RCPCH position paper in response to the Shape of Training Review

October 2017

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

Executive Summary

The Shape of Training report[1] provides a timely opportunity to review how doctors are trained to meet changing needs of patients in the UK. The RCPCH wishes to see more integration between paediatric, primary care and mental health training, in particular increasing opportunities for:

- doctors entering general practice to receive paediatric training
- flexibility in training to take into account changes in career intentions
- paediatric trainees to transfer to other specialties
- paediatric trainees to work across international boundaries.

The RCPCH has concluded that a two-level training programme is desirable, incorporating flexibility, out of programme opportunities, and provision of a broader curriculum in the earlier stages of training to include increased exposure to primary care and mental health.

The indicative training time will be seven years. The training programme may be completed within a minimum of five years subject to achieving the required capabilities but is anticipated that the majority of trainees will require a longer period. The training model will be populated with the 2018 curriculum (subject to GMC approval).

Introduction

This position paper sets out the position of the Royal College of Paediatrics and Child Health (RCPCH)[2] on the structure for UK-wide paediatric specialty training in relation to the Shape of Training (SoT) report and the UK Shape of Training Steering Group (UKSTSG) report[3]. Both reports recommend the training of doctors in a general specialty area following which there would be opportunity for further credentialed training to deliver more specialised care. They state that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations. An additional fully funded optional year is recommended within the SoT report to enable development of skills in research, education or medical management. The anticipation for clinical academic training is that it retains a similar structure to the current programme.

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1 https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

2 The RCPCH is responsible for the training and assessment of training of paediatricians in the UK. It sets standards for UK paediatrics and contributes to the development of health service delivery models to ensure better healthcare for infants, children and young people (0-19 year olds) age-groups.

3 http://www.shapeoftraining.co.uk/1739.asp

1. Overall considerations

The introduction of a new model of paediatric specialty training will require retention of a workforce with general paediatric capabilities at consultant level, maintenance of on-call rotas, outpatient clinics, complex care provision, and ability to deliver newborn care including emergency neonatal care. An additional consideration is the need to retain consistency and quality in paediatric speciality services throughout the UK.

Uncertainties include the training and registration of children's nurses, availability of advanced paediatric nurse practitioners and children's community nurses, changes to General Practitioner (GP) training, development of physician associates, the priorities of Heath Education England (and equivalent bodies in the devolved nations), new junior doctor contracts, and the impact of these on the ability to predict workforce needs reliably.

In addition, the processes and timescale for the adoption of the UKSTSG recommendations are to be determined and the mechanisms for funding, particularly training beyond Certificate of Completion of Training (CCT) and revalidation requirements are unclear.

2. Opportunities

There are a number of opportunities offered by restructuring of paediatric training:

- Opportunity to transfer into other specialties with paediatric capabilities e.g. GP training (currently less than 50% of GPs have had opportunity for paediatric training)
- Opportunity to provide truly flexible training, recognising that it may take some time to be certain about career intentions and that aspirations can change
- Opportunity for greater clarity about international equivalences at each level of paediatric training; this would benefit UK trainees wishing to work abroad and the ability of overseas doctors to work in the UK; the medical workforce is increasingly mobile across international boundaries
- Opportunity to develop a training model that enhances the care of children out of hospital
- Opportunity to ensure that standards of training for all professionals involved in the care of infants, children and young people are consistent across common capabilities.

3. The RCPCH position

The RCPCH has a responsibility to design training pathways, curricula and assessments that produce a fit-for-purpose workforce, taking into consideration the UKSTSG recommendations, likely service transformation to enhance care out of hospital, and new models of acute and specialist care.

The RCPCH position is to introduce a two-level "run-through" training programme. The two levels are Core Paediatrics and Specialty Paediatrics. Core Paediatric training can

be achieved in an indicative time of 4 years, to include General Paediatrics and Neonatology, Integrated Care, Public Health and Child and Adolescent Mental Health. There will also be the option for placements in paediatric specialties, including Community Child Health and tertiary Neonatology. During Core Paediatrics, all trainees will carry out at least 12 months' paediatrics at tier 2 level (middle grade). It is anticipated that this period at tier 2 level (core) will predominantly be spent in General Paediatrics, although it could include Neonatology and/or Community Child Health placements outside of a tertiary centre. The MRCPCH theory exams must be achieved before moving onto the Tier 2 rota (currently FOP - Foundation of Practice, TAS – Theory and Science, AKP – Applied Knowledge in Practice); the full MRCPCH must be gained before the completion of Core Paediatrics.

