1. Over the next 30 years, how do you think the way patients are cared for will change?

The Royal College of Paediatrics and Child Health (RCPCH) expects that primary and secondary care should be more integrated, based around the patient and family. It should reflect increased expectations and survival of children with severe disease, complex conditions, preterm delivery, and genetic disorders. Health care for children should be built around expected standards and outcomes such as Facing the Future\(^1\), NICE quality standards for 7 day care (in development)\(^2\). The model of care should include:

- Paediatric and Child Health (P&CH) teams around the child and family
- P&CH care teams will include child health doctors, technicians, Advanced Nurse Practitioners, paramedical services, school nurses, allied health professionals, pharmacists
- Multidisciplinary (multi-professional) networks
  - Networks of clinical care around geographically defined areas. Continuity for children and families, and easy access to a network of expertise for families and team members\(^3\)\(^4\)
- Fewer and larger centralised specialist services in hospitals with good access (telecommunications and transport) and preservation of continuity of care
- Where possible care closer to home
- Increased focus on care out of hospital, preventative strategy, education of patients and families, self-management and chronic disease management
- Outpatient care will use telemedicine to a greater extent\(^5\)
  - Improved access to expert P&CH

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\(^1\) RCPCH (2011) Facing the Future; Royal College of Paediatrics and Child Health, UK
\(^2\) See [http://www.nice.org.uk/media/5D9/88/SevenDayWorkshop291112Summary.pdf](http://www.nice.org.uk/media/5D9/88/SevenDayWorkshop291112Summary.pdf)

\(^3\) RCPCH (2011) Bringing care to life: Royal College of Paediatrics and Child Health, UK

- GPs may have virtual consultation with or without patients, triaging to A&E/clinics
- GP surgeries will be larger, with integrated general P&CH
- Part of a network

- There should be growth in the P&CH workforce in the community to manage increasing numbers of complex patients treated in the community due to advances in technology e.g. survival rates of extremely premature babies
- Everyone who deals with children and young people will be required to have appropriate knowledge, skills and competency (ranging from acute care to safeguarding)
- There is a need for seamless care between GP and secondary P&CH: P&CH general specialist in secondary care should come out to work in local health care with GPs and give support to family practitioners and local health care teams
- Configured service so that local short stay and assessment units provide care close to home with easy access to in patient centres, and if needed in major centres:
  - teams working across traditional boundaries, and political fiefdoms
  - patient transport services
  - child and family accommodation in major centres
- Transition to adult services that meets the needs of young people, particularly if they have complex needs.

2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

We will need doctors in all sectors who are innovative communicators and have an understanding of preventative strategies in health, and are employed across organisational boundaries.

**Primary Care:**

- GP with only paediatric patients (joint training with RCPCH and RCGP using, for example paediatric SPIN (Special Interest) modules)
- Specialists in General Paediatric and Community Child Health who work primarily in community or primary care setting with service and training links to local hospitals
- Multi-professional members of an integrated care team

**Secondary Care:**

- Acute general paediatric specialists in P&CH – teams in larger 24/7 centres also providing care in associated short stay paediatric assessment units:
  - as hospital admissions and episodes of unscheduled care continue to increase in number
  - consultant delivered care is important with consultant presence during times of high clinical activity

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appropriate workforce planning for the number of acute general paediatric specialists needed in the future

- Networks providing integrated care e.g. diabetes team, cystic fibrosis team
- Community child health specialists with areas of expertise e.g. multi-system disability, adoption
- P&CH subspecialists in major centres where integrated services can be provided:
  - concentrated in centres determined by population need
  - available network of expertise to other P&CH specialists and primary care
  - infrastructural support (e.g., patient transport, telecommunication)

The consultant is likely to do less high intensity work in the later career stage and should be able to move between care settings with appropriate training.

There will be fewer specialty trainees and staff grade doctors to support the service.

Paediatrics and Child Health requires Workforce Planning to ensure that training aligns with the service needs, and the needs and expectations of the trainees in order to support future service requirements.

3. **What do you think will be the specific role of general practitioners (GPs) in all of this?**

**Currently**, most care given to infants and children is within General Practice

- Children represent around 25% of population and 40% of primary care consultations
- Most have had 5-7 weeks undergraduate training and no postgraduate training in P&CH
- Dependent upon their geographical location
- Worrying trend that GPs refer cases that they could deal with but don’t refer more serious cases if they have reached their cap with associated consequences
- Significant variation in referral patterns and referral numbers are increasingly placing an extra burden on hospital-based services
- Unpredictable degree to which GPs are confident to share care in chronic (diabetes, cerebral palsy) or more serious childhood (malignancies, epilepsy, cystic fibrosis)
- Out of hours care for children primarily taking place in secondary care

**Future** P&CH needs:

- Integrated care pathways around child and family

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7 RCPCH (2012) Consultant delivered care – an evaluation of new ways of working in paediatrics; Royal College of Paediatrics and Child Health, UK
4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors’ training (including GP training) change to meet these needs?

- Training should be in the environment in which doctors are likely to work in the future i.e. both hospital and community based
- Training should be flexible so transfer between general specialties and sub-specialties is possible
- Training extending over a career – doctors will not expect to work to same job description from 30 years old to 70 years old – the phased consultant career anticipates, allows for and advances career transition. This may require periods of structured training for the consultant
- Extension of GP training to four years
- GPs that see children should complete at least six months of P&CH training and the Diploma in Child Health (RCPCH DCH)
- General Paediatric specialists and specialists in Community Child Health should complete the same training as required now i.e. levels 1, 2 and 3 of paediatric training. Doctors have, in the main, no experience of paediatrics prior to starting specialty training unlike, for example surgery
- Paediatric sub specialists should complete the same training as currently required.
- More recognition of transferable competences to enable doctors to move across specialties
- Recognition that less than full-time training (LTFT) should be more flexible for individual trainees
- Recognition that the feminisation of the paediatric workforce is significantly higher than other specialties and should be considered in workforce planning to allow for more flexible training options
- LETBs and NHS employers need to plan for lifelong learning rather than just postgraduate education.

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5. How can the need for clinical academics and researchers best be accommodated within such changes?

All doctors are academics as understanding science and evaluating the evidence is part of clinical activity. Doctors need understanding of research in order to be able to incorporate best evidence into their clinical decision-making and contribute to health services research. Research opportunities in programme would enable trainees to achieve the research competences.

- Academic and Research development is key to the future of P&CH
- Specialists in Research are divided into:
  - Users – all specialists in P&CH (eg use of evidence based medicine)
  - Contributors – a majority will recruit to trials, work in research groups etc. linking to the Academic Health science networks (England only)
  - Leaders – academic experts working within clinical networks engaged in scientific, clinical and health service research
- Integrated clinical / academic training pathways
  - Generic P&CH and Specialty specific academic training pathways
- Multicentre, multi-professional research teams
- Academic networking between universities, district hospitals and primary care
- Better support and recognition for health services research and educational research

6. How would a more flexible approach to postgraduate training look in relation to:

6a. Doctors in training as employees?

- Generic initial postgraduate training with a broad base, moving into P&CH to train for accreditation as general paediatric specialist or subspecialist
- Access to modular training in subspecialties of paediatrics governed by workforce planning
- Single end point of training not appropriate (viz CCT), and this does not mark the completion of training
- Clearly defined end points (rather than just one)
- Need open and transparent career paths to provide choice
- Paid time to reflect and debrief is essential
- Career guidance provision
- Masters degree structure
- Training will continue after accreditation (CCT). For some this will allow subspecialisation or change in career
- Accreditation of transferrable competences between training pathways
- Broad based training will develop a practitioner with a wide perspective of healthcare and promote greater integration and understanding within the specialties involved
- Academic themes: support for future academic leaders

6b. The service and workforce planning?
- Trainees should be actively involved in the decision-making on this as it is crucial that workforce planning has meaningful engagement from the people who are going to be at the heart for it for the next 30-40 years
- There are relatively small numbers of doctors wanting to move between specialities; these can be managed by deaneries and should be encouraged and facilitated
- Ambulatory units (short stay or acute assessment units) closer to home and large DGHs or teaching centres on one site
- Work in integrated care (social, schools, nurses, GPs, Child Psychiatry, Psychology, Mental Health, public health, Paediatric) – with a broader start point there will be more flexibility in progression. The GMC approved Broad Based Training for Paediatrics, General Practice, Psychiatry and General Medicine is a good example
- Impact of raising retirement age and more mature graduates:
  - specialists cannot deliver overnight service until 65, 68 or 70 years old
  - newer specialists may deliver 14 hour service, rewarded appropriately
  - recognition of phased consultant career with clear time frames
- Recognition of non training posts with access to appropriate training to encourage specialty doctor (SSASG) career with option on CESR
- Annualised working
- UK planning of subspecialty training aligned to workforce needs
  - undergraduate numbers and expectations
  - open information on career numbers and competition
  - career guidance
- Look at the continental, North American models – but with caution - subspecialists are most effective dealing with selected populations of patients who benefit from their expertise and in support/education of other health workers

6c. The outcome of training - the kinds and functions of doctors?
- primary care; general specialist; subspecialist
- ensure we do not train redundant “ologists” (specialists) post CCT
- leaders of healthcare – not just being “doctors”
- consultants leading the service with non training doctors in each department with particular skills providing the continuity of care
- recognition and respect for the role of specialty doctor

6d. The current postgraduate medical education and training structure itself (including clinical academic structures)?

Recommendation: There should be flexibility in training to give trainees the opportunity to undertake e.g. research, education, public health, overseas work without going out of programme.

- There is a value in the competence-based programme for the paediatrics specialty that enables trainees to progress at a rate that is applicable to their capability
- Does undergraduate training need to be 5 years?
• In P&CH, all consultants require generic skills before entering training for accreditation as a general paediatric specialist or subspecialist
• In the phased consultant career, some will crossover between general specialist and subspecialist roles during the consultant career
• Recognition that some subspecialties train to be competent in general on call duties
• Broad based training at start – better base with more transferable skills
• Clinical standards determine service configuration which defines training and workforce needs
• Academic – need research integrated centres as well as tertiary. Accredited university post for teaching as much as research
• Non restricted academic training
• Acceptance that some doctors will train flexibly, less than full-time for many years before reaching consultant status.

7. How should the way doctors train and work change in order to meet their patients' needs over the next 30 years?

• Doctors should train in an environment and culture that is patient focused
• Integrated teams to deliver multi-professional care
• Children, young people, parents and carers want:
  o to see someone that speaks with authority or someone who has an easy link to authority
  o to see someone with expertise/experience so that they have to attend fewer appointments with less waiting
  o fewer doctor or healthcare professionals seeing their child before a settled diagnosis is made
  o facilities close to them where possible, but centralisation of expertise where necessary
• Resolution of tension between some perceptions of what patients want [local hospital with 24/7 comprehensive services] and need for more centralised specialist and subspecialist services
• Large centres with 24/7 comprehensive service, local centres providing general specialist services and visiting subspecialists.

Other considerations/changes:

• The way in which doctors should train and work will diverge over the next 30 years
• Locality is important with differences in policy & structures in devolved nations
• Differences in delivery of care in rural v urban environments
• Training could be shortened but only if post “CCT” structured training was available – a move to the concept of lifelong learning is required
• Re-examination of apprentice model and consultant held skills in final years of training.
8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

We agree this is important. It does matter. Children and families should be confident that their doctor is competent. Specialty doctors and more senior trainees provide good and expert care.

There is a problem with the current labelling/branding of doctors in training which can be broken down into two general areas:

1. The current ST labelling system is not recognised by patients & public. Doctors, nurses etc. still use the Senior House Officer, Registrar labels (including to patients/parents/public). A label that differentiates trainee capable of “registrar” duties would be helpful. Patients need to know where the doctor is on the training pathway

2. General issue with the concept of ‘the trainee’. After the membership exam (MRCPCH) a doctor is not a trainee but a doctor in paediatrics. The analogy was raised with other professions i.e. sergeant is not a trainee Major just because they haven’t become a Major yet. It was also noted that Consultants never stop developing/learning. In a sense, all Consultants are ‘in training’.

It is important for patients to be able to identify the doctor who has ultimate responsibility for their care and to have full information about who is seeing them with the reassurance that the doctor/health professional is equipped to deal with the presentation or will arrange further input from a more senior colleague.

9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

**Recommendation:** There should be joined up workforce planning for the children’s workforce.

- In paediatrics there is a strong track record of multi-professional working because of the various professional groups caring for children
- Doctors to be trained to work with and in how to work with other members of the MDT. GPs need to be trained in paediatrics as 40% of the patients they will see will be children
- More paediatrics to be based in GPs surgeries, with paediatricians doing more outpatient work and more 9-5 clinics. Groups of paediatricians may work locally with groups of GP practices
- RCPCH needs to have a wider role in training non-paediatricians and non-doctors to treat children. Do patients need or want to see a paediatrician first or do they just need to have a quick access to a specialist paediatric service?
- Collaborative planning of training of Advance Nurse Practitioners in paediatrics
- Leadership skills expected of doctor in MPT
- MPT service delivery is key in Paediatrics and Child Health.
10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

- Yes more or less but there is a greater need to support them than before, in spite of the current time in training
- Consultant jobs need redefining first in order to understand and develop training for these posts. They vary depending on type, size and location of trust they are in
- The principle of a consultant delivered care service and the Facing the Future standards\(^9\) require paediatric consultants and some other specialties to be prepared for new ways of working particularly the need for providing hands-on care
- In paediatrics, most are able to step into consultant roles clinically but are often short on learning and experience to be able to take on leadership, quality improvement, service redesign and educational leadership roles
- Paediatric specialty training is very broad to cover the spectrum of pre-term to 18 years of age, different care settings and legal aspects/child protection issues
- Subspecialist training will vary in length and complexity
- P&CH is little taught at undergraduate level. The challenge faced by the general specialist is considerable
- No doctor is fully trained for their roles over a career to 70 years of age.

11. Is the current length and end point of training right?

**Recommendation:** Specialty paediatric training remains competence-based with an approximate time of 8 years to reach CCT. General paediatrics is a specialty and requires similar time as subspecialist, for example, a neonatologist, paediatric oncologist.

- Paediatric training is competence-based and the curriculum allows for some variation in the speed of progress, with flexibility in time at each level
- The general specialist or subspecialist in P&CH must have competence and confidence to deal with a wide variety of problems in the infant, child and young person against a background of little training at undergraduate level, and limited possibilities at Foundation level
- The General Specialist in P&CH needs a breadth of experience and expertise and the challenges of developing as a generalist are complex and varied, needing careful thought and sufficient time and experience. We do not believe this can be achieved in less time than the subspecialty training
- The focus on subspecialisation will happen post generic training
- Some subspecialist training will follow “CCT” and may take place later in the phased consultant career plan
- Training later in consultant career may vary in shape (1 day/week for 3 years versus full time for 6 months).

12. If training is made more general, how should the meaning of the CCT change and what are the implications for doctors’ subsequent CPD?

\(^9\) RCPCH (2011) Facing the Future: Royal College of Paediatrics and Child Health, UK
**Recommendation:** CCT is not perceived as the end of training. It marks the point that doctors can practise independently. Post CCT training consists of further learning in the same specialism or acquiring new skills or a move to another specialism.

- A culture of lifelong learning needs to be embedded
- Duration may need to lengthen
- CCT is the end of specialty training but the start of a consultant career is a steep learning curve
- New specialists should be expected to work supported in a team through a mentorship system
- Subspecialist training needs a full programme of support (as RCPCH National Grid: robust, managed, accredited, supported). Trainees in subspecialties need targeted and programmed CPD and educational supervision and mentoring in organisations
- Special Interest (SPIN) modules offer subspecialty elements of training during or after general paediatric specialty training
- Change perspective – CCT is just a step on the way to a consultant care
- The new consultant is junior and needs more support without this being seen as a “subconsultant”
- Difficulty for new consultant: may not be allowed/have time to still be considered ‘in learning’, and working outside of a supportive team and not able to be ‘new.’

**13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?**

- Doctors have to follow and fulfil the approved curriculum and assessment requirements to demonstrate they have experienced the breadth and quality of learning opportunities
- Doctors have to be in formally approved training placements, as part of a functioning team
- Doctors in training need proper supervision from properly trained supervisors – time in job plans and better training
- 7 day consultant care/presence
- Trainees should learn how to reflect in practice and have the capacity in their workload to do so. They need time during their work to acquire the correct training experience
- Quality training can be acquired in providing service. We should make optimal use in gaps in training posts
- Service needs affect trainees’ ability to gain subspecialty experience – there is a tension between service and training needs
- Risk that space, time to think and reflect and debrief are undervalued activities due to nature of busy shifts
- Consultants and other trainers should support, supervise and facilitate in service training so that their future colleagues can gain maximum experience from exposure to clinical experience.
14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

- Annual changeover modified to ensure safety for patient, security for doctor, and efficiency for service
- Consultant skills, other than those of direct clinical care of individual patient, should be part of specialist training and assessment strategy. START is RCPCH assessment for level 3 trainees to demonstrate readiness for consultant level
- Apprenticeship model as part of preparation for transition to “registrar” and to consultant
- Greater support in a functioning team and mentorship with appropriate training and allocated time
- Recognised value of mentoring to support trainees at transition points. Recognised and rewarded when senior trainees and consultants do mentoring
- Could use revalidation process and Responsible Officers to look at improving dysfunctional teams particularly if affecting training posts’ efficacy
- The more senior trainee should have opportunity to take responsibility for managing a service under supervision before moving into independent practice. Leadership skills are key
- Skills needed to be a consultant include understanding NHS systems, commissioning, Trust functions, preparing business plans, networked working, clinical governance, litigation, national audits, outcomes, standards. These should be included in specialty curricula.

15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

- In P&CH, we believe the balance is about right
- 7 day Consultant Present Care should address some of the issues so supervision is available during out of hours service
- Concentrating on service delivery can have an impact on training primarily if trainees spend the majority of the time clerking in patients and not making clinical decisions
- There is a tendency to take away any decision making from the trainees by supervisors which is likely to be detrimental to their ability to function later as a consultant
- The number of trainees on a rota must allow for gaps so that trainees have opportunities to attend outpatient clinics
- Trainees should make the most of every training opportunity and take responsibility for finding out outcomes for patients
- Staffing on rotas is based upon the assumption of a steady arrival of patients. Intelligent, flexible rota design may optimise use of consultant time and training opportunities
- Training across various settings needs to be maintained i.e. acute inner city, suburban mixed acute and community and rural. Exposure to varying psychosocial experiences makes for a more rounded trainee
• A balance is required to ensure that trainees are able to learn/train whilst undertaking service, but that the service does not become reliant on trainees filling the rotas
• Trainees should carry out tasks appropriate to their training
• Senior trainees should rotate to allow them to develop clinical decision making skills and see patients over a longer period of time
• Many posts provide the right balance between service and learning; the learning components of some posts need significant rebalancing
• Negative impact of high out of hours demand may be mitigated by employing a high proportion of SSASG paediatricians and by developing specialist nursing and AHP roles.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

Recommendation: Trainees should not be supernumerary as after CCT they would be taking up post without any practical experience on which to draw and without opportunity for skilled feedback from a trainer (peer feedback would not be the same, nor sufficient). Trainees of necessity should contribute to the service to gain experience and be properly trained.

• Service should have some reliance on trainees but not be trainee dependant. There is evidence that the removal of training from a centre can mean closure of services due to dependency on trainees
• Overnight service delivery in acute paediatrics (and 24/7 subspecialties) should be provided by trainees, making optimal use of this as a training opportunity
• An expansion of paediatric training posts integrating needs of GP trainees would be a useful addition. GP Trainees would be then mandated to undertake experience in acute paediatrics and community paediatrics
• Acute service provision could be shared between GPs and general specialists. Services could invest in more Advanced Nurse Practitioners to allow trainees more time for training and allow them to be put in those decision making roles
• Develop training in paediatric triage to assist those working in primary care.

17. What is good in the current system and should not be lost in any changes?

• The role of the College to:
  o Develop and disseminate competencies in P&CH
  o Set and constantly review clinical and service standards and play a role in their audit and outcomes
  o Quality assure training with UK agreed standards
  o Involve trainees in shaping training
  o Providing advice and unique data for the workforce and service planning process e.g. networked care pathways
• The RCPCH START assessment and the structured assessment framework against the curriculum
• The MRCPCH examination
• The length of the training period is roughly right i.e. between five and eight years
• Learning while providing service
• Consistently applied assessments, Supervised Learning Es nationally
• Curricula with stratified learning objectives made explicit
• Trainees seeing individual opportunities and using them to best effect
• Patient centred training is essential; it cannot be done in a classroom
• National Grid has been an excellent way of managing training and development of subspecialties in paediatrics and should be integrated with future subspecialty service and workforce planning
• Improved capability of committed trainers/educational supervisors training the next generation of trainees
• Deaneries’ acting as training managers and the Royal College as quality managers has driven up standards in paediatric training. The introduction of robust assessment systems and tools focusing on competence has empowered both trainee and trainers in ensuring that the quality of training and the standard of trainees produced have risen
• Broad exposure to DGH and teaching hospitals
• Value of the general specialist paediatrician
• Young, fit junior doctors doing out of hours works makes sense and should be retained
• Consultants are able to act in a way that allows generic practice/skills necessary for a flexible role
• Option to enter a SSASG post can provide trainees with a valuable alternative career path for the short or long term thereby retaining their skills within the specialty.

18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years’ time that we have not touched on so far in this written call for evidence?

All solutions must allow for:

• Development of trainees as rounded clinicians who are able to take up posts as leaders and deploy a range of non-clinical skills as well as performing in their clinical role should be addressed. In paediatrics this is assessed by the RCPCH START assessment in the penultimate year of training
• Faculty development must be properly addressed. GMC definitions of trainers and educational and clinical supervision must be followed through into raising the status of training, ensuring it is carried out properly
• Consultants who do not engage with training should not be allowed to have trainees working with them
• 48 hour week demands structured training and support of the EWTR
• CCT is not the completion of training
• Paediatrics and Child Health needs BOTH general specialists and subspecialists
• P&CH supports enhanced primary care training
• Structured training should be available to the trainee and the consultant
• Consultants will not work in same post from 32 years old to 70 years old
The phased consultant career: agreed periods of different clinical emphasis [most often moving from 24/7 responsibility in early years, with agreed endpoint]; family friendly solutions e.g. LTFT, slot sharing

Stronger focus on evaluation and meaningful education research. Evidence based training could be a vital outcome of this review

E-learning opportunities need to be maximised in order to fit the training around the rotas.

Any other comments?

- Paediatrics and Child Health involves all problems in 25% of the population. It relates to 40% of GP consultations. It has impact on lifelong health.
- P&CH occupies 5-8 weeks of most undergraduate 5year programmes. A minority of foundation doctors gain P&CH experience. This experience should be gained by both medical students and foundation doctors.
- Reducing the length of training of the paediatric general specialist risks increasing costs to the NHS. Competence and experience are needed to offer advice and reassurance and only to offer admission or investigation when appropriate.
- Doctors should be trained as generalists. Generalist experience must be valued and seen to be valued. The profile and prestige attached to generalist work must be promoted.
- Entry to specialist experience should be carefully planned to relate to workforce needs.
- Consultants will not do the same job until 70 years of age, and post CCT training must allow for this.

The RCPCH welcomes the opportunity to be called to give evidence to the Shape of Training Review group.

Julia O’Sullivan

Director of Education and Training

On behalf of Royal College of Paediatrics and Child Health

julia.osullivan@rcpch.ac.uk