care Medicine and Neonatal Medicine.

The paediatric workforce

The paediatric workforce provides expert care for an age group that makes up **25%** of the total population but 100% of our future, and child health conditions have long-term consequences for adult care. There is an average 20% deficit in the number of resident paediatric doctors on Tier 1 and Tier 2 rotas, and evidence shows they are increasingly overworked and burnt out. An overstretched service will always struggle to provide good quality training.

This year, applications to join the paediatrics training pathway surged but only 25% were offered an interview, an issue that is increasing each year. With a system where waiting lists are a persistent reminder that need is outstripping supply, training the child health workforce requires a whole system approach to workforce planning. Not only do we need to retain the vital senior educator and decision-making workforce, but also succession plan, deploy efficiently and plan required expansion to ensure standards continue to be met in the future.

The moral and economic reasons for prioritisation of the health of CYP are clear[1] , our moral obligation to promote children's health is within UK law and in the UN Convention on the Rights of the Child. Implementation of transformational change in the NHS will require substantial job planning and training to facilitate new ways for working, and it is essential that CYP and the workforce that supports them are not lost in considerations for adult medicine.

2. A listening exercise: What our communities think

Principle 1: Listening to PGDiTs and doctors who train

We have organised our submission based around 6 principles that we would expect to see from a medical training review that plans to make a tangible difference to PGDiTs, their trainers, and, most importantly, their patients. This requires a holistic review that covers recruitment, training and assessment, employment, workforce and patients.

As a member organisation, the RCPCH is in a continual listening exercise with its members, as well as our patients, and that has developed our response here. We are always careful to ensure wide, diverse and inclusive input into our voice as a college and represent that voice transparently and fairly – we would expect this national training review to do the same.

As part of our continual listening work, we are already aware of the immediate issues with training in paediatrics. Some of these we are empowered to recommend to the regulator as changes to our curriculum and assessments, but a number sit beyond our remit.

We have therefore included quotations direct from our members as part of our consultation for this submission and from previous related work.

Principle 2: Make the review's driving ethos to provide high quality training that prioritises safe patient care

"Training programmes should be seen as integral to delivery of quality services to the population, not a separate entity. Training is not a stepping stone to a career it is the career, and every type of doctor role is important."
Consultant

The position of learning within the current NHS

When the medical training review was announced, as a college representing its members, we were enthusiastic about the opportunity for what are often perennial problems to be heard and addressed. Our concern after the announcement is how much financial savings will be the unseen driver behind this work. We therefore call strongly upon NHS England and the Department of Health and Social Care to ensure that high quality training that prioritises safe patient care remains the driving ethos of the learning from this review.

1 Viner R M. NHS must prioritise health of children and young people BMJ 2018; 360 :k1116 doi:10.1136/bmj.k1116

Training programmes have many purposes including providing an effective learning experience for PGDiTs, allowing career flexibility, but also, and essentially, ensuring that safe and effective patient practice remains at its heart.

The NHS, like the government, has the benefit of a separation of powers across training. The part of the system, Royal Colleges, that define safe, effective and high-quality training and examinations, are separate from the parts of the system that are concerned about ensuring the rapid throughput of doctors. The benefit of this dual relationship is that there is a healthy conversation between, on one side, safety and quality, and on the other, immediate workforce needs and priorities.

However, there has been a slow but concerningly steady decline in the position of training/education within the NHS over the last 20 years. Training is now too often seen as a system luxury, or considered as notionally independent from the service realities that often impact upon it. There is often no consideration of the time and space required to train and feedback to effectively deliver this training. We explore some of this in the next section of this submission.

Changes in training and assessment

The RCPCH has been a system leader in curricula and assessments, with our Progress curriculum (2018) being the first to convert to the GMC's new holistic Excellence By Design structure and then Progress+ (2023) being one of the few curricula that brought in principles from the Shape of Training review, including reducing the indicative length of training. A forward-thinking assessment review is already in development at the RCPCH considering a more holistic assessment strategy for the specialty, including a focus on reducing the burden of assessment. The consequence of all the above is the Progress+ curriculum is already designed as a flexible foundation for an inclusive and broad training programme.

"The core skills of clinical decision making and disease management are best learnt at bedside. There has been a significant decline in bedside teaching in paediatrics due to the conflicting demands on the clinician which then significantly impacts training and trainees experience, especially in District General Hospitals (DGH). It has been increasingly challenging to deliver a structured educational programme locally at the deanery level due to lack of allocated supporting professional activities (SPA) time for clinicians to commit to postgraduate teaching."
Consultant

There is, however, considerable regional and local variation in how the curriculum is managed and delivered:

- Restrictions on administration recruitment in NHSE has limited the ability of regional administration teams to support the delivery of core activities in relation to ARCP and rotational planning. This has increased the burden of work for Training Programme Directors (TPDs) and Head of Schools (HoS) and thereby reduced their ability to further innovate delivery of paediatric specific regional training and focus on measures to improve wellbeing in training. This can be seen by GMC NTS survey results for example in Yorkshire and Humber in relation to regional specialty specific teaching.

- Whilst there are many benefits to the longitudinal supervision recommended by paediatric training (including ongoing pastoral support), it has been variable in implementation. Often placement clinical supervisors are not allocated job plan time for their work. Longitudinal supervisors are also often not allocated job plan time when their PGDiTs rotate away from their hospital, further disincentivising its implementation.

- There is a high burden of supervision placed on paediatric consultants particularly in DGH settings where they can be asked to provide clinical supervision +/- educational supervision to in excess of 4 PGDiTs and potentially other roles, such as Locally Employed Doctors (LEDs) and Advanced Clinical Practitioners (ACPs) without protected/allocated time in their job plans. .

- The shortening of the paediatric training programme means that PGDiTs are stepping up to Tier 2 duties with less clinical experience. Therefore, it is essential that they receive high quality direct clinical supervision to ensure that they have the competencies to be able to take on this responsibility at an earlier stage in their training programme. This increased burden of supervision and assessment that falls on the consultant team needs to be valued with recognised time to train.

Over the last 5 years, there has also been a more than doubling of the number of doctors who wish to work and train less than full time and consequent increase in the number of doctors in the training programme at any one time. Despite this increase, the curriculum delivery budget has remained static. These doctors still need to be able to recertify their life support skills with the same frequency as full-time PGDiTs and still need the same access to study leave both mandatory and discretionary.

The view of children and young people (CYP)

We also co-ordinate 'RCPCH &Us', a network for children, young people, parents and carers that actively seeks and shares their views to influence and shape training, policy and practice. We have included some examples from our CYP voice bank below about what children want to see from their paediatricians in training.

Children and young people have shared with us what matters to them in the way that doctors interact with them. They shared views on wanting to feel listened to and trusted as experts in their own experience, having doctors that show empathy and who can communicate well with children and young people of different ages and development stages:

> ***Train staff not to assume that just because we are young, everything is okay physically. Stopping signs early prevents bigger problems as we age.***
>
> ***I think many people in the NHS need to be trained better to work with people with learning disabilities and autism.***
>
> ***Have people that are trained to talk to the youth that struggle with anxiety/stress.***
>
> ***Include children in all decisions made on their health, communicate well and offer support. All staff should be patient and understanding to make it as least stressful as possible and should be trained to deal with kids who may have mental or physical needs***
>
> **RCPCH &Us advocates**

It is vital that CYP continue to have the right paediatricians to care for them. As part of RCPCH Paediatrics 2040, over 3,000 CYP views were captured to share their hopes for supporting the best possible paediatric services and staff of the future. They were asked: "what knowledge, skills and attitudes do doctors need when working with children and young people?" The top three themes were:

- Good medical conduct – be respectful, kind, supportive and friendly
- Be professional, open-minded and aware of different experiences
- Communication – be empathetic, understanding and actively listen

> ***We also want paediatricians to have experience in working with a range of children and young people during their training. It would be great if paediatric services link with other services such as schools, play and youth workers and other professionals to support us.***
>
> ***Keep doctors human***
>
> **RCPCH &Us advocates**

3 Training, support and employment

"The curricula and assessment structure tries to ensure doctors at the same level of training have the same capabilities, and it helps trainers know what to expect of their trainee. It is always a balance, and current systems would work a lot better with continuity of trainees and adequate time to supervise and train them. We've spent a lot of time changing curricula, when the environment that curricula is delivered in is equally if not more important."
Consultant

Principle 3: Consider the areas that take time away from being a doctor

From our work with our members, most specifically our PGDiT members, we have heard for many years how many small and medium issues, usually related to aspects of employment, impact training by taking time away from training experiences or by adding layers of stress that could otherwise be avoided. We summarise some of these recurrent issues below. We are aware that the Workforce Improvement Directorate of NHS England was looking at some of these areas, and hope that work will not be lost during the transition to DHSC.

- **Payroll:** PGDiTs have multiple issues with payroll. These include payroll delays, being paid incorrectly (especially for those who are less than full time training (LTFT)) and mistakes made on tax codes. These add complex administrative issues for them to try and resolve, and it can take many months until they are paid correctly. Due to rotational training, they are often navigating this again every 6 months.
- **Lead employer:** Unlike in Scotland and Wales, England is still largely without a lead employer model. This model can significantly simplify the employee burden on PGDiTs and contributes to issues like payroll errors.
- **Rotations:** Whilst there are some benefits to a rotational model for experience, rotational changes can be too frequent and planned without much notice for the tumult it can cause to a PGDiT's personal life (childcare, travel costs, time lost commuting etc.).
- **Facilities:** Hospitals are now often without basic facilities and resources that make the workplace of PGDiTs hospitable and conducive to wellbeing. This includes a lack of access to hot food (or in many cases, any kind of food), lockers to store personal belongings, and decent sleep facilities for long shifts.
- **Study leave:** Study leave, an essential component of allowing doctors to both achieve basic learning requirements and to allow their careers to flourish, is offered variably between

hospitals and deaneries. There is often a considerable delay between payment of courses and reimbursement.

- **Deanery staff:** Deanery staff numbers have declined following multiple downsizing plans across HEE and then NHSE. The feedback from our PGDiT members and the experience of an increase in calls to our training teams indicates that deanery staff can be unable to give PGDiTs timely support for areas such as ARCPs, rotations, placements and other general training queries. National Recruitment Offices have experienced the same staff reductions or freezes, providing often delayed or even poor support to PGDiTs as they move from foundation to core/specialist training. It has also contributed to a growing number of mistakes made across national recruitment processes.
- **Deanery clinical leads:** The lack of resourcing has spread to key clinical leadership roles, including Training Programme Directors, who are not recruited in a timely fashion or at all.

"Lack of lockers for PGDiTs communicates that they are not a valued part of the team. The jobs where there has been sufficient space for PGDiTs to store their bags, coats and food safely have been few."'
PGDiT

"The stress around HR and pay services that PGDiTs go through with each rotation is significant and, again, feels unnecessary. If one body could hold our details and be our consistent employers, it would reduce many, many hours of stress and time on the phone trying to get through to HR +/- pay services to sort out errors such as not getting paid in the first month of a new job."
PGDiT

"Rotas arriving late means it is hard to plan life which again causes unnecessary stress and has a negative impact on wellbeing. Late arriving rotas particularly impacts on the ability to organise appropriate childcare or plan/book family holidays and/or celebrations for significant life events."
PGDiT

"From an employer perspective, rotational training makes it very difficult to plan our service. Sometime we get very little notice of who is coming to work with us, and even then, we might not know how long for. This makes planning for their training needs very difficult. Continuity of trainees would really help with this."
Consultant

In 2024, the RCPCH published rostering guidance for PGDiTs in England. Our guidance explains rota design and rostering best practice for specialty PGDiTs and foundation doctors, and outlines what to expect from a working week, including time for education and training, and exemplar work duties and rota in different paediatric settings. It also includes details on minimal staffing levels, flexible working and different types of leave. The comprehensive document spans the early stages of roster preparation and creation through to exception reporting and review; and sits alongside our Training Charter and Trainee Toolkit .

As part of rostering best practice, the guidance outlines that PGDiT should expect:

- To be provided with their rota at least six weeks before they start their job and from thereon, six months into the future.
- To be facilitated in taking annual and study leave provided six weeks' notice has been given.
- To be supported in exception reporting or hours monitoring

- Rotas that account for adequate rest and recovery during and between shifts
- Education on healthy lifestyle, sleep and risks of fatigue as part of inductions and education programmes.
- Provision of appropriate rest facilities when working resident on-call night shifts or if feeling unsafe to travel.
- A positive culture towards taking contractual rests and breaks; and access to hot food and hydration on all shifts.

There is a potential risk to training paediatric subspecialists of the future; understaffed on-call paediatric rotas often take subspecialty PGDiTs away from their training to cover acute services. Whilst there are important skills to learn from acute takes, this often leads to interrupted and fragmented subspecialty training time."
Consultant

Principle 4: Good training requires time to train

SPA time for trainers and PGDITs

Training, examining, and educating all make training the future NHS service possible and should not been seen as system luxuries. There needs to be a clear outcome from this training review about ensuring that the NHS develops and supports the next generation of doctors and brings this back to the centre of how hospitals manage their day-to-day business. Without training and examining, we cannot produce the high quality doctors of the future. Without education, those doctors cannot grow, progress and become the leaders of the future.

Paediatrics has the highest percentage of LTFT training, and this is increasingly the case for consultant job plans too. However, trainers are given less and less time to be able to train their new colleagues, with Supporting Professional Activities (SPA) time under threat. The latest RCPCH data on advertised paediatric consultant posts from Advisory Appointments Committee activity shows an alarming decrease in average SPA time in paediatrics consultant job plans since the end of the pandemic:

Year	Average Direct Clinical Care Time	Average SPA Time
Q1 2023	7.4	2.0
Q2 2023	7.8	2.0
Q3 2023	7.7	1.9
Q4 2023	7.1	1.9
Q1 2024	7.7	1.8
Q2 2024	8.2	1.6

A significant proportion of the paediatric consultant workforce is over the age of 50 years. This has a profound effect on the availability of senior decision makers within paediatrics, as well as availability on the ground. TPDs and HoS are persistently being asked to do more with less. An RCPCH survey of senior paediatricians reported an overwhelming deterioration in working lives over the last 10 years, caused by the impact of rota gaps, fewer PGDiTs and loss of continuity of care. Over 15% of services reported absence due to stress and 45% of Clinical Leads reported concerns about future absences.[2]

Consultants not being given protected time to supervise and train PGDiTs, and also support

2 https://www.gmc-uk.org/-/media/documents/national-training-survey-results-2021---summary-report_pdf-87050829.pdf

national exams and interview processes, is a vital issue impacting training. Without an expansion in the consultant paediatrics workforce that balances increased service requirements whilst

preserving (rather than reducing) time for training, there will be a shrinking capacity in the NHS to train the next generation. The impact of this will be considerable harm to the infrastructure of educational delivery for those in training. This will not just affect doctors on CCT programmes, but locally employed doctors wanting to access learning opportunities and progress their careers, and other roles in paediatric services that consultants help teach and train.

Non-clinical self-development time or supporting professional development time allows doctors – both trainers and PGDiTs – to learn, improve and diversify their knowledge. For PGDiTs, while many of our curricula key capabilities can be met in direct clinical time, others cannot. These non-direct clinical capabilities are a vital part of our broad, generalist curriculum that reflects the General Medical Council (GMC) Excellence by Design. They include areas such as audit, research and education – factors that ensure the enhancement and continued safety of patient care. RCPCH requires that SPA time is built into work schedules for PGDiTs. At 8h per week for tier 1 doctors and 16h per week for tier 2 doctors, this is less than many other colleges, however it is still often not being achieved. A recent PGDiT survey conducted by the RCPCH Trainees Committee showed over 75% of ST1-3 and 76% of ST4+ PGDiTs do not get rostered SPA time. This means that many PGDiTs are doing this work in their own time, contributing to burnout. Nearly 20% of paediatrics PGDiTs were reported as being at high risk of burnout in the latest GMC national training survey report.[3]

A driving ethos across paediatrics is to provide safe and high-quality training. Curriculum delivery budgets have not increased and discretionary study leave is considered expendable to direct clinical care, exposing funding cuts and/or restrictions across all Schools and Deaneries.

Support for regional training roles

As well as the large system issues, training experiences are also limited by small system failures. Restrictions in recruitment to administrative roles to local Deaneries are impacting core business, including National Recruitment Offices. Funding freezes at NHSE are severely affecting educator roles (~200 impacted in paediatrics) with blockers in place preventing the recruitment of new TPDs as people come up to the end of their tenure leaving job posts vacant. Unfortunately, whilst the recent news about NHSE may offer opportunities, it is likely to temporarily worsen these role freeze issues which will have an impact felt for many years afterwards.

4 The specialist workforce and training

Principle 5: Good training comes alongside a good career

Since 2019, the number of applications to enter paediatric training in the UK has seen a year-on-year increase with over 2,500 applications for less than 500 training posts in 2025. This has unfortunately come alongside both a reduction in the support for doctors to give their time to areas like recruitment, and to investment in deanery staff (including in National Recruitment Offices), as described in Section 3 above. These has led to a significant imbalance between applications, national training numbers, and interview slots. The RCPCH saw a reduction in interview slots for 2025 despite having a significant increase in applications.

3 Support for child health workforce needed after GMC says nearly 20% of paediatric trainees are at high risk of burnout | RCPCH

When the last government made a significant investment in medical school places, we had called for the development of an onward plan into foundation and specialist training, that would ensure that we would not been in a position of the huge competition ratios we are now seeing across medicine. Without assurance of a training career and consultant career ahead, the stressful uncertainty of training is significantly heightened.

An emerging view from both our PGDiTs and the medical students and foundation doctors we work with, is a significant concern that there will not be jobs at both specialist training and consultant level for doctors. Many of the stresses and challenges of a doctor's career are survivable due to the knowledge there is relative job security, i.e. the financial and emotional investment in training will have a reasonable chance of leading to permanent employment. That social contract between the NHS and its aspiring PGDiTs is at real risk of being permanently severed without clear onward workforce planning. Many of these views were expressed in our recent workforce survey, the results of which can be found here Workforce CCT survey 2025 | RCPCH.

Principle 6: Good training arises from a strong workforce

"We should not lose sight of the fact that we are training the senior paediatricians of the future. The environment they experience and the workforce they see directly impact on their career choices and how they act. Adult learning is flexible and opportunistic, as well as structured. Role modelling in an understaffed service is poor training on many levels."
Consultant

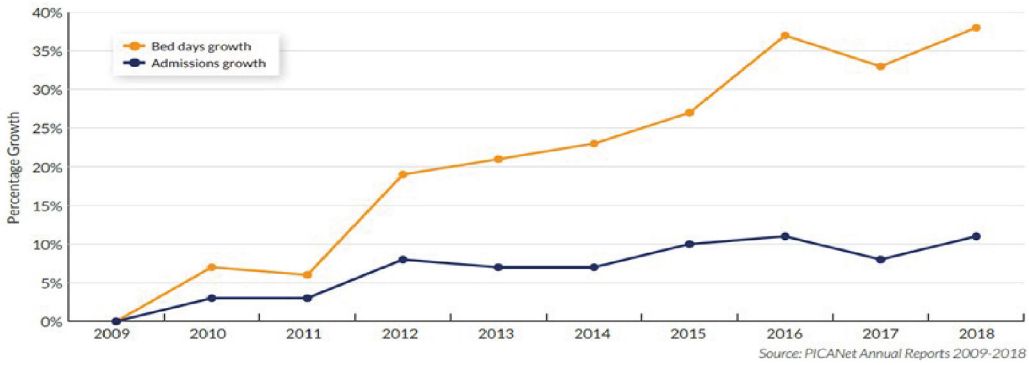
The prevalence of life-limiting and life-threatening conditions in CYP has increased by 40% per 10,000 since 2001 and is expected to increase by a further 20% per 10,000 by 2030. The National Child Mortality Database showed in 2023, the child death rate was 31.8 per 100,000 children, an increase from 29.3 in 2022. The infant death rate also increased from 3.6 per 1,000 live births in 2022 to 3.8 per 1,000 in 2023:

- 75% of all mental health problems are established by the age of 24.
- 1 in 11 CYP live with asthma (1.1 million in total). The UK has one of the highest prevalence of ED admissions and death rates for childhood asthma in Europe.
- 2.5 million children in England are affected by excess weight or obesity. The number of children who are severely obese doubles between reception and year six, and 1.2 million CYP are living with complications from severe obesity.

In September 2023, the Academy of Medical Royal Colleges, identified the following five indicators of health — healthy weight, oral health, vaccinations, clean air and mental health — as priority areas for improving child health in their publication Securing our healthy future – Prevention is better than cure. We believe they demonstrate most acutely the benefits when prevention and early intervention of ill health are realised to ensure healthy children can grow up to be healthy adults. The results of inaction are highlighted when this is not the case.

Within paediatrics community services, children are waiting longer than adults with a significant capacity-demand mismatch. In March 2023 there were 92,622 CYP with an open "suspected autism" referral, a 26% increase from April 2022. In June 2023, over 14,000 patients aged 0-17 years with an open suspected autism referral waited more than 13 weeks to receive a first appointment, and 44% of community paediatric services report median waiting times between 13-52 weeks.

PICU activity data from a 2022 GIRFT report on Paediatric Critical Care shows the extent of increasing numbers of CYP bed days and admissions in the last decade:



Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Admissions	14366	14760	14827	15567	15377	15306	15862	15959	15474	16011
Bed Days	82596	88414	87286	98696	99803	101448	105302	113450	110026	113756

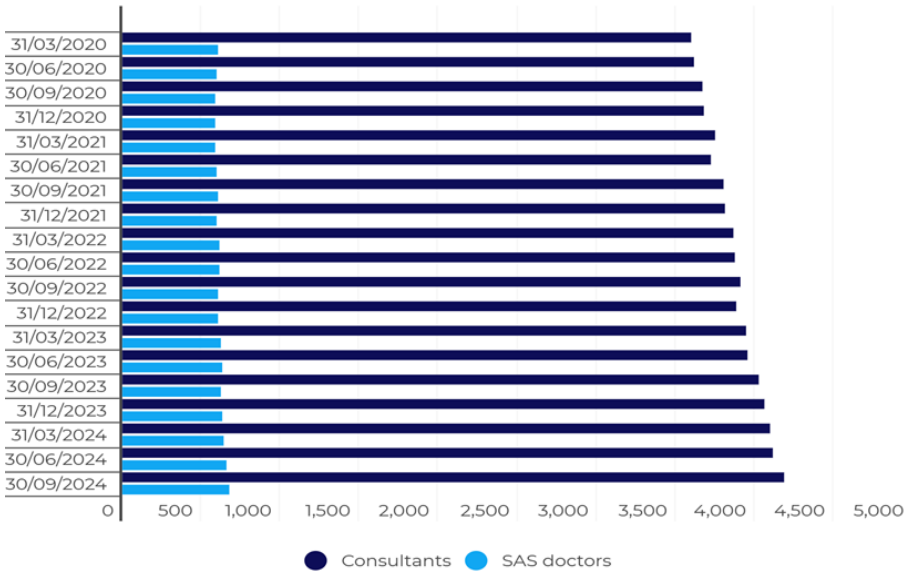
Against this backdrop of accelerating patient demand and complexity, and extensive waiting times; enduring issues in the paediatric workforce with understaffed rotas, staff burn-out and unfilled vacancies will continue to intensify concerns for training. As highlighted in the RCPCH submission of evidence to the Darzi review in August 2024, demand for paediatrics services is outstripping workforce capacity.

Each year, over 300 paediatric PGDiTs complete their certificate of completion of training, but the total number of consultant/SAS full time equivalent (FTE) capacity in England has seen minimal growth. In 2019, the RCPCH recommended 600 ST1 training posts each year for five years and an additional 850 paediatric consultants were needed to meet demand – this has never been achieved.

We have increasing feedback from our members who are in training that they are struggling to line up consultant roles upon CCT, with some not concerned there will be available jobs for them at all. This significantly adds to the stress of training.

Optimising current national training posts at the recruitment stage have been proactively explored with HoS and the National Recruitment Office. For 2023/24, training posts were maximised by recruiting to whole time equivalent rather than head count (up to 3 for every 2 posts) and additional national recruitment rounds for ST1 and ST3 entry at both September and March in the training year were introduced.

At the moment, working 80% WTE is usual, and that may reduce further, both for PGDiTs and consultants. Any long term plan needs to build that in to plans, as we will need significantly more consultants because of reduced WTE and retiring earlier. This is not unique to paediatrics.



FTE growth of paediatric Consultant/SAS workforce 2020-2024 in England.

Total ST1 training posts have remained below 500 year-on-year since 2018. Despite recent efforts to maximise the national training envelope, 58% of respondents in a RCPCH members survey said workforce and rota gaps were their greatest challenge, followed by burnout (35%) and work-life balance (34%). 84% of clinical leads stated, "a lack of paediatric training posts and rota gaps pose a significant risk to their service or to children, young people and their families".

GMC national training data shows there are 3,786 paediatric PGDiTs in England; over **40% of them work LTFT** and this has doubled since 2015. In comparison to other specialties, paediatrics has the highest percentage of LTFT PGDiTs.[4] 46% of those that request Category 3 LTFT training are from paediatrics, with most requesting 80% activity.[5] Increasing numbers of LTFT PGDiTs makes rotas planning more complex. RCPCH research in 2024 showed there was an average 20% deficit on Tier 1 and Tier 2 paediatrics rotas.[6]

RCPCH data triangulated against data from Statutory Education Bodies indicated a figure of around 5% attrition in paediatrics training.[7] CCT holders surveys and detailed trends analysis in 2020 showed the average training time in paediatrics has increased from 9.8 years to 11.3 years. There has also been a move to **consultant resident on-call with an increase from 20% to 35% over a six-year time period**. Consultants undertaking resident on-call out of hours require compensatory rest and the necessary expansion in the senior decision-making workforce that is required to ensure day-to-day activity and high-quality training is maintained, has not been guaranteed.[8]

4 https://www.gmc-uk.org/about/what-we-do-and-why/data-andresearch/national-training-surveys-reports
5 https://www.hee.nhs.uk/sites/default/files/documents/HEE%20LTFT%20Cat%203%20Initiative%20Year%201%20Report_0.pdf
6 https://www.rcpch.ac.uk/resources/rota-gaps-2024
7 Redman M, Jay N et al, Searching for the true attrition rate of UK paediatric trainees, Archives of Disease in Childhood, 2021:106:903, available at: https://adc.bmj.com/content/106/9/903
8 https://www.rcpch.ac.uk/resources/cct-class-2017-where-are-they-now-follow-survey

5 Other areas raised by the medical training review consultation

In this section we cover questions raised by the medical training review consultation that were not addressed in detail in our narrative above.

Method of national recruitment

The overall method of national recruitment is a generally positive one. National recruitment ensures fairness and stops PGDiTs from having to undergo multiple regional interviews.

What has started to be lost in national recruitment is the feeling that those applying are individuals rather than numbers in a bigger system. Part of that, as noted above, relates to a reduction in Deanery staff who are able to manage these processes well and sympathetically. These are the kinds of doctor-facing NHSE roles that need to be preserved and grown during the transition.

Distribution of training posts

The current distribution of training posts clearly still has a lot to do with what hospital posts could be converted into training posts during the transition to Calman and the decade aftermath that followed. There are changes in population demographics and regional complexity of care that need to be considered.

We understood that this was already under review by NHSE with a distribution plan in draft. Our only concern noted about the redistribution was to ensure that it was (a) undertaken carefully and sympathetically rather than in a big bang and (b) that it recognised that some English regions are currently less attractive for recruitment. The risk of ignoring (b) is that redistribution only succeeds in reducing the number of posts filled as the less attractive regions return unfilled posts. There should be a focus on why regions prove unpopular and what can be done to incentivise recruitment in those areas.

Health inequalities and distribution of posts

The paediatric workforce provides expert care for an age group that makes up 25% of the total population and child health conditions have long-term consequences for adult care. This is persistently underrepresented in the distribution of training posts. Emphasis on modelling by birth rate and population growth has led to inaccurate planning, with unpredicted reversals in projections (1.8% increase in birth rate 2021 -2022 with Total Fertility Rate up for the first time since 2012), and unforeseen changes in the immigration and child health inequalities landscape. Consistently rising complexity in CYP disease burden and care has led to demand now clearly outstripping workforce capacity in paediatrics services.

The RCPCH heatmap has analysed the ratio of paediatric consultants in relation to the population of CYP aged 0 to 16 by region. There is clear discrepancy between geographical regions with 6.13 consultants per 10,000 CYP in London to 3.1 consultants per 10,000 CYP in the Southwest. The 2024 RCPCH Rota Gaps Survey showed similar regional variation with 14.6% gaps on average across Tier 1 and 2 rotas in London, and 26.8% gaps in the West Midlands. Plans for an uplift and redistribution of paediatrics training numbers had been in progress under HEE.

RCPCH Progress+ curriculum states:

Health promotion and illness prevention:

- *Understands the factors which contribute to child health inequalities and the consequences of those inequalities in terms of disability, life expectancy and health economics.*
- *Understands the effects of the environmental, economic and cultural contexts of health and healthcare on illness prevention.*

Ensuring quality and inclusivity in training for doctors from diverse backgrounds, including those from minority ethnic groups and those with disabilities

Reality of training: One key component of reducing differential attainment is to create equity on opportunities to receive training, find mentors and understand what support options are open. As detailed above, the current trend in the NHS away from training as a core component of its business is that training is often fought for / opportunistic, potential mentors are often struggling to find time to give support due to lack of SPA time, and support for PGDiTs in general is variable and sometimes very poor. It is vital for PGDiTs to have this support in order to limit negative consequences at ARCP and exam progress.

The College's work: Over the last three years our work in equality, diversity and inclusion (EDI) has seen us achieve several objectives from the 'putting ladders down' and 'working for change' programmes of work. As we enter a new phase of our EDI strategy, our plan for 2023/24 outlines four new themes and a set of actions which focus on 'making EDI everybody's business'. One of these workstreams is our most ambitious and follows on from 'the working lives of paediatricians' from the Working for change programme. We understand that in order to fulfil our vision of leading the way in children's health we have to better support those who are delivering the critical care. This workstream therefore focuses on the areas where members have either asked us for help or we have identified an area for improvement. This encompasses differential attainment, reasonable adjustments, neurodiversity, as well as our ongoing reciprocal mentoring programme.

Reasonable adjustments: In 2021, the RCPCH published best practice guidance on reasonable adjustments at work led by our Trainees' Committee. It highlights that paediatricians should expect the same kindness and equality that they routinely show their patients, carers and families. Doctors with disabilities are an asset and are to be welcomed into the profession and valued for their individual contributions. Paediatrics should be an equally achievable prospect for all PGDiTs whether they have additional needs or not.

"I was diagnosed with ADHD in my 30s whilst at medical school. One of my supervisors recently had the humility to have an engaged conversation with me, she spent time letting me talk about myself, my strengths and challenges, and really listened to what I said. I noticed a change in her behaviour, when we had meetings, for example, she would give me a heads up what it would be about beforehand. She educated herself outside of the time we spent together and has taken it seriously in a land where that has never happened before. Although it's not been perfect it made such a difference."
PGDiT

Community based working

In August 2023, RCPCH implemented the Progress+ curriculum aligned with national commitments to generalism and to training the paediatrician of the future by expanding opportunities to work outside of the hospital environment and to build working and training links with colleagues in primary care, public health and child mental health. Developing training opportunities and curriculum delivery in these environments has not been possible outside of small areas reliant on local relationships and goodwill, and initiatives have failed due to lack of overall system support and pulls to acute service delivery. This has been reflective of both systemic inertia but also the lack of capacity from trainers to drive forward a change that will ultimately improve patient care.

The implementation of Progress + curriculum, provided there is adequate time allocated for high-quality supervision, will deliver an adaptable paediatric workforce with generalist skills that will be equipped to work in hospital / community setting and also able to skill up/ use digital technology to potentially provide care to young people/young adults and fill current gaps in service in primary and secondary care settings. This is very much needed with the loss of the equivalent of 1,881 full-time fully qualified GPs since 2015. In November 2023, almost 63.03 million patients were registered with GP practices in England, which is equivalent to an average of 2,293 patients per each full-time equivalent GP[9]. Age-standardised GP consultation rates in children and young people (CYP) fell between 2007-2017. The Emergency Department (ED) attendance rate in CYP in England increased over the same period[10] , with indications that many of these attendances were amenable to treatment in primary care[11,12,13]. Evidence shows ED attendance rate in CYP is directly associated with access and availability of GP consultations[14] .

NHSE data shows **CYP account for 25% of ED attendances and are the most likely age group to attend A&E unnecessarily**. A&E attendances among CYP is anticipated to increase by 50% and CYP outpatient attendances to specialist paediatrics care is forecast to increase by 48% (16.5 million annually) by 2030 if current trends continue. 25% of GP appointments are related to CYP and 25% of all current calls to NHS111 are with regards to CYP aged under 16 years - the majority of these calls result in referrals to other services, including primary care and A&E.

Since 2020, the NHSE CYP Transformation Programme Team have been looking to build on high impact integration test sites and pilots to set out a road map for wider systems to follow. The aim has been to bring paediatric expertise into community and primary care with a strong evidence base that shows embedding paediatric expertise into the community improves care for CYP and their families, reduces duplication across the system and finds efficiencies:

- **NHS111 Paediatric Clinical Assessment Service (PCAS)** service is hosted by a single provider and accepts referrals from all NHS111 providers through a national clinical queue. By embedding paediatric clinicians within NHS111 PCAS, over 51,000 calls have been responded by PCAS with 58% of calls resulting in self-care (compared to 20.51% in wider CAS), and around 30,000 presentations diverted away from GP, ambulance services and ED since August 2021.[15]

9 https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice-data-analysis
10 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7228511/
11 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4427415/
12 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6047147/
13 https://pubmed.ncbi.nlm.nih.gov/27288373/
14 https://pubmed.ncbi.nlm.nih.gov/26791971/
15 Stilwell PA, Fissler S, Burkitt S, et al. NHS 111 Clinical Assessment Services: paediatric consultations. *Arch.Dis.Child* 2022;107:e1-e5

- **Connecting Care for Children** has shown efficiency savings of at least triple the investment[16] (net economic benefit), including total efficiency gains due to:

  - 40% fewer paediatrics outpatient appointments
  - 17% fewer paediatrics hospital admissions
  - 22% fewer CYP presentations to ED
  - 16% fewer CYP attendances to GP

Digital health

To make the best use of digital changes in the coming years, we need to provide opportunity for PGDiTs to learn about this during their training. The limitations of this are currently:

- It remains very difficult to access training opportunities in these areas and Colleges are restrained in introducing curricula changes that are not deliverable across all regions and areas of the UK.
- The NHS's own digital hardware and software are often significantly behind current digital developments.
- Limited study leave allowance for PGDiTs to attend digital learning opportunities.
- We would enthusiastically support a greater focus on digital healthcare innovation and use for PGDiTs.

Career expectations and system gaps/issues impacting on satisfaction

As part of the consultation we were asked to consider questions regarding the most and least important factors and barriers for a rewarding and satisfying postgraduate medical training pathway. Factors listed included:

- Ability to train and work in one's desired location
- Ability to train and work in one's desired specialty
- Access to high quality mentorship and supervision
- Flexible training options
- Work-life balance and workload

As a membership organisation it would be inappropriate for us to provide 'top 3' answers as all of the options are clearly important and it is likely that each of our members would answer differently depending on their specialty, stage of training and regional/hospital differences.

16 https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

6 Recommendations

Training programmes and training support

- Support Deaneries in being able to apply the full flexibility of the curriculum, including out of programme activities.
- Support Deaneries in being able to manage rotations so they give minimal disruption to PGDiTs, including planning rotations across as much of the total programme as is possible and making placements longer wherever possible.
- Robust administrative support for Deaneries across their medical workforce teams and their recruitment teams to create a more personalised and efficient experience.
- Review of curriculum delivery budgets in line with inflation and the number of PGDiTs in the programme to ensure all PGDiTs have equitable access to study leave/study leave budget for mandatory and discretionary study leave throughout their training programme, irrespective of training region.

Employers and service providers

- Lead employer for all PGDiTs.
- Protected SPA time for both trainers and PGDiTs.
- Ensure employers see all the activities that make training and learning possible (examining, course running etc.) are not seen as system luxuries.
- eRostering AI tools that allow efficient use of those working/training flexibly.
- Service-led discussions about out of hours work and alternative models of care. The College would be happy to support these, but as it's role is advisory, it would need to be invited. We attempt to influence models of care with work like our Facing the Future Standards.

Wider workforce considerations

- All national workforce plans (i.e. the Long Term Workforce Plan in England), need to ensure that Children and Young People, their growing needs and their key role in prevention, are reflected.
- Expansion of training numbers in line with changes in working and demand.
- Expansion of consultant workforce in line with changes in service and demand.

Wider NHS considerations

- The College would be fully supportive of a wider national conversation about the importance of two areas raised in the overall Medical Training Review survey: health inequalities and community-based working.
- To consider whether the role of nationally set curricula is purely to represent the status quo or to help develop new learning opportunities and ways of working (i.e. promoting the transition to more learning on digital healthcare).

NHS England
Postgraduate medical training review 2025

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