Specialty Paediatrics (level 2) will be an indicative time of 3 years, during which time all trainees will need to maintain generic capabilities in the parent specialty of Paediatrics and may therefore require some input into acute tier 2 rotas (general/neonatal), depending upon training need. For specialty trainees, the balance between time contributing to general and specialty rotas will vary in accordance with the requirements of their relevant specialty curriculum.

Whilst the minimum length of training remains unchanged at 5 years, it is unlikely that many trainees would complete the programme in this timescale. It is anticipated that most trainees will require the indicative time of 7 years, particularly given the service pressures affecting training.

The programme will use capability-based training and progression, rather than time-based progression. It is therefore possible for more able trainees to progress through training quicker than the indicative time, although will also be dependent upon the quality of training and availability of learning opportunities.

The programme has a broader curriculum, particularly in the early stages, to include increased exposure to primary care, integrated care and mental health, and creates more cross-boundary learning opportunities. The training programme structure aims to have greater flexibility to allow for transferability between specialties, out of programme opportunities including academic research and opportunities for SAS (Specialty and Associated Specialty) doctors to re-enter the training pathway at a point dependent on their experience and capability.

The terms 'speciality' and 'specialist', rather than 'sub-specialty' and 'sub-specialist', are used throughout the proposals to reflect that in paediatrics, the holistic care of the child and family is integral to how all consultant paediatricians work, irrespective of whether a paediatrician gains expertise in a specific organ system or choses to specialise in general paediatrics.

The RCPCH proposal is summarised in Figure 1 with the following notes regarding the challenges of implementing such a pathway:

- RCPCH is not proposing a reduction in trainee numbers and has stated that an increase to 465 each training year (in an 8 year training programme) is required to meet the Facing the Future standards[4]. If the training time is reduced from the

[4] http://www.rcpch.ac.uk/sites/default/files/user31401/2015%20RCPCH%20State%20of%20Child%20Health%20The%20Paediatric%20Workforce%20v1.1_1.pdf

current 8 years to an indicative time of 7 years, there will be fewer overall paediatricians in training. Such a reduction in trainee workforce would need to be allowed for by increasing numbers of career-grade paediatricians, general practitioners with paediatric expertise, paediatric nursing staff, or service reconfiguration. Given the problems and lack of progress in achieving any of these, the RCPCH would propose increasing the intake into paediatric training, so as to maintain the overall trainee numbers until alternative workforce and service provision is achieved.

- There is both support for trainees and a robust assessment process, so that trainees may progress dependent upon capability, particularly at the critical waypoints of moving onto the tier 2 rota and readiness for consultant practice.
- The RCPCH is not proposing to use the current sub-specialty selection and matching system for all trainees, including those who wish to train as general paediatricians, as this would be unfeasible and unwieldy. The method of determining suitability for all specialties, including general paediatrics, will require reform – this will be from both the trainee's viewpoint ("is the specialty right for me?") and the viewpoint of the specialty ("is this trainee best suited for this specialty?").

The benefits are:

- Meets SoT principle to train generalists
- Meets SoT principle of completing specialty paediatric training within 5 years, given the highest quality training
- Flexibility within the programme
- Capability-based training
- Recognises and provides support for the move to Tier 2 working
- Addresses the need for clinicians to possess capabilities in integrated care
- Results in a safe, knowledgeable, independent practitioner (CCT-holder) with ability to cover Level 1 and 2 neonatal units and manage acute paediatric emergencies
- Recognises general paediatrics as a specialty in addition to the existing paediatric specialties
- Continued provision of specialty training through a national process pre-CCT
- 2018 curriculum can be populated onto the model
- Facilitates mapping the workforce against standards

The RCPCH wishes to ensure our training programme is fit for modern purpose and enhances patient safety. Our thinking for the future training programme reflects this for the following reasons:

a) Undergraduate and Foundation Training in paediatrics

Paediatric training placements usually start after the current two year foundation programme, as the majority of foundation placements do not include paediatrics. In

contrast training placements in adult medicine commence immediately upon completing medical school.

Undergraduate paediatric training and experience is normally limited to 5 to 8 weeks within the 5 years of medical training. Therefore doctors coming into paediatric specialty training do so from a lower knowledge base than adult medicine. Children are not small adults and although there are some crossover generic competences, much of the learning is new. This includes the 'three way consultation including parents/carers', genetics, developmental physiology and pathology from extreme preterm to post-adolescence, impact of illness on the developing brain, body and psychology, communication challenges, and societal and political impacts upon child health.

b) Promoting patient safety

The proposed training programme aims to produce a well-rounded consultant paediatrician, trained to work in an integrated way with GPs, and capable of taking responsibility for patient care.

The Consultant role as now recognised goes beyond a set list of pre-defined clinical competences. Inherent to what it is to be a "Consultant" is the capacity for independent working, expert decision making, communication with all age groups, families, and a wide range of professional colleagues, leadership and innovation across multiple domains including service design, research, patient safety, education and training, as well as pastoral support of the broader health care team. This is what patients, the public and clinicians recognise in a desire for "Consultant" delivered care. Without consultant delivered care patient safety and efficient secondary and tertiary services are compromised[5]. The standards and levels of performance required to achieve a CCT in Paediatrics will not be diminished.

c) Provision and design of services

Currently paediatric trainees, particularly middle grade doctors, play a very significant role in service provision. The RCPCH 2015 Workforce Census showed that over 1300 paediatric ST4-8 trainees worked on middle grade rotas in the UK; i.e. 63% of all staff on those rotas.

Despite these numbers, the most recent RCPCH Rota Compliance and Vacancy survey (2017) reports that vacancies and gaps represented 23.4% of middle grade posts. This infers that alternative staffing options such as advanced nurses and SAS doctors are not currently able to make up this difference.

Reconfiguration to reduce the numbers of rotas required was highlighted in the RCPCH report, *Facing the Future* (2011). There has been a reduction of around 33 paediatric in-patient units in the UK (25 in England) but this has had very little impact on reducing demand for middle grade doctors, or general consultants. Rather, reconfiguration has facilitated organisations' abilities to meet the Facing the Future standards for consultant cover and presence, and rota numbers.

[5] http://hee.nhs.uk/healtheducationengland/files/2012/08/Time-for-training-report.pdf

The RCPCH does not anticipate any change in the requirement for overall paediatric trainee numbers in the foreseeable future and therefore proposes that overall trainee numbers are not reduced.

d) Duration of training

The Working Time Directive that limits junior doctor working hours, an important element of assuring patient safety, has meant that longer periods in postgraduate training are needed to meet experiential learning requirements and acquire clinical capabilities.

The RCPCH two-level training programme can be completed in 5 years but in practice most trainees take approximately 7-8 years to gain CCT (of 297 trainees gaining their CCT between July 2016 and June 2017 1% spent less than 6 years in whole time training, 13% spent 6-7 years , 49% 7-8 years and 37% more than 8 years).

The RCPCH maintains that the indicative training times to CCT should be the same for those training to be a general paediatrician as those training to be a specialist paediatrician.

4. Going forward

The RCPCH has recently designed a modern, flexible, outcomes-based curriculum to be introduced in 2018 (subject to GMC approval), which will be used to populate the proposed two-level training programme by September 2020. This will ensure that CCT paediatricians have the appropriate skills, knowledge and capabilities to provide excellent care for children.

The following issues regarding the new model are highlighted for further discussion with relevant stakeholders:

- What will the content of Core Paediatrics (level 1) include? e.g. more CAMHS, more integrated care; can trainees be given exposure to specialist placements?
- How to make judgements to enable trainees to move safely onto Tier 2 (middle grade) during the latter stages of core paediatrics (level 1) – how much support is required to prepare trainees for middle grade responsibilities?
- Trainees should have the same educational supervisor through Core training to provide consistency of training and assessment. Some deaneries already adopt this approach, which could be used as examples of good practice.
- There is no guarantee of current Community Child Health or Neonatology placements being filled with trainees at the current ST4-5 level, although the curriculum requirements would still need to be satisfied.
- Specialties would need to attract trainees to their programme through offering rotations or taster days, as the proportion of time spent in specialty paediatrics during core paediatrics (level 1) would necessarily decrease – as the opportunities for training in integrated (primary/secondary) care, mental health, etc, increase.
- It is likely that changes to CCT certification will be required to reflect the changing relationship between general paediatrics and specialty paediatrics, i.e. the certification to reflect training more accurately than it does presently.

- The correct proportion of generalists and specialists that are required to meet patient needs and which, if any, specialties are suitable for post-CCT training (as credentialed training, once the process for credentialing is in place).

Ongoing consideration will take place in collaboration with relevant organisations including Royal Colleges and the European Academy of Paediatrics on the following:

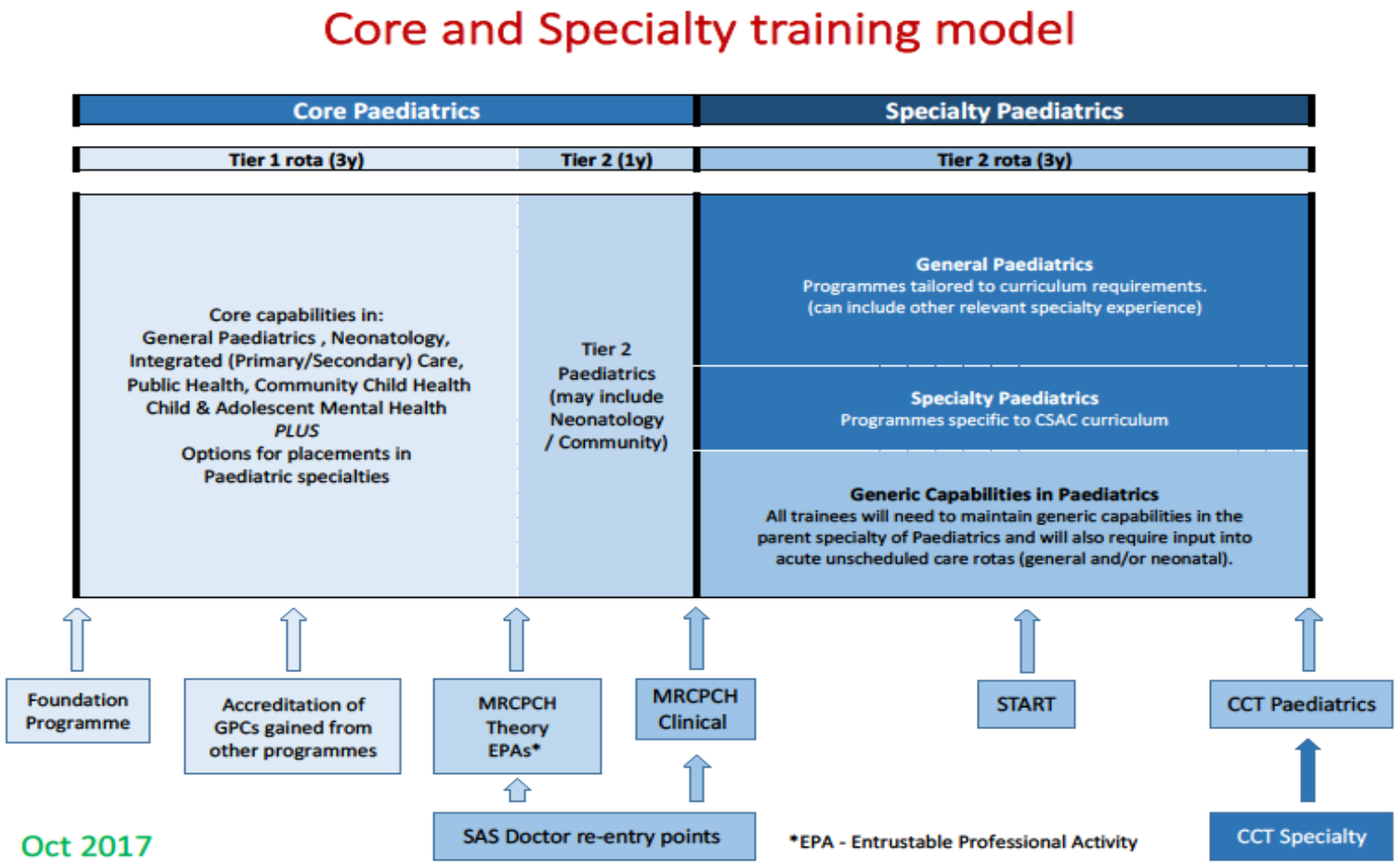
- Greater flexibility for academic trainees
- Potential to provide credentialing through special interest (SPIN) modules to CCT holders and other medical professionals
- Competences for child health care delivered by GPs
- Equivalence with European and International training programmes

5. Conclusions

The RCPCH recommends a two-level, knowledge and capability-based approach to training a consultant general or specialist paediatrician capable of independent practice. We desire flexibility and accept there will be variability around the time taken to complete the programme.

SoT provides a welcome opportunity to review models of training, in particular to facilitate child health doctors working in an integrated way with primary care, addressing the scarcity of paediatric expertise in general practice and strengthening training in child mental health.

Figure 1: Proposal for UK-wide paediatric specialty training in relation to the Shape of Training (SoT) report



Appendix 1

Definitions

General Paediatrician: a specialist paediatrician with expertise in general paediatrics and child health

Specialist Paediatrician: a paediatrician who works most of their time in one part of paediatrics and child health; there are currently seventeen sub-specialties in paediatrics recognised by the General Medical Council (GMC)

Specialties: areas of medicine that require particular sets of knowledge, skills and experience

Specialty training in paediatrics: following completion of the Foundation Programme, a training programme recognised by the GMC leading to the achievement of Certificate of Completion of Training in paediatrics.

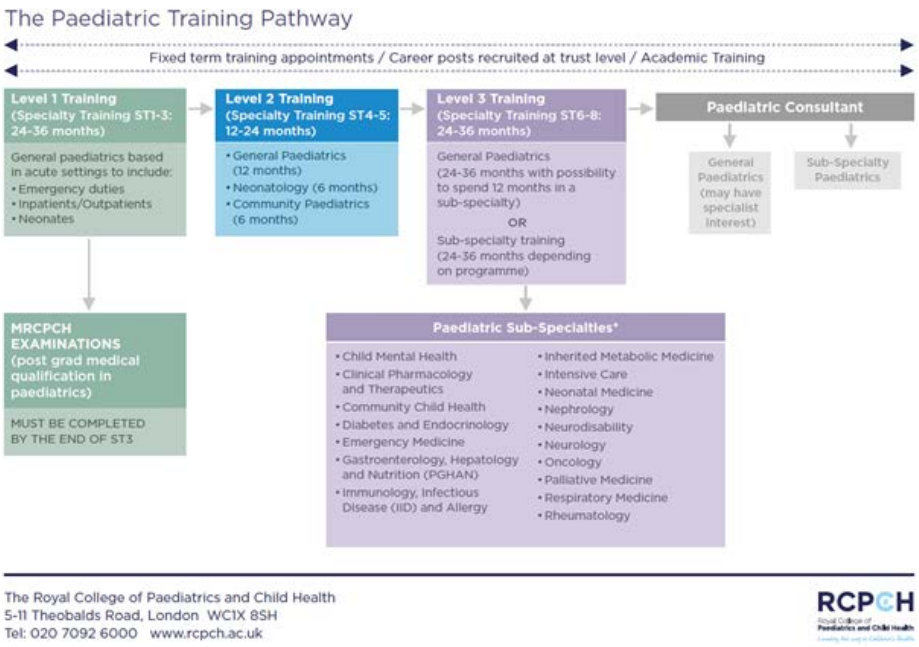
Sub-specialty: