

# **RCPCH MMC Cohort Study (Part 4)**

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Royal College of  
**Paediatrics and Child Health**

*Leading the way in Children's Health*

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# Contents

<b>Executive summary</b>	<b>1</b>
Background and methodology	1
Key findings	2
<b>Background</b>	<b>5</b>
Current challenges in the paediatric workforce	5
MMC cohort study (part 4 after 7th year in training)	6
<b>1 Methodology</b>	<b>7</b>
<b>2 Results</b>	<b>9</b>
2.1 Response rate and cohort demographics	9
2.2 Current post and preferences	14
2.3 Training progress	16
2.4 Geographic preferences and constraints	25
2.5 Career intentions	29
2.6 Resident shift working	34
<b>3 References</b>	<b>37</b>

# 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. This will produce support for the College, NHS providers and commissioners to 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)<sup>i</sup>, after 3 years of training (part 2)<sup>ii</sup> and after 5 years of training (part 3)<sup>iii</sup>. The 4<sup>th</sup> part of this survey took place after their 7<sup>th</sup> year of training.

2007 was the first year that trainees could enter run through training after the introduction of MMC. The cohort would have been through the foundation year pilot schemes which may have affected the behaviour of this group and makes those trainees unique in their career development.

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 previous responses. This report presents the findings of part 4 of the study.

## Key findings

### Response rate and cohort demographics

1. Overall, 47.5% of the original cohort responded to part 4 of the study, this represents 209 individual respondents. 196 were currently working in the UK and 185 (88.5%) were training in paediatrics, 178 in the UK.
2. Only 37.7% had progressed as far as ST7, ST8 or have completed training.
3. An estimated 3.6% of trainees leave the training scheme each year.
4. 47.7% (83/174) were working full time. 31.0% (54/174) were working less than full time an increase from 21.9% in part 3 of this study. Of those working less than full time, 94.3% (50/53) were female and 5.7 (3/53) were male. 9.8% (17/174) were on maternity leave and 11.5% (20/174) were out of programme. The calculated participation rate is 67.2%.
5. Of 89 trainees who stated that they are undertaking specialty training in grades ST6-8, only 40 (44.9%) said they were doing this on the grid.

### Current post and preferences

6. More trainees would like to train part time than are currently doing so. When broken down by gender, 27.8% (15/54) of female trainees currently in full time training would prefer to train part time and 3.0% (1/33) of male trainees currently training full time would like to train part time.
7. Overall 47.8% of the cohort would like to work less than full time on becoming a trained paediatrician and amongst female trainees this rises to 60.3% (82/136).
8. 73.2% of those who answered are happy with choosing paediatrics as a career and males appear to be happier, with 81.6% (40) compared to 70.3% (102) of females.

### Training progress, confidence and support from seniors

9. Overall, 79.4% (158) were confident or reasonably confident of obtaining their chosen post on completion of training. Males showed higher levels of confidence with 43.1% compared to only 19.6% of females saying they were confident.
10. Confidence in obtaining their chosen post is highest amongst those intending to be paediatricians in community child health (20/21) and lowest among trainees intending to become academic paediatricians.
11. Between parts 3 and 4 of the study, there has been a noticeable decrease in those who are not confident in obtaining a consultant post from 31.5% to 18.2%, 84.4% of respondents to part 4 (27/32) stated that there were an insufficient number of consultant posts available as a reason for their lack of confidence. This must be seen against a 4.3% per annum growth in UK consultants between 2011 and 2013 and a consultant vacancy rate of 2.5% recorded in 2013.
12. Half (91/182) of the trainees felt either totally or very well supported by seniors in their training and development. Only 3.8% who answered felt poorly supported. The results suggest that respondents who are confident or reasonably confident are more likely to feel better supported than those who are not confident.

## Access to teaching time

13. 18.1% (33/182) had an hour per week of protected teaching time and 37.9% (69/182) had more than an hour. Since part 3 of the study, the proportion of respondents who stated that they had no protected teaching time has decreased from 43.4% (93/215) in part 3 to 37.8% (68/180).
14. 21.7% (39/180) had one hour and 38.9% (70/180) had more than one hour of other teaching time.
15. There appears to be some association between the amount of protected teaching time and a trainee's happiness with choosing paediatrics as a career. 78.3% of those reported to have more than an hour per week and 81.8% of those that have an hour a week are happy with their career choice compared to only 50% who have less than 1 hour per week and 63.2% who have no protected teaching time.

## Time out of training

16. Female respondents were more likely to have taken time out of training in the previous 2 years - 59.6% (81/136) in comparison to male respondents 36.4% (16/44). Half of the female trainees' reasons related to parental leave and 4/19 (21.1%) of males took time out for parental leave. Over a third of those taking time out had done so for academic related activities.

## Geographic preferences

17. Out of the 185 currently in training, 15 (8.1%) stated they would like to work abroad - 10 permanently and 5 temporarily.
18. 75.0% of the cohort says their application for a consultant post will be limited due to geographical constraints. Location of a spouse's job was seen as a constraint for consultation applications (82.7%) and in regards to the training programme (86.8%). Home ownership is the next largest geographical constraint.

## Career and subspecialty intentions

19. The largest proportion of respondents, 90 (46.2%) intend to be general paediatricians. The percentage of trainees intending to be subspecialty paediatricians has increased from 24.4% in part 1 to 31.0% in part 4.
20. The proportion of respondents in the cohort intending to be community paediatricians has increased since from 4.2% in part 1 of the study to 10.7% (21/197) in part 4. All of those intending to work in community child health are female.
21. In addition to community child health, the most popular subspecialties (reflecting the greater number of trainee placements) are neonatology (21.0%) with 17 trainees intending to enter this subspecialty - 14 female and 3 male; and paediatric intensive care medicine (7.4% or 6/61) - 3 were female and 3 were male.
22. The career intentions of the cohort do not match the existing consultant workforce, 7.7% more wish to become general paediatricians and 7% fewer to become community paediatricians. However the workforce implications of Facing the Future revised standards<sup>iv</sup> are for an increase in general paediatric consultants.

## **Resident shift working**

23. 52.2% of those in training expect to be working resident shifts after they have completed training. Respondents who have worked in a unit where consultants do resident shift work are more likely to expect to do so; 58.5% compared to 48.7% of those who have not worked in such a unit.
24. 69.8% of respondents would be very or reasonably happy to accept an option in which consultants do twilight shifts and weekend working with a move to a phased career option later on in their career.
25. 46.9% of respondents agreed that resident shift working provided better quality service. This rose to 53.7% for respondents who had worked in a unit where consultants participate in resident shift work.
26. 60.9% of respondents felt that in the long term, resident shift working is not sustainable.

## Background

The Modernising Medical Careers (MMC) programme was introduced to specialist training in 2007. 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 RCPCH used the start of MMC as an opportunity to track a cohort of paediatric trainees and to study their career pathways and intentions. This continues to provide valuable information to influence both the current training programme and workforce planners.

2007 was the first year that trainees could enter run through training after the introduction of MMC. The cohort would have been through the foundation year pilot schemes which may have affected the behaviour of this group and makes those trainees unique in their career development.

## Current challenges in the paediatric workforce

Since this cohort of paediatric trainees started their training programme in 2007, there have been a series of major changes to the NHS, and policy developments that will inevitably affect their future careers as paediatric consultants. This backdrop will impact on the characteristics of the future workforce, and means that once members of this cohort complete their training they will be working in a very different organisation from that when they began medical school.

The European Working Time Directive (EWTD)<sup>y</sup> was fully implemented for trainee doctors in 2009. The Regulations have resulted in a change in the working patterns of all paediatricians over the last few years, including the introduction of consultant resident shift working. Trainee weekly hours are limited to an average of 48 over a 26 week period.

Consultant delivered care models have been developed both as a solution to the challenges of the EWTD and a means to deliver safer care for children at the times when it is most needed. It provides dual advantages of both providing cover for trainee rota gaps, and ensuring presence of a senior decision maker at times of peak activity.

The current government elected in 2015 is putting great pressure for health trusts and professionals to implement a 24/7 health service. Acute and neonatal paediatrics already operate 24/7 rotas across the UK and this College is supportive of the principle of providing the same excellent level of service to children attending hospital whether it be Tuesday lunchtime or 3 am on a Sunday morning.

The 2012 Health and Social Care Act<sup>vi</sup> implemented in 2013 for England, introduced a wide range of changes including the setting up of NHS England and Clinical Commissioning Groups (CCG) to be responsible for commissioning the majority of NHS services. Of particular relevance to trainees is that Health Education England (HEE) has been established to lead workforce planning, education and training. HEE has 13 local offices (HEELOs) who are responsible for the training and education of NHS staff within their local area (and taking over the functions previously carried out by deaneries).

In 2013, Professor David Greenaway published The Shape of Medical Training Review Final Report<sup>vii</sup> and delivered it to all four UK governments. At the time of writing no final decision has been made on implementation but the RCPCH position is that the current training pathway should be retained with 3 levels, including the subspecialty Grid training. However, further consideration of the structure and content of the training programme is required whereby there is more flexibility and options, and increased exposure to primary care.

In 2015, RCPCH revised its Facing the Future standards for acute general paediatric services<sup>iv</sup> (originally published in 2010) and produced standards for acute care out of the hospital in Facing the Future Together<sup>viii</sup>. Both sets of standards have implications for the size and type of the future consultant workforce in order to comply with the requirements for consultant presence. In addition standard eight states that all general paediatric training rotas are made up of at least ten whole time equivalent (WTE) posts compliant with UK working time regulations and the EWTD.

Paediatrics has one of the highest levels of women in its workforce compared to other medical specialties - over 75% of recruits at ST1 are female. As a result, the specialty also has high levels of parental leave. Less than full time working among trainees is relatively common compared to other specialties, along with other absences from training for out of programme activities (OOP). It is important that these data and the evidence from this study on attrition and length of training are acknowledged and used in workforce planning processes at a local and national level to complement that produced by postgraduate schools and HEELOs (England).

## **MMC cohort study (part 4 after 7<sup>th</sup> 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 4<sup>th</sup> part of this survey took place after their 7<sup>th</sup> year of training.

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

- Make 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 their 5<sup>th</sup> year as a trainee.
- Establish the current status of training careers in terms of grid training, participation of specialist trainees on general paediatric rotas, access to teaching and participation rates.
- To identify those who are no longer in paediatrics and assess the attrition rate and to carry out further investigations as to why trainees have left paediatrics.
- To look at changes in career intentions throughout the period of the study, to identify work-life balance issues and attitudes towards resident shift working.
- To inform the NHS workforce planning process in all 4 UK nations.
- 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 all 4 parts of this study are available to download from the College website: [www.rcpch.ac.uk/mmc](http://www.rcpch.ac.uk/mmc).

# 1. 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 3<sup>rd</sup> 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 5<sup>th</sup> 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.

Part 4 was conducted after the cohort's 7<sup>th</sup> year of training. The whole cohort was contacted, apart from those who had previously stated they had left paediatric training to work in a different medical specialty or a different career.

In part 4, 387 were invited to respond to the survey, and 209 replied, giving a response rate of 54.0% (or 46.9% of the original cohort).

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:

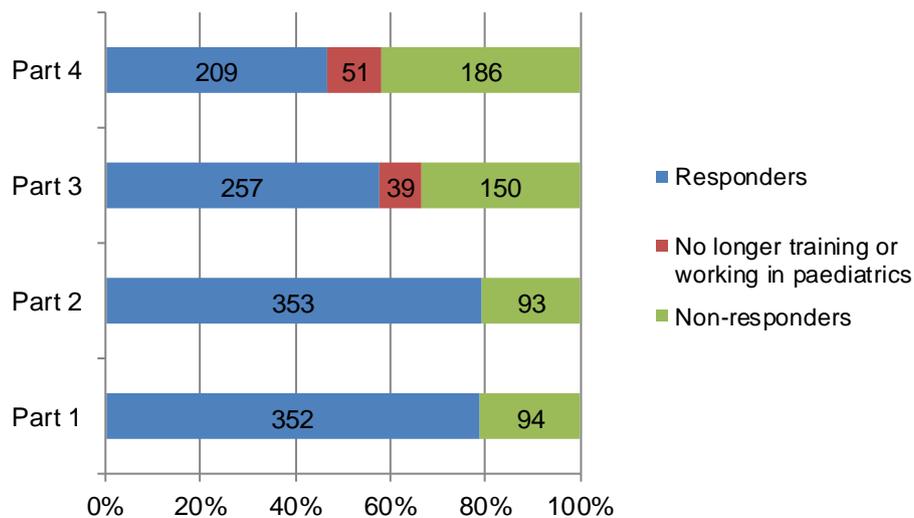
Survey	Time in training	Response rate (of original cohort)	Reference
Part 1	After 1 year	78.9% (352/446)	<a href="http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/MMC%20Cohort%20Study_main%20findings%20link.pdf">http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/MMC%20Cohort%20Study_main%20findings%20link.pdf</a>
Part 2	After 3 years	79.4% (354/446)	<a href="http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%202%20Report.pdf">www.rcpch.ac.uk/system/files/protected/page/MMC%20part%202%20Report.pdf</a>
Part 3	After 5 years	57.6% (257/446)	<a href="http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%203%20final_0.pdf">http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%203%20final_0.pdf</a>
Part 4	After 7 years	46.9% (209/446)	This report

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

## 2. Results

### 2.1. Response rate and cohort demographics

Part 4 of the study’s survey was sent to 395 members of the original cohort of 446 doctors who started paediatric training in 2007. We had established before part 4 that 51 were already either no longer in training or no longer working in paediatrics. Figure 1 indicates the response rate at each stage of the cohort study.



**Figure 1: Comparison between part 1, part 2, part 3 and part 4 responders and non-responders**

Overall, 47.5% of the original cohort responded to part 4, this represents 209 individual respondents. There were 186 non-responders; one of whom had obtained their CCT at the time of the survey.

#### 2.1.1. 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 responses to these questions are detailed in Table 1, according to whether the respondent is working in the UK or not.

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

	Training in paediatrics	Working in paediatrics but not training	Not training or working in paediatrics		Total
			Training in other specialties	Working in different career/not known	
Working in UK	178	8	5	5	196
	96.2%	57.1%	100.0%	100.0%	93.8%
Not currently working in UK	7	6	0	0	13
	3.8%	42.9%	0.0%	0	6.2%
<b>Total</b>	185	14	5	5	209
<b>%</b>	88.5%	6.7%	2.4%	2.4%	

Of the 209 respondents, 196 stated that they are currently working in the UK, and 13 stated that they are not currently working in the UK. A total of 185 (88.5%) are currently training in paediatrics, 178 of whom are based in the UK. 75.8% (135/178) of UK trainees in this cohort are female. 14 respondents stated they are working in paediatrics but not training, of whom 2 had completed training at the time of the survey. 8 of these doctors are working in the UK. A total of 5 (2.4%) respondents, all based in the UK, stated that they are training in other specialties. Two of these are now training in clinical genetics, a further two are training in general practice and 1 is training in public health. Of the remaining respondents, 4 stated that were in a different career (of whom 2 were not specific) and 1 did not answer whether training in another specialty or working in another career.

**Table 2: Reasons for leaving paediatric training**

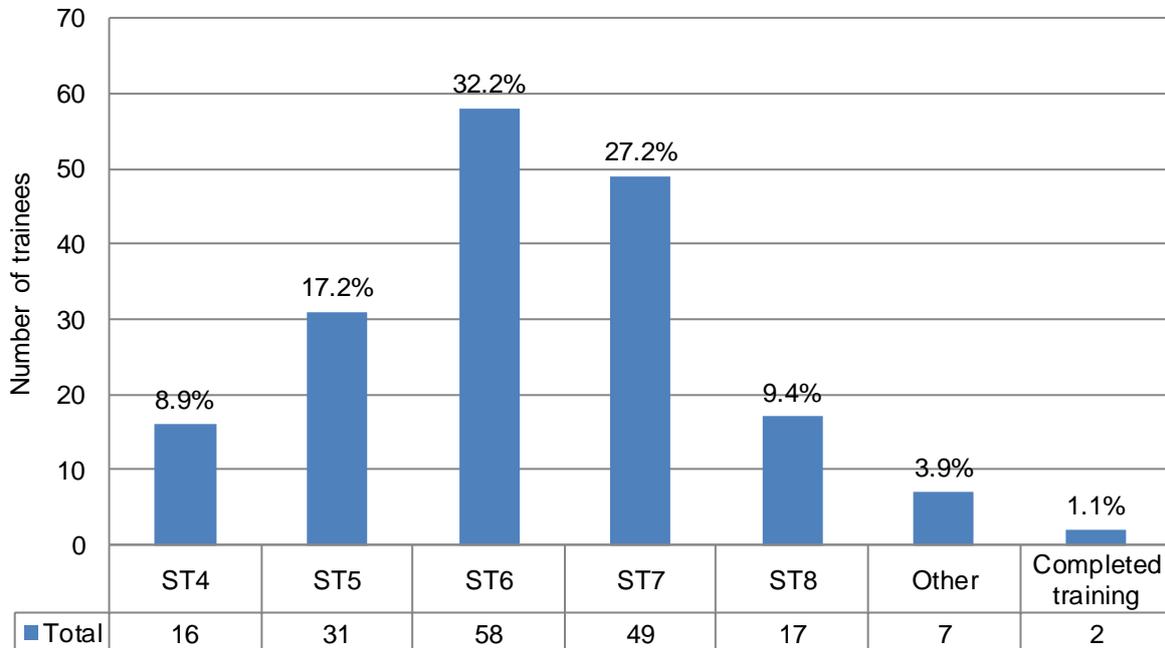
	No.
Family commitments	7
Joined another training scheme	5
Poor work/life balance	5
Training programme design	4
Examination/training programme failure	3
Poor experience as part time trainee	3
Moved overseas	2
Completed training	2
To take up paediatric SAS doctor role	2
To take up a research career	1
<b>Total</b>	<b>34</b>

*\*Respondents were able to provide more than one answer.*

Those that had left training, either to work in paediatrics or to leave paediatrics altogether, provided a reason for doing so (Table 2). The most commonly cited reason was family commitments (7), followed by joining another training scheme (5), poor work/life balance (5) and training programme design (4).

### 2.1.2. Current training grade

If trainees in the UK had progressed without taking time out of training or fast-tracking since they commenced run through training in 2007, they would have reached ST7 before the annual change in August 2014. Figure 2 shows the training grades of those members of the cohort who are currently training in the UK.



**Figure 2: Training grade of respondents in UK on 1st August 2014\***

\* 7 respondents were recorded in the following training grades: Academic Clinical Fellow, Clinical Research Fellow, Locum, OOPE, OOPR.

The results in Figure 2 indicate that only 37.7% have progressed at least as far as ST7 (27.2% (49/180) were at ST7, 9.4% (17/180) at ST8 and 1.1% (2/180) had completed training.

The largest proportion (32.2% or 58/180) had reached ST6 on 1<sup>st</sup> August 2014. 17.2% (31/180) were at ST5 and 8.9% (16/180) at ST4. Overall 58% of doctors were behind their expected year based on the original MMC modelling.

### 2.1.3. Attrition from training

An estimate of the proportion of trainees who leave the paediatric training programme can be made by comparing the part 4 outcomes for those doctors who stated that they were in training in part 3 of the study.

There were 222 members of the cohort in training in part 3 and 168 responded to the part 4 survey. Of these, 156 were still in paediatric training and 12 were not. This equates to a 7.1% decline or an attrition rate of 3.6% per annum.

Of the 12 doctors who had left paediatric training, 9 were still working in paediatrics, 2 were working in clinical genetics and 1 did not provide a response.

### 2.1.4. Working pattern by grade

Table 3 explores the working pattern of cohort according to current grade.

**Table 3: How currently working by training grade**

Training grade		Full time	Less than full time	Maternity leave	Out of programme (OOP)	Total
ST4	No.	6	8	1	1	16
	%	37.5%	50.0%	6.3%	6.3%	9.2%
ST5	No.	11	13	3	3	30*
	%	36.7%	43.3%	10.0%	10.0%	17.2%
ST6	No.	21	25	5	5	56**
	%	37.5%	44.6%	8.9%	8.9%	32.2%
ST7	No.	29	6	5	8	48***
	%	60.4%	12.5%	10.4%	16.7%	27.6%
ST8	No.	13	2	2	0	17
	%	76.5%	11.8%	11.8%	0.0%	9.8%
Other	No.	3	0	1	3	7
	%	42.9%	0.0%	14.3%	42.9%	4.0%
<b>Total</b>	<b>No.</b>	<b>83</b>	<b>54</b>	<b>17</b>	<b>20</b>	<b>174</b>
<b>%</b>	<b>%</b>	<b>47.7%</b>	<b>31.0%</b>	<b>9.8%</b>	<b>11.5%</b>	

\* 1 respondent in ST5 did not specify how they are currently working.

\*\* 2 respondents in ST6 did not specify how they are currently working.

\*\*\* 1 respondent in ST7 did not specify how they are currently working.

Across all training grades, 47.7% (83/174) were working full time, 31.0% (54/174) were working less than full time – an increase from 21.9% in part 3 of this study, and of those working less than full time, 94.3% (50/53) were female and 5.7% (3/53) were male. 9.8% (17/174) were on maternity leave and 11.5% (20/174) were out of programme (Table 3). Although the male rate of less than full time working is low in this cohort, it is interesting to note that 42.9% of doctors completing their foundation training in 2015 who stated that they wished to work less than full time were male<sup>ix</sup>.

The rates of less than full time working are much higher among those who have progressed to ST4, 5 and 6 than those who have reached ST7 and 8, reflecting the greater amount of time needed to train by less than full time trainees.

### 2.1.5. Participation rate

We can calculate a participation rate for those currently in training as follows:-

- There are 83 full time trainees
- There are 54 less than full time trainees at 0.623 average WTE = 33.64 WTE trainees
- There are 37 trainees on maternity leave and OOP = 0 WTE

Participation is therefore 83 plus 33.64 = 116.64, say 117

Participation rate = 117/174 = 67.2%

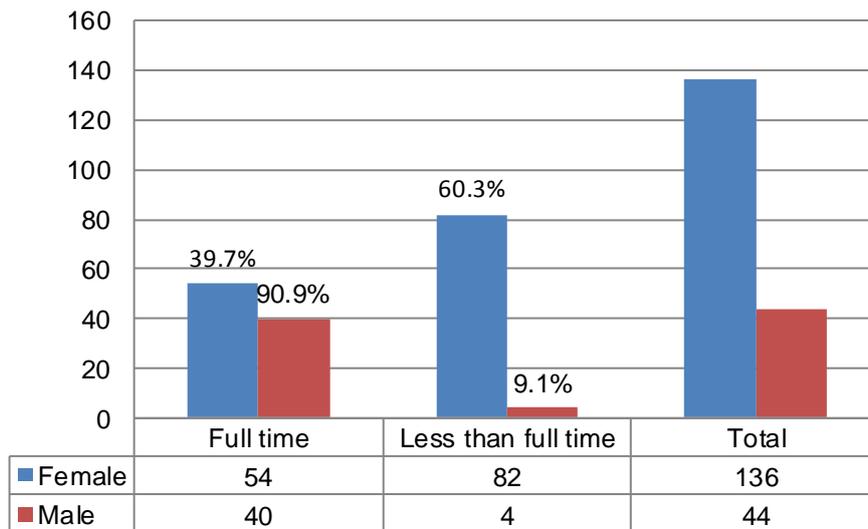
### **2.1.6. Training on grid by subspecialty area**

Respondents were also asked whether they had received training on the RCPCH specialty grid which is undertaken between ST6-8, according to the area of paediatrics they are training in. The response received was sometimes unreliable in that around 5 ST5 trainees stated they had undertaken grid training. Of 89 trainees who stated that they are undertaking specialty training in grades ST6-8, only 40 (44.9%) said they were doing this on the grid. This includes 13 out of 23 neonatal subspecialty trainees, 8 out of 11 undertaking paediatric intensive care medicine and 5 out of 12 in community child health.

## 2.2. Current post and preferences

This section considers trainees preferences in terms of full or part time working in both their trainee role and how they would like to work as a trained paediatrician. Their happiness with having chosen paediatrics as a career is also discussed.

### 2.2.1. Full time/Less than full time working preference as a trained paediatrician



**Figure 3: How would like to work as a trained paediatrician by gender**

\* 5 did not respond to this question.

Figure 3 indicates how those in training would like work when they become a trained paediatrician, by gender. Amongst female trainees, 60.3% (82/136) would like to work less than full time. Amongst male trainees, only 9.1% (4/44) would prefer to do so. Overall 47.8% of the cohort would like to work less than full time on becoming a trained paediatrician. This represents a small decrease in those wishing to work less than full time from 51.4% when we surveyed the cohort for part 3 of the study.

### 2.2.2. How much less than full time work preferred?

When respondents who said they would like to work less than full time when fully trained were asked what percentage of WTE they would like to work, the largest proportion of respondents 65% (56/86) specified that they would prefer to work 50%-70% of a WTE post, while a further 33.7% (29 respondents) would prefer to work between 75% and 100% of a WTE post. 1 respondent would like to work less than 50% of a WTE post.

### 2.2.3. Are trainees working in their preferred way?

We asked those in training whether their full time/less than full time status is their preferred way of working as a trainee. 39 of the 185 in training were either on maternity leave or out of programme and a further 5 respondents did not provide their current working status.

Of those who are currently working full time, 81.6% (71/87) stated that this is their preferred way of working as a trainee and 18.4% (16/87) state that it is not.

Of those currently working less than full time, 88.9% (48/54) stated that this is their preferred way of working as a trainee, while 11.1% (6/54) stated that this is not their preferred way of working.

There are 10 more full time trainees than less than full time trainees who are not working in their preferred way indicating that the proportion of less than full time trainees would increase if preferences were realised from 38% (54/141) to 45% (64/141). When broken down by gender, 27.8% (15/54) of female trainees currently in full time training would prefer to train part time and 3.0% (1/33) of male trainees currently training full time would like to train part time.

#### **2.2.4. How much less than full time being worked?**

The majority (70.3% or 38/54) of less than full time trainees are working at 60% of a WTE post. A small proportion of less than full time trainees (5.6% or 3/54) are working at 50% of a WTE post and a further 5.6% are working at 70%. 16.6% (9/54) are working at 80% of a WTE post. 1 respondent did not specify an amount.

#### **2.2.5. Work life balance**

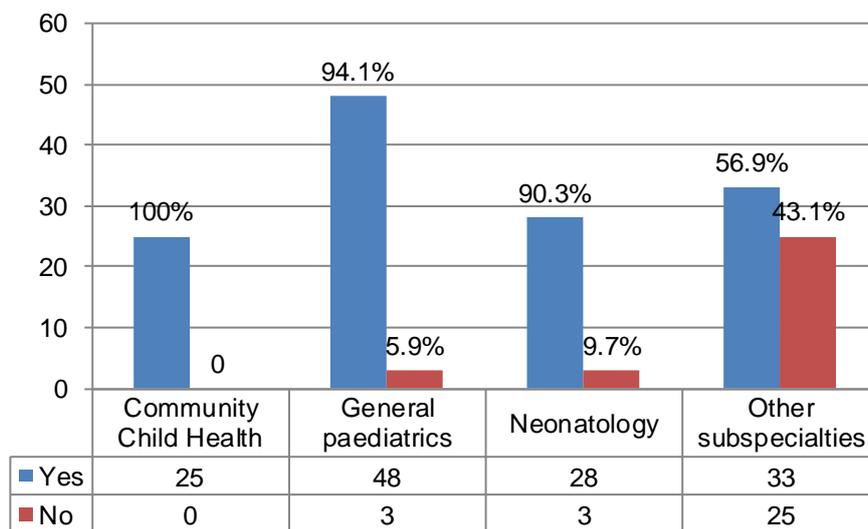
Respondents who were either in training or working in paediatrics were asked if they are happy with choosing paediatrics as a career, taking into consideration their current work life balance. 15 doctors did not give an answer, but among the rest of the respondents 73.2% of those who answered are happy with choosing paediatrics as a career. Males appear to be happier, with 81.6% (40) happy choosing paediatrics as a career compared to 70.3% (102) of females.

## 2.3. Training progress

A number of questions were asked in order to provide a picture about the cohort’s training progress including information about rota participation, confidence in career outcomes, support from seniors, access to protected teaching and other teaching time, plus how much time had been taken out of programme. This information has value for workforce planning and for assessing the morale of trainees.

### 2.3.1. Training rotations

Respondents who were in UK training positions were asked whether they take part in the general paediatric or neonatal rota. The findings are indicated in Figure 4 according to the area of paediatrics that they state they are training in and in order of the proportions who take part. 12 respondents stated that they were out of programme or did not specify their area of training so are not included in this graph.



**Figure 4: General paediatrician/Neonatal rota by area of paediatrics training in**

The data shows that all community paediatric trainees work on either general or neonatal rotas and that the majority of general and neonatal trainees also do so. Amongst trainees in other sub-specialties, there are a substantial proportion of doctors (43.1%) who do not take part in general or neonatal rotas. Numbers training in each specialty apart from community child health and neonatology are small, but the specialty where the fewest trainees take part in these rotas paediatric intensive care medicine at 7.7% (1/13). All trainees in gastroenterology (5) and endocrinology (4) participate in the rotas.

Respondents who took part in general paediatrics or the neonatal rota were also asked to specify what times of day they took part in the rota, and the findings are displayed in Table 4. Respondents were able to provide more than one answer; therefore totals are more than the number of respondents.

**Table 4: Number participated in general paediatrics/neonatal rota**

Rota participation	No.	% of total respondents
9 to 5	90	50.6%
Out of hours	140	78.7%
Weekend	133	74.7%

*\* Respondents were able to provide more than one answer.*

The findings show that a majority of trainees (78.7% or 140/178) participated in general paediatrics or neonatal rotas out of hours and at weekends (74.7%) whereas only 50.6% (90/178) participated in general paediatrics or neonatal rotas weekday 9 to 5 rota.

### **2.3.2 Completion of MRCPCH final exams**

As in previous parts of the cohort study, respondents were asked whether they had completed their MRCPCH exams. All but one respondent who answered this question had completed their exams, and this appears to be incorrectly entered data as the respondent stated that they were in ST7 grade.

### **2.3.3. Confidence in obtaining chosen post**

The cohort respondents were asked a set of questions regarding the level of 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 whether they are considering other options.

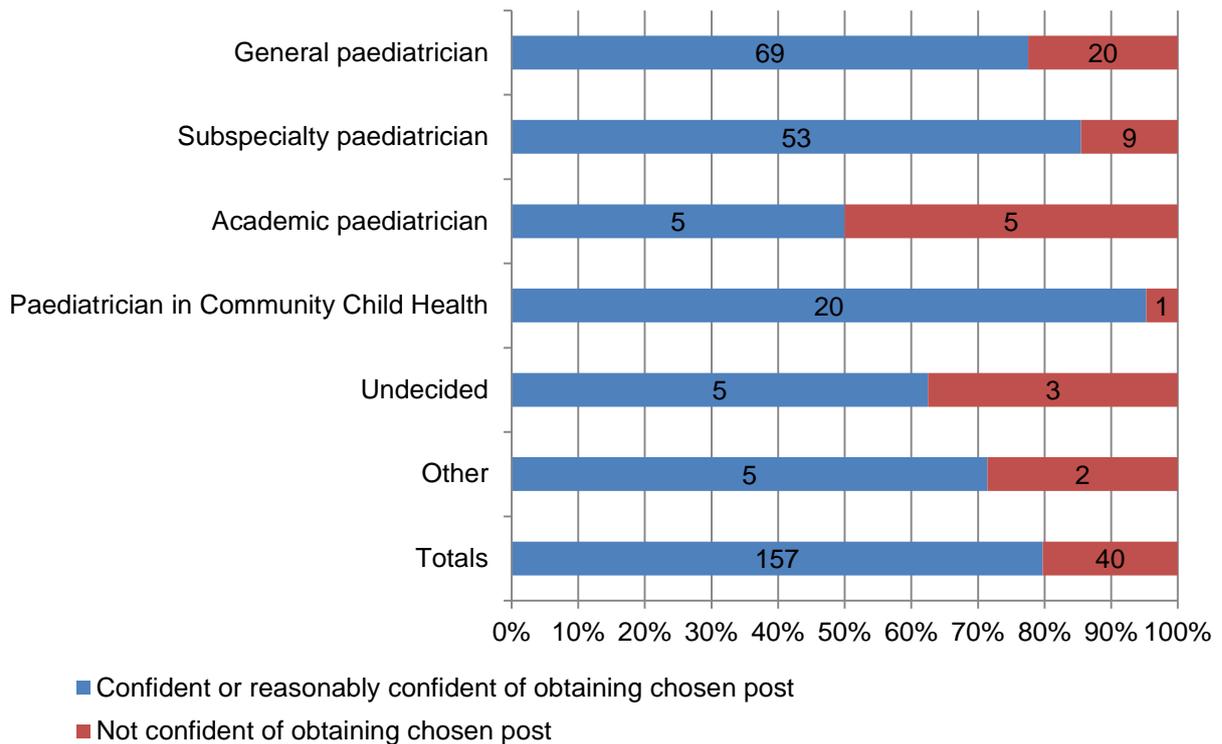
All participants who are either still in training or working in paediatrics were asked to select their level of confidence in obtaining their chosen post at the end of training.

Overall, 25.6% (51) were confident of obtaining their chosen post, 53.8% (107) were reasonably confident and 20.6% (41) were not confident.

Males showed higher levels of confidence overall with 43.1% compared to only 19.6% of females saying they were confident. Only 15.7% of males said they were not confident, compared to 22.3% of females.

### **2.3.4. Confidence by intended job type**

Figure 5 analyses confidence levels of obtaining a post according to respondents' intended job type. This analysis covers those who are currently training or working in paediatrics and shows those who are confident or reasonably confident in blue as a proportion of each group with a particular intended type of post.



**Figure 5: Confidence of getting chosen post by type of post intended**

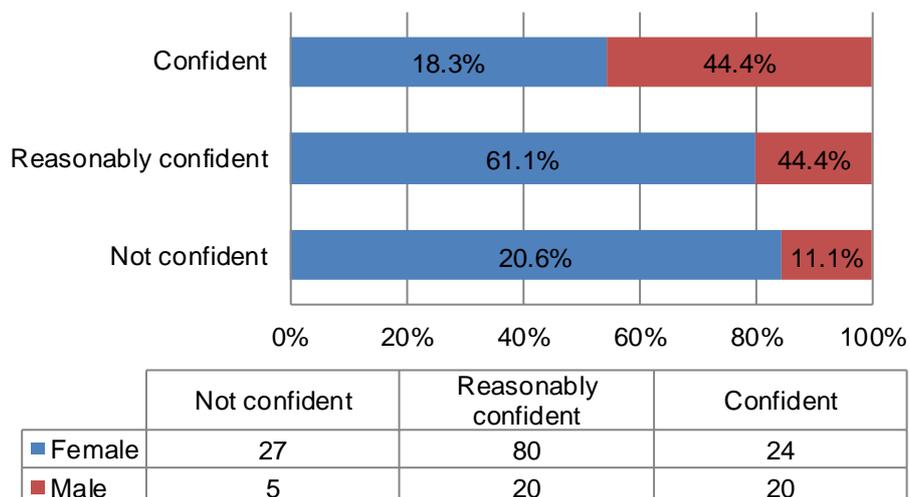
\* 2 have no intentions of becoming paediatricians.

Overall, 20.3% (40/197) were not confident of obtaining their chosen post (see Figure 5). Confidence is highest amongst those intending to be paediatricians in community child health (20/21) perhaps reflecting the perceived vacancy levels in community paediatrics.

Those intending to work in subspecialties also showed higher confidence levels with only 9/62 not confident. Trainees intending to become academic paediatricians were least confident of obtaining their chosen post; 50.0% (5/10) stated they were not confident, followed by those who were undecided (37.5% or 3/8).

### 2.3.5. Confidence of becoming consultants

We asked those in training or working in paediatrics whether they wish to be a paediatric consultant in the future which produced a subset of 176 doctors whose confidence in obtaining their intended post is shown according to gender in Figure 6.



### Figure 6: Of those intending to be paediatric consultants, confidence in obtaining chosen post by gender

Figure 6 shows that a larger proportion of males tend to be more confident in obtaining a consultant post - 44.4% (20/45) in comparison to 18.3% (24/131) of females. The proportion of females who are not confident of obtaining posts is 20.6% compared to only 11.1% of males.

#### 2.3.6. Confidence trends

Between parts 1 to 3, there was a statistically significant decrease in trainees' confidence of obtaining a consultant post. However, between parts 3 and 4, there has been an increase in those that are confident in obtaining a consultant post (25.0% or 44/176).

For those who are not confident, there has been a noticeable decrease between parts 3 and 4 from 31.5% to 18.2% (32/186).

#### 2.3.7. Reasons why not confident and other options

Respondents who intend to become paediatric consultants, and stated that they are not confident in obtaining their chosen post were asked for reasons why they were not confident.

- 32 respondents stated that they were not confident in obtaining their chosen posts.
- 84.4% (27/32) stated that there were an insufficient number of consultant posts available.
- Other reasons as to why respondents were not confident in obtaining chosen posts included geographical constraints, poor training system, high levels of competition and not enough grid posts.

These reasons must be set against a 4.3% per annum growth in UK consultants between 2011 and 2013 and a consultant vacancy rate of 2.5% recorded in 2013<sup>xi</sup>. It is probable therefore that concerns about insufficient number of consultant posts being available are based upon local rather than national perspectives.

Those who were not confident of obtaining their chosen post were asked whether they were looking for other options.

**Table 5: Of those not confident in obtaining chosen post, other options considered**

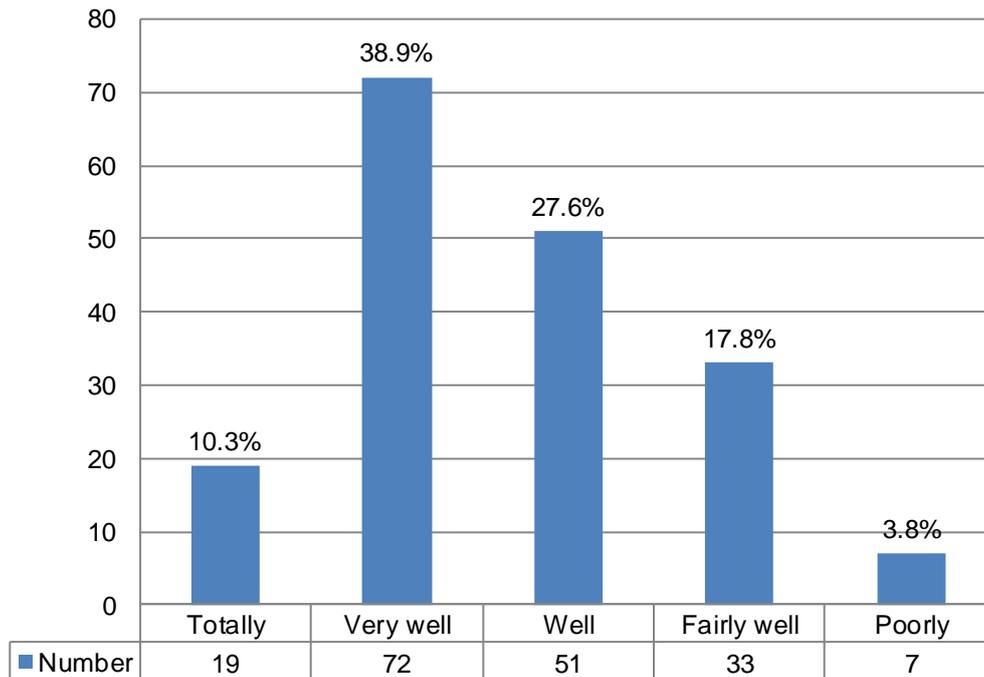
	No.	%
Other paediatric specialty	8	28.6%
Leaving medicine	4	14.3%
SAS grade post	4	14.3%
Locum work	3	10.7%
Leaving NHS	2	7.1%
Moving to a different region/country	3	10.7%
Other specialty outside paediatrics	2	7.1%
Other	2	7.1%
<b>Total</b>	<b>28</b>	

Table 5 provides a breakdown of the options being considered. 28 respondents who are not confident in obtaining their chosen post are considering other options outside of

paediatric training or working. A substantial number of these were still considering working in paediatrics – 8 were thinking about another paediatric specialty, 7 others were considering a SAS grade post or moving a different region/country. It is only clear that 6 of the 28 i.e. 4 leaving medicine and 2 other specialty outside paediatrics clearly saw their future outside paediatrics.

### 2.3.8. Support from seniors and access to teaching time

Respondents in training were asked how supported they feel in their training and development by their seniors and to rate this support on a five point scale from totally supported to poorly supported. The results from this rating are shown in Figure 7.



**Figure 7: How supported trainees felt by seniors in their training and development**

*\* 3 respondents did not answer this question.*

It is encouraging that half (91/182) of trainees who answered this question felt either totally or very well supported by seniors in their training and development. Only 3.8% who answered felt poorly supported.

Table 6 analyses whether there is a relationship between support from seniors and confidence in obtaining a post.

**Table 6: How supported trainees felt by their seniors by how confident they were of obtaining their chosen post in paediatrics**

How supported trainees felt by seniors	Confidence of obtaining chosen post			Total
	Confident	Reasonably confident	Not confident	
Totally (5)	9	9	1	19
Very well (4)	19	45	8	72
Well (3)	11	27	13	51
Fairly well (2)	3	16	14	33
Poorly (1)	1	2	4	7
<b>Total</b>	<b>43</b>	<b>99</b>	<b>40</b>	<b>182*</b>
<b>Average score</b>	<b>3.7</b>	<b>3.4</b>	<b>2.7</b>	<b>3.3</b>

*\* 3 did not answer this question*

A value was given from 1 to 5 to each of the answer options about support from seniors as set out in Table 6. This value was multiplied by the number of respondents who were confident, reasonably or not confident, and averaged to see if there was an association between support and confidence of obtaining their chosen post. The results suggest that respondents who are confident (3.7) or reasonably confident (3.4) are more likely to feel better supported than those who are not confident (2.7).

### 2.3.9. Protected Teaching Time

We asked respondents how much protected teaching time per week they have allocated in their current job. The findings are set out in Table 7.

**Table 7: How much protected teaching time do you have?**

Protected teaching time	No.	%
No protected teaching time	68	37.4%
Less than an hour per week	10	5.5%
An hour per week	33	18.1%
More than an hour per week	69	37.9%
Not specified	2	1.1%
<b>Totals</b>	<b>182*</b>	

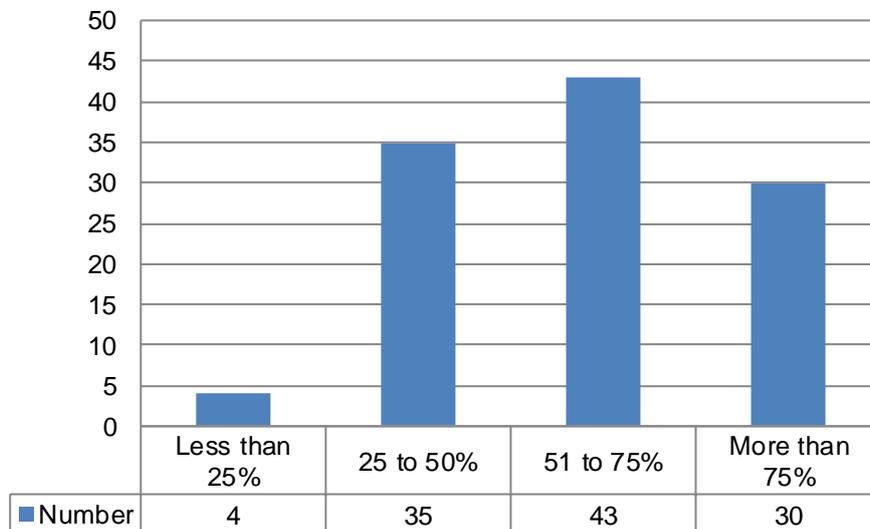
*\* 3 trainees did not answer this question.*

37.4% (68/182) stated that they had no protected teaching time, 5.5% (10/182) had less than an hour per week, 18.1% (33/182) had an hour per week, 37.9% (69/182) had more than an hour per week and 1.1% (2/182) did not specify how much protected teaching time they had.

Since part 3 of the study, the proportion of respondents who stated that they had no protected teaching time has decreased – from 43.4% (93/215) in part 3 to 37.8% (68/180) in part 4. Those who have less than an hour per week of protected teaching time also decreased – 10.7% (23/215) in part 3 to 5.5% (10/182) in part 4. Conversely, the proportion of those that reported having more than an hour per week of protected teaching time has increased – 26.5% in part 3 to 37.9% in part 4.

### 2.3.10. Ability to attend protected and other teaching time

The 112 trainees with protected teaching time were asked how much they were able to attend and this is shown in Figure 8.



**Figure 8: How much protected teaching time able to attend**

*\* 2 did not specify how much teaching time they are able to attend.*

26.8% (30/112) were able to attend more than 75%, 38.4% (43/112) were able to attend 51%-75%, 31.3% (35/112) were able to attend 25%-50% and 3.6% (4/112) were only able to attend less than 25%.

In addition to protected teaching time, respondents were asked how much other teaching time was available to them in their job plans and results are set out in Table 8.

**Table 8: Other teaching time available**

	Other teaching time in job plan	%
More than 1 hour	70	38.9%
Less than 1 hour	46	25.6%
1 hour	39	21.7%
No other teaching time	25	13.9%
<b>Total</b>	<b>180</b>	

*\* 5 did not specify how much other teaching time was in their job plans.*

38.9% (70/180) had more than one hour, 21.7% (39/180) had one hour, 25.6% (46/185) had less than one hour, and 13.9% (25/180) had no other teaching time.

Table 9 shows how much of that other regular teaching time they are able to attend.

**Table 9: How much other regular teaching time are you able to attend?**

	Able to attend other regular teaching time	
	No.	%
Less than 25%	35	22.7%
25 to 50%	61	39.6%
51 to 75%	38	24.7%
More than 75%	20	13.0%
<b>Total</b>	<b>154</b>	

*\* 1 did not specify how much other regular teaching time they are able to attend.*

13.0% (20/154) were able to attend more than 75%, 24.7% (38/154) were able to attend 51%-75%, 39.6% (61/154) were able to attend 25%-50% and 22.7% (35/154) were able to attend less than 25%.

Table 10 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 10: Happy with choosing paediatrics as a career by how much protected teaching time**

Protected teaching time	Considering current work life balance, happy with choosing paediatrics		
	Yes	No	Total
No protected teaching time	43 63.2%	25 36.8%	<b>68</b>
Less than an hour per week	5 50.0%	5 50.0%	<b>10</b>
An hour per week	27 81.8%	6 18.2%	<b>33</b>
More than an hour per week	54 78.3%	15 21.7%	<b>69</b>
<b>Totals</b>	<b>129</b> <b>71.7%</b>	<b>51</b> <b>28.3%</b>	<b>180*</b>

*\* 5 did not respond to this question.*

There appears to be some association between the amount of protected teaching time and a trainee’s happiness with choosing paediatrics as a career. 78.3% of those reported to have more than an hour per week were happy with choosing paediatrics and 81.8% of those that have an hour a week are happy with their career choice, compared to only 50% who have less than 1 hour per week and 63.2% who have no protected teaching time.

### 2.3.11. Time taken out of training

Respondents were also asked whether they had taken any time out in the programme in the last two years. The findings show female respondents were more likely to have taken time out of training 59.6% (81/136) in comparison to male respondents 36.4% (16/44).

Respondents who had taken time out of training were asked to give reasons as to why they had taken time out during the programme. Table 11 indicates the reasons provided.

**Table 11: Reasons for time taken out of training**

	Female	%	Male	%	Total
Parental leave	35	40.7%	4	21.1%	39
Academic related activities	23	26.7%	11	57.9%	34
Maternity leave	8	9.3%	0	0.0%	8
Out of Programme	7	8.1%	1	5.3%	8
Travel/Work overseas	6	7.0%	1	5.3%	7
Personal reasons	3	3.5%	2	10.5%	5
Family commitments	2	2.3%	0	0.0%	2
Sick leave	1	1.2%	0	0.0%	1
Leadership and management fellowship	1	1.2%	0	0.0%	1
<b>Total</b>	<b>86</b>		<b>19</b>		<b>106</b>

Respondents were able to provide more than one reason and the 97 respondents provided 106 reasons. Half of the female trainees' reasons related to parental/maternity leave and 4/19 (21.1%) of males took time out for parental leave. Time out for academic related activities accounted for 26.7% of female trainees and 57.9% of male trainees' reasons. 7 women and 1 male stated that they had been out of programme (OOP) but had not specified the type of OOP. Other reasons provided included travel or work overseas, personal reasons, family commitments and sick leave.

## 2.4. Geographic preferences and constraints

In order to assess the relative attractiveness of paediatrics as a career in the UK and abroad, respondents in training were asked where they would like to work on completion of training. The results are analysed in Table 12 according to gender.

**Table 12: Where would like to work on completion of training**

Location preference	Females	Males	Total
UK	130	39	169
	94.2%	84.8%	91.8%
Abroad	8	7	15
	5.8%	15.2%	8.2%
<b>Total</b>	<b>138</b>	<b>46</b>	<b>184*</b>

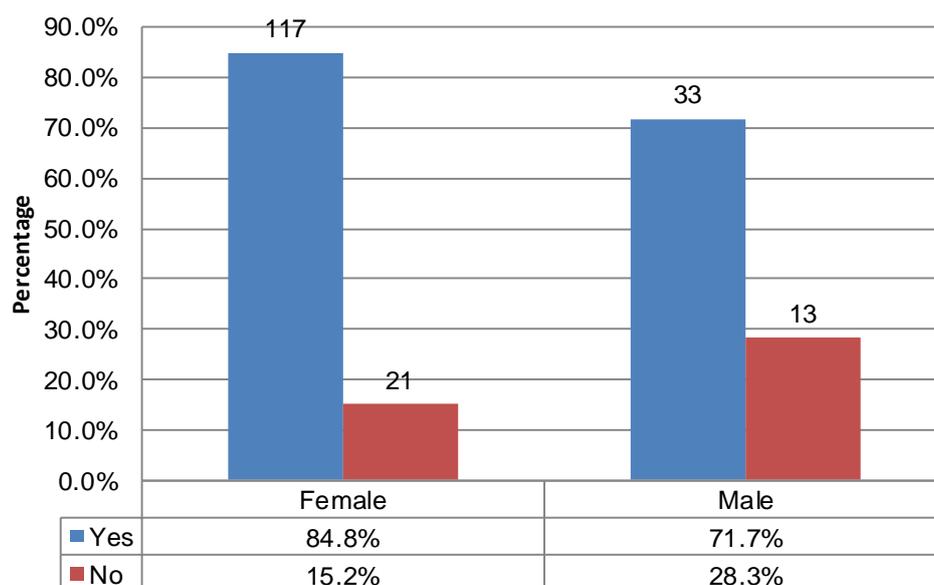
*\* 1 respondent did not respond specify where they would like to work on completion of training.*

Out of the 185 currently in training, 15 (8.1%) stated they would like to work abroad – 10 would like to work abroad permanently while 5 want to work abroad temporarily. This matches closely the data collected in the RCPCH studies of new CCT holders where we found 11.9% from 2011 and 10.2% from 2012 do actually go abroad after completion of training<sup>x</sup>.

Of the 15 trainees who would like to work abroad, almost half (7) are male indicating that male trainees are more likely to have ambitions to work abroad. The numbers who intend to work abroad permanently is similar for both genders - 71.4% (5/7) for males and 62.5% (5/8) of females.

### 2.4.1. 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 9.



**Figure 9: Will your application for a consultant post be limited due to geographical constraints?**

*\* 1 respondent did not answer this question.*

75.0% of the cohort says their application will be limited suggesting a certain lack of mobility amongst the future workforce. A higher proportion of females (84.8%) have constraints compared to 71.7% 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 13, by gender.

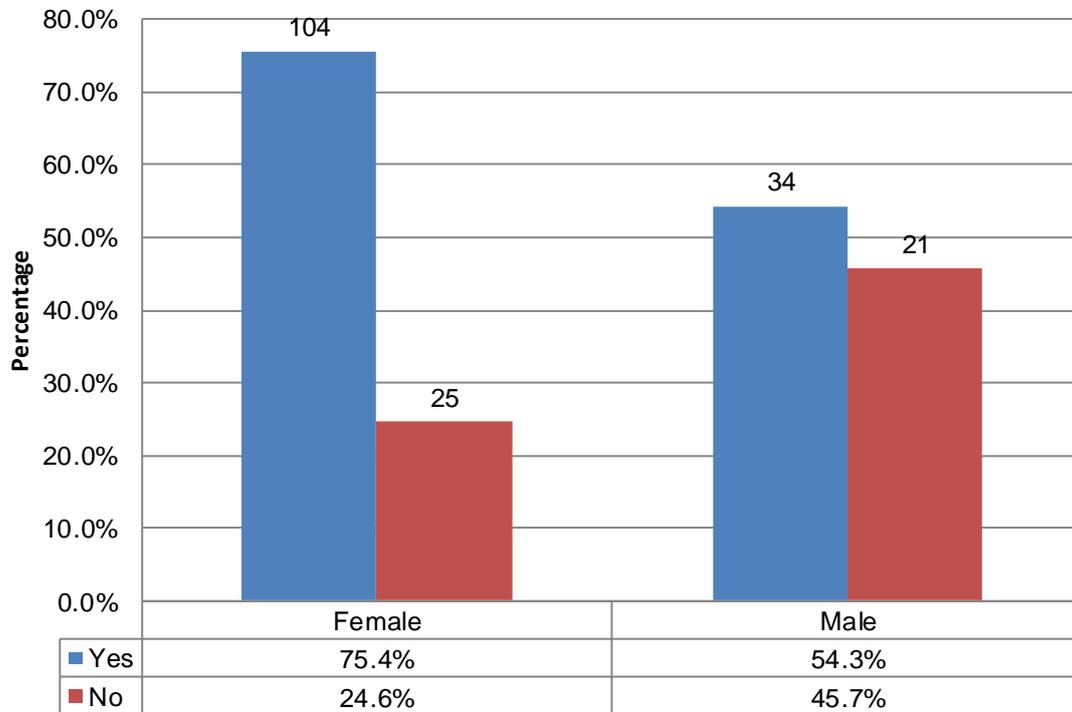
**Table 13: Geographical constraints in applying for consultant post**

	Female	Male	Total
My partner/spouse job is fixed to this area	96	28	124
	82.1%	84.8%	82.7%
I own a house	91	24	115
	77.7%	72.7%	76.7%
I like it here and my social network is in this area	80	22	102
	68.4%	66.7%	68.0%
My childcare is fixed to this area	61	17	78
	52.1%	51.5%	52.0%
I like my work place	24	10	34
	20.5%	30.3%	22.7%
My subspecialty position in different region	7	3	10
	6.0%	9.1%	6.7%
Family commitments	5	1	6
	4.3%	3.0%	4.0%
<b>Total respondents</b>	<b>117</b>	<b>33</b>	<b>150</b>

82.7% of those reporting constraints stated that their spouse's job was fixed to a particular area and 76.7% of respondents stated that they own a house. A small number 6.7% of respondents highlighted that their subspecialty position is in a different region.

### 2.4.2. 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 indicated in Figure 10.

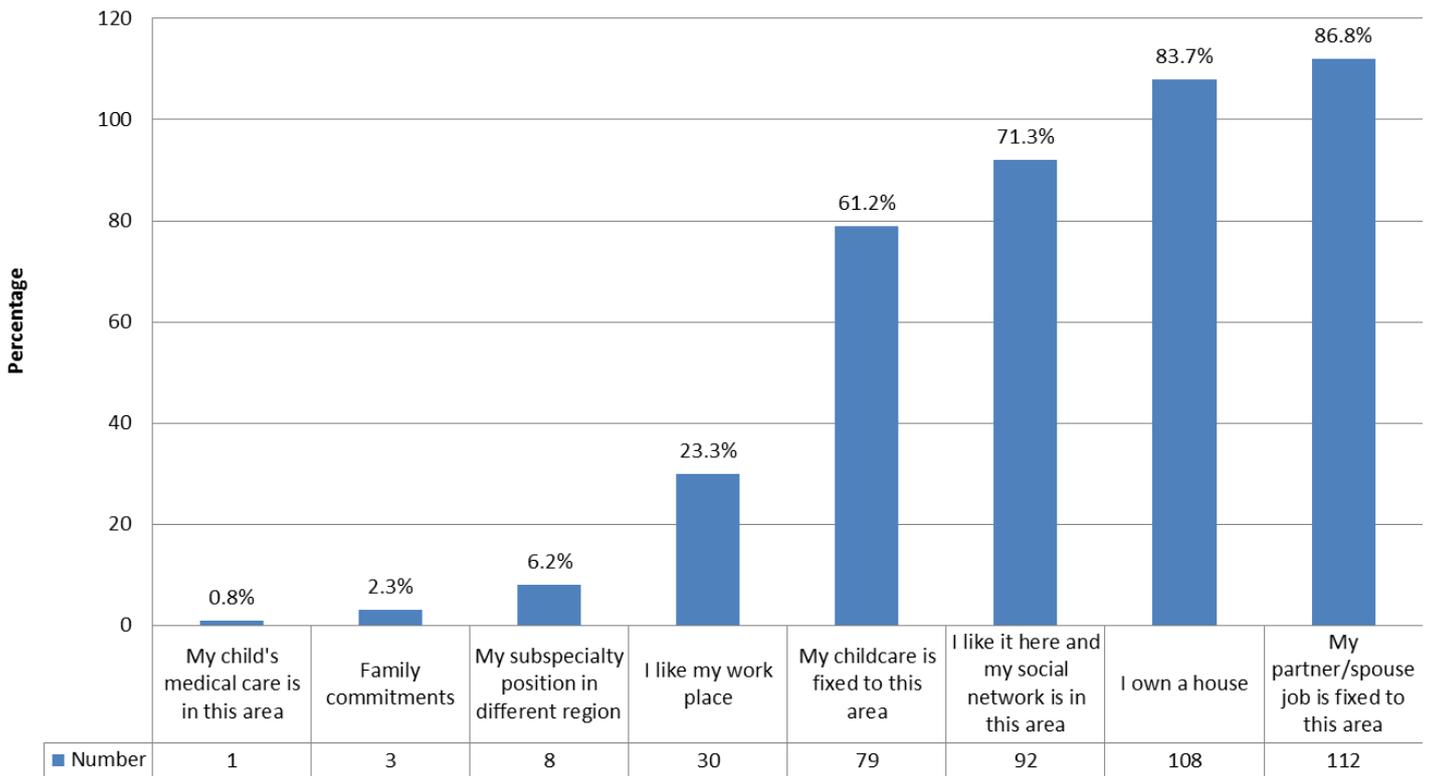


**Figure 10: Is choice of training programme limited due to geographical constraints?**

*\* 1 did not answer this question.*

Figure 10 shows that 75.4% of female respondents' choice was limited by geographical constraints while 54.3% of men were limited in the same way.

Those respondents who stated that 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 Figure 11.



**Figure 11: Geographic constraints in regards to training programme**

Similar to the geographical constraints in applying for a consultant post, the most common reasons given for geographical constraints in regards to training programme relate to the jobs of the doctors' spouses (86.8%) and home ownership in a particular area (83.7%). Both these reasons were slightly more common for women. Almost half 48% (12/21) of men stated that the fact that they liked their workplace was a constraint compared to only 17.3% of women (18/104).

### 2.4.3. Application for deanery transfer

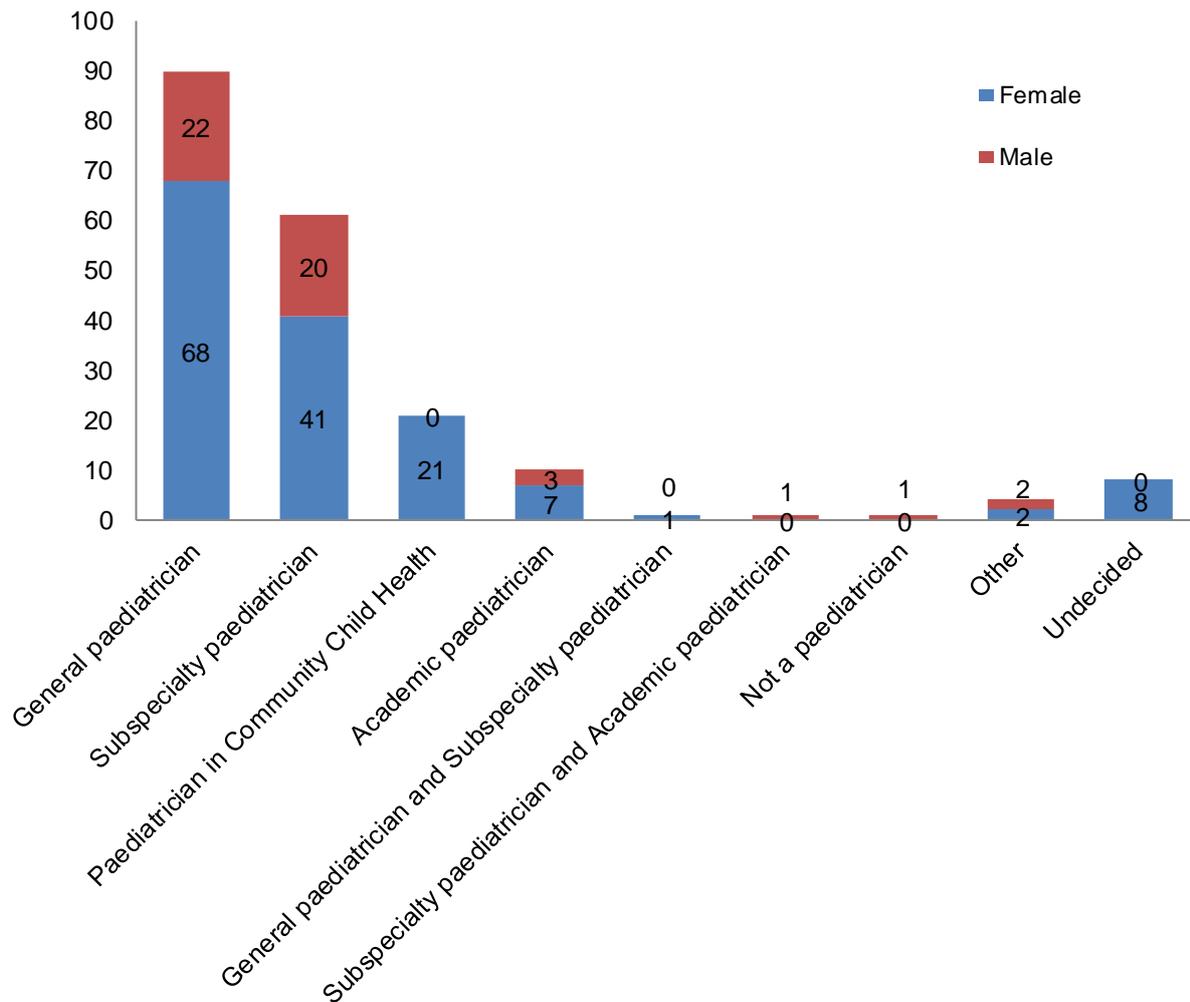
Respondents were asked whether they had made an application for deanery transfer since starting their training. 14.6% (27/185) had made an application for transfer, and of these, 77.8% (21/27) were successful. When respondents were asked this question in part 3, 15.6% (40/257) had made an application and 80% (32) were successful.

The number of unsuccessful applications was low (6) and these were spread across trainees working in 5 separate deaneries.

## 2.5. Career intentions

The study asked those in training and working in paediatrics 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 12 shows the response regarding the type of paediatrician respondents intend to be by gender.



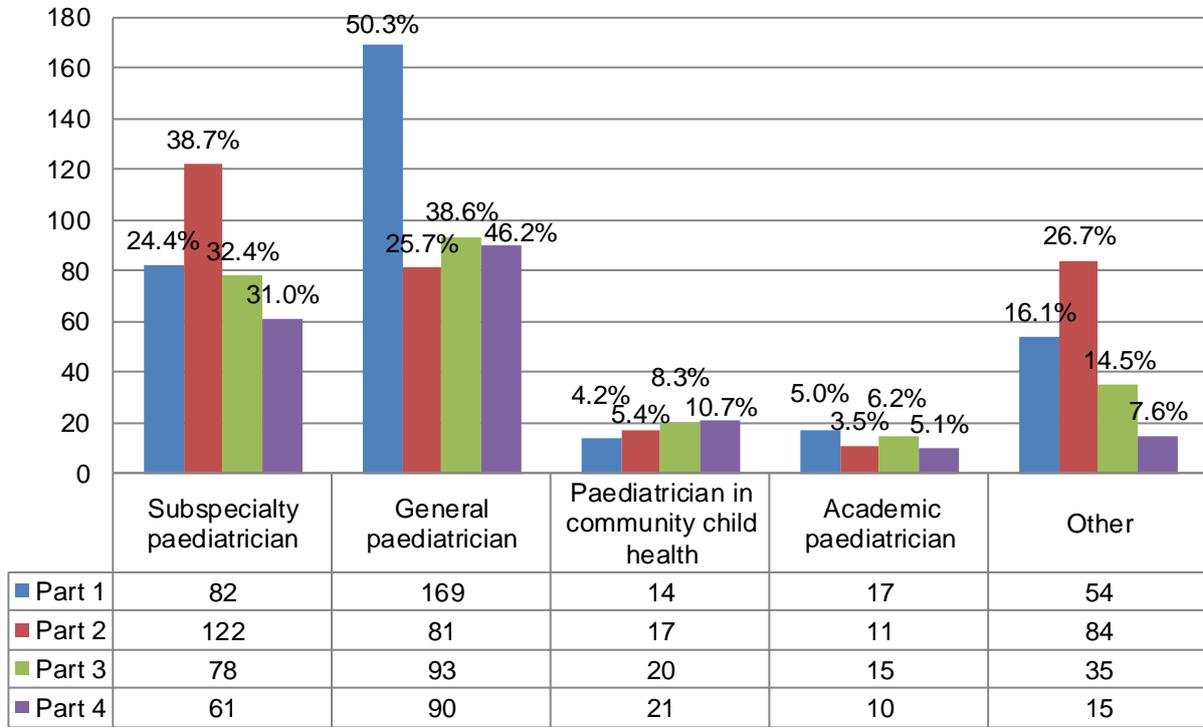
**Figure 12: Type of paediatrician intention by gender**

*\* 2 had completed training.*

The largest proportion of respondents, 90 (46.2%) intend to be general paediatricians, 61 (31.0%) intend to be subspecialty paediatricians, 21 (10.7%) intend to be paediatricians in community child health and 10 (5.1%) academic paediatricians and 8 doctors (4.1%) are undecided. 1 does not intend to be a paediatrician.

The graph shows that there were no males intending to be paediatricians in community child health, but that almost half of male respondents 23/49 (46.9%) intend to be other subspecialty or academic paediatricians compared to only 32.4% (48/148) of female respondents who do so.

We asked about specialty intentions in parts 1, 2 and 3 of the study and the comparison with part 4 is shown in Figure 13 to ascertain whether trainees' intentions have changed during the period of the study. The graph shows the numbers intending to be each type of paediatrician at each stage of the study and the proportion this represents of all those responding to the stage.



**Figure 13: Paediatrician intention - trends throughout study**

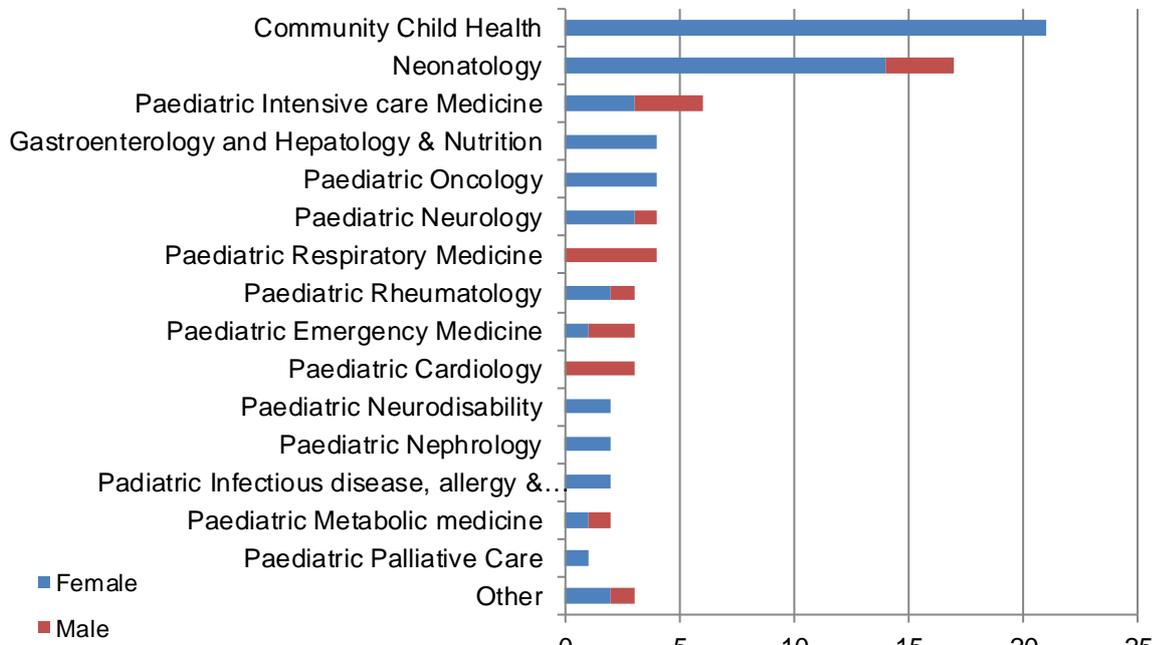
\* 'Other' includes those categorised as Combined - acute and community paediatrician, Other, Not a paediatrician and Undecided.

The percentage of trainees intending to be subspecialty paediatricians has increased from 24.4% in part 1 to 31.0% in part 4, although it peaked at 38.7% in part 2. Those intending to be general paediatricians increased by 7.6% from 38.6% to 46.2% between parts 3 and 4.

It is reassuring to note that the proportion intending to be community paediatricians has more than doubled since the cohort began from 4.2% to 10.7% (21/197) in part 4. There has been a significant decrease in the percentage of trainees who were undecided across parts 2, 3 and 4, from 26.0% in part 2, 10.4% in part 3 and 4.1% in part 4. 5 of the 8 respondents who were undecided in terms of the type of paediatrician they intended to become stated that they had a special interest (2 in paediatric infectious disease, allergy and immunology, one in neonatology, one in paediatric endocrinology and one unspecified).

### 2.5.1. Subspecialty intentions

Each of the 61 respondents who intend to become a subspecialist indicated which subspecialty they would like to work in and Figure 14 provides a breakdown of these subspecialties by gender. Those who also previously stated they intended to become paediatricians in community child health were also added to the community child health category in Figure 14.

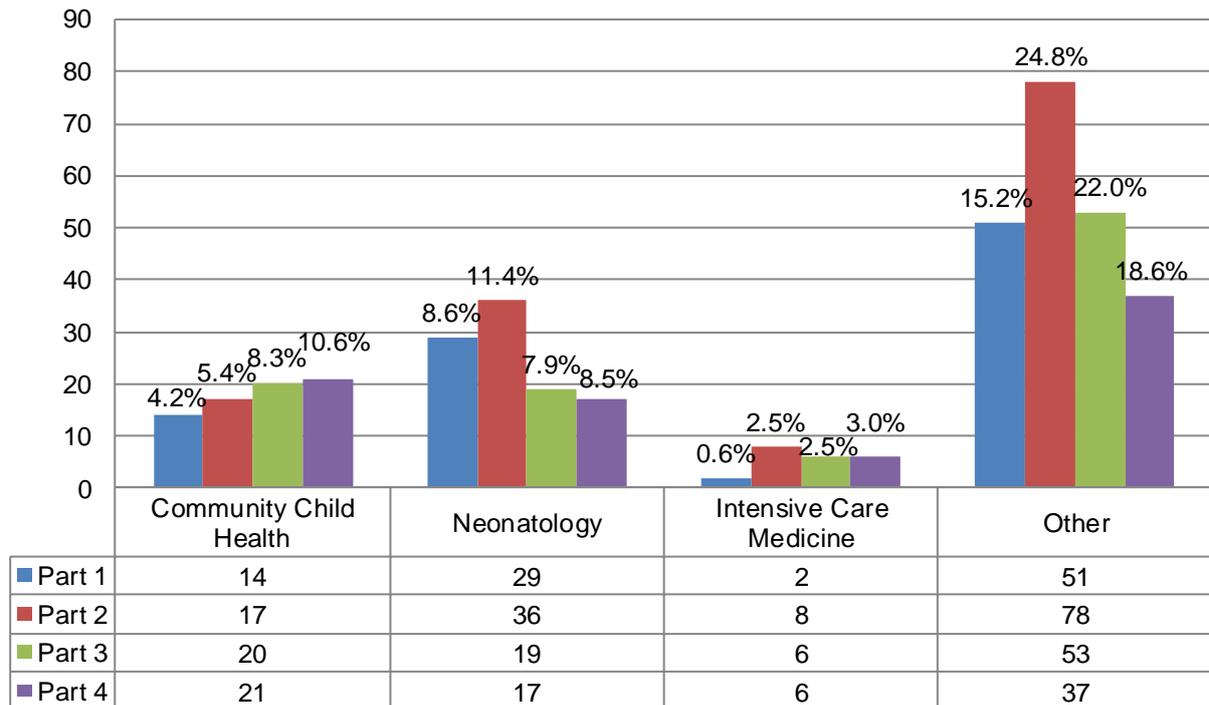


**Figure 14: Subspecialty intentions of those who intend to be paediatric subspecialists**

The largest proportion of those intending to be subspecialists plan to go into community child health with 21 (25.9%). These are followed by 21.0% in neonatology with 17 trainees intending to enter this subspecialty (14 female and 3 male), 7.4% in paediatric intensive care medicine – 3 female trainees and 3 male trainees and 4.9% in gastroenterology, hepatology and nutrition, paediatric oncology, paediatric neurology and paediatric respiratory medicine.

As previously mentioned, 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, cardiology and emergency medicine are male.

A similar question was asked in the earlier parts of the study and a comparison of the response with parts 1, 2 and 3 are shown in Figure 15. This graph shows the numbers intending to go into the largest 3 subspecialties – community child health, neonatology and intensive care medicine plus all the other subspecialties grouped together at each stage of the study. The denominator for percentage is all career intentions.



**Figure 15: Subspecialty intentions - trends through the study**

The number of trainees specifying a subspecialty intention was 81 (40.7%) in part 4. In parts 2 and 3, 139 (44.1%) and 98 (40.7%) respectively stated a subspecialty intention. The number of trainees with subspecialty intentions for community child health has increased slightly from 20 (8.3%) in part 3 to 21 (10.6%) in part 4. The proportion of those intending to work in neonatology has increased from 7.9% (19) in part 3 to 8.5% (17) in part 4.

In Table 14 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 2013 RCPCH Census<sup>xi</sup>. The proportions of each career type has been calculated excluding undecided and those not intending to become a paediatrician, so therefore differs from Figure 12.

**Table 14: How career intentions match job availability**

	Part 4	Consultants 2013
Academic paediatrician	10	143
	5.0%	3.7%
General paediatrician	90	1534
	47.6%	39.7%
Paediatrician in Community Child Health	21	697
	11.1%	18.1%
Subspecialty paediatrician	61	1487
	30.7%	38.5%
Other	7	N/A
	3.5%	
<b>Totals</b>	<b>189</b>	<b>3861</b>

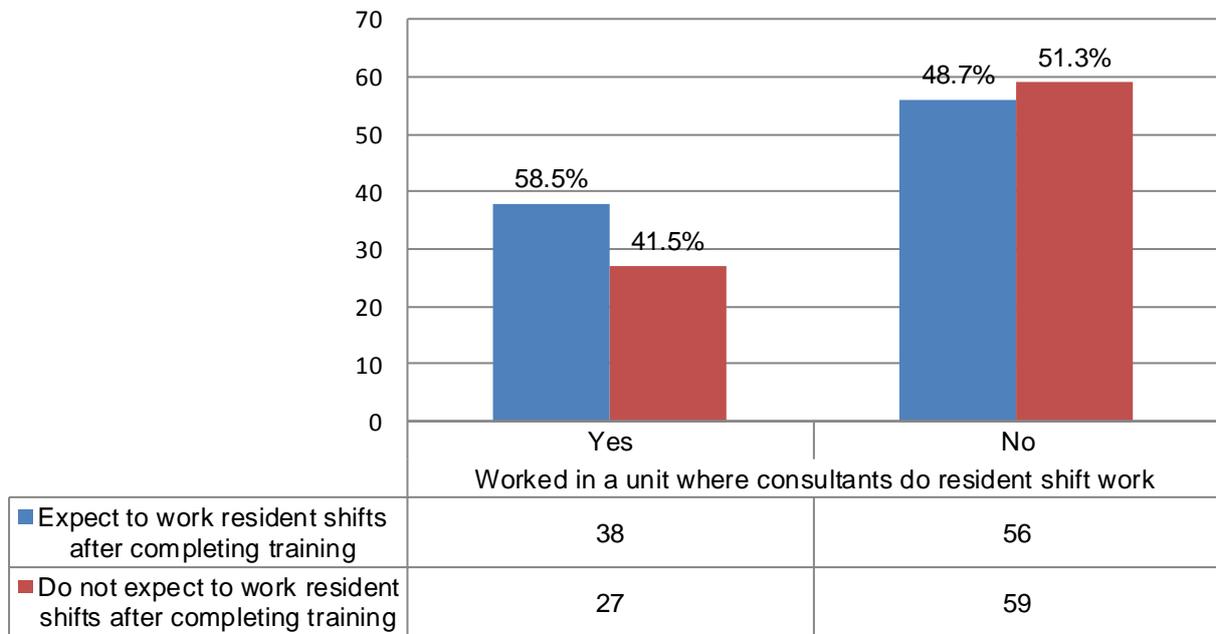
*\* 8 doctors were undecided in regards to career intentions. 2 doctors did not intend to become a paediatrician.*

Similar to the findings in part 3 of this study, there is a difference between the career intentions of the cohort and the current breakdown of job types in the current consultant workforce. This could be interpreted as a potential oversupply in those intending to become general paediatricians (7.7%) and a potential shortfall in community paediatricians (-7.0%) if the view is that the proportions in the current workforce need to be maintained. However the workforce implications of the revised Facing the Future standards indicate an additional demand of 325 WTE general consultants across the UK to meet the new demand for consultant cover; it is therefore expected that new posts should be available to meet any oversupply.

The study also intended to establish whether the cohort (those in training and working in paediatrics) wished to become consultants or specialty doctors in the future. The responses show that 88.4% in part 4 wish to become consultants, 4% specialty doctors, 2.5% are unsure and 5% did not state a grade. This corresponds quite closely with outcomes for new CCT holders and has not varied greatly since the study began, albeit a rise from 1.2% (4) to 4% (8) in the number intending to be specialty doctors, which is likely to reflect attrition from training.

## 2.6. Resident shift working

Members of the cohort were asked a series of questions in regard to their views on resident shift working for consultants. In Figure 16, the expectations of those in training of working resident shifts following training are considered according to whether they have worked in a unit where consultants do resident shifts.



**Figure 16: Expectations of resident shift working against experience of working in a unit with resident shift working consultants**

*\* 5 did not respond to this question.*

Overall 52.2% of those in training expect to be working resident shifts after they have completed training. Respondents who have worked in a unit where consultants do resident shift work are more likely to expect to do so - 58.5% compared to 48.7% of those who have not worked in such a unit.

Respondents, including those working in paediatrics, were asked to rank a series of options for resident shift working in their consultant post. The results are shown in Table 15.

**Table 15: Views on resident shift working as part of a consultant career**

Resident shift working options	Very happy to accept		Reasonably happy to accept		Unsure about accepting		Reluctantly accept		Will not accept under any circumstances		Totals
	No.	%	No.	%	No.	%	No.	%	No.	%	No.
Option 1: RSW involves working day, twilight and some night resident shifts with no phased career options.	5	2.6%	9	4.7%	29	15.1%	58	30.2%	91	47.4%	192
Option 2: 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.	25	13.0%	48	25.0%	42	21.9%	50	26.0%	27	14.1%	192
Option 3: RSW involves twilight shifts* and/or some weekend working** with no phased career options.	19	9.9%	54	28.1%	50	26.0%	34	17.7%	35	18.2%	192
Option 4: RSW involves twilight shifts*and/or some weekend working** with a move to a phased career option to be non-resident in later career.	74	38.5%	60	31.3%	27	14.1%	21	10.9%	10	5.2%	192
Option 5: No resident shifts in contract.	158	82.3%	17	8.9%	11	5.7%	0	0.0%	6	3.1%	192

*\*7 did not answer this question.*

The responses unsurprisingly show that an option which does not involve any resident shifts in contracts is most popular, 82.2% of respondents would be very happy to accept. Option 2 in which consultants do twilight shifts and weekend working with a move to a phased career option later on in their career is also popular with respondents and reflects recent development in job plans and service cover arrangements – 69.8% of respondents would be very or reasonably happy to accept this way of working.

The option which was least popular with respondents was working day, twilight and some night resident shifts with no phased career options; 47.4% of respondents stated that they would not accept this option under any circumstances.

In order to understand further about respondents' views on resident shift working for consultants, we also asked whether they believe that resident shift working provides a

better quality service. The results are shown in Table 16 according to whether trainees have worked in a unit where consultants do resident shifts.

**Table 16: 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	36	16	15	67
	53.7%	23.9%	23.4%	
No	54	29	42	125
	43.2%	23.2%	33.6%	
Total	90	45	57	192*
	46.9%	23.4%	29.7%	

*\* 7 did not answer this question.*

Overall 46.9% of respondents agreed that resident shift working provided better quality service. When respondents had worked in a unit where consultants participate in resident shift work and therefore could see the effects of resident shift working first hand, a larger proportion of these respondents agreed resident shift working provided better quality service (53.7%). Since part 3, there has been a decrease in the proportion of respondents who are undecided as to whether resident shift working provides a better quality service, from 37.9% (85/224) to 29.7% (57/192).

Respondents were also asked whether they felt that resident shift working is sustainable in the long term. Over a quarter (26.6%) stated that they did not know, only 12.5% of respondents felt that it was sustainable and 60.9% of respondents felt that in the long term, resident shift working is not sustainable.

### 3. References

- <sup>i</sup> Modernising Medical Careers (MMC) Cohort Study – Part 1. 2008. RCPCH. Accessed 25 January 2016. Available at: [http://www.rcpch.ac.uk/sites/default/files/asset\\_library/Research/Workforce/MMC%20Cohort%20Study\\_main%20findings%20link.pdf](http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/MMC%20Cohort%20Study_main%20findings%20link.pdf)
- <sup>ii</sup> Modernising Medical Careers (MMC) Cohort Study – Part 2. 2013. RCPCH. Accessed 3 February 2016. Available at: <http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%202%20Report.pdf>
- <sup>iii</sup> Modernising Medical Careers (MMC) Cohort Study – Part 3. April 2014. RCPCH. Accessed 25 January 2016. Available at: [http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%203%20final\\_0.pdf](http://www.rcpch.ac.uk/system/files/protected/page/MMC%20part%203%20final_0.pdf)
- <sup>iv</sup> Facing the Future: Standards for Acute General Paediatric Services. Revised 2015. RCPCH. Accessed 25 January 2016. Available at: <http://www.rcpch.ac.uk/sites/default/files/page/Facing%20the%20Future%20Standards%20web.pdf>
- <sup>v</sup> European Working Time Directive (EWTD). 1998. Accessed 25 January 2016. Available at: <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>
- <sup>vi</sup> Health and Social Care Act, 2012. Accessed 21 January 2016. Available at: [http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga\\_20120007\\_en.pdf](http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf)
- <sup>vii</sup> Securing the future of excellent patient care. 2013. Shape of Training. Accessed 25 January 2016. Available at: [http://www.shapeoftraining.co.uk/static/documents/content/Shape\\_of\\_training\\_FINAL\\_Report.pdf\\_53977887.pdf](http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf)
- <sup>viii</sup> Facing the Future: Together for Child Health. RCPCH. Accessed 4 February 2016. Available at: <http://www.rcpch.ac.uk/facing-future-together-child-health>
- <sup>ix</sup> F2 Career Destination Report. 2015. The UK Foundation Programme Office. Accessed 21 January 2016. Available at: <http://www.foundationprogramme.nhs.uk/pages/home/keydocs>
- <sup>x</sup> CCT Class of 2011 and 2012: where are they now? November 2013. RCPCH. Accessed 17 December 2015. Available at: <http://www.rcpch.ac.uk/system/files/protected/page/CCT%20Class%20of%202011%202012%20report%20FINAL%20for%20web.pdf>
- <sup>xi</sup> RCPCH Medical Workforce Census 2013. December 2014. RCPCH. Accessed 25 January 2016. Available at: [http://www.rcpch.ac.uk/system/files/protected/page/RCPCH%20Workforce%20Census%202013%20Final\\_0.pdf](http://www.rcpch.ac.uk/system/files/protected/page/RCPCH%20Workforce%20Census%202013%20Final_0.pdf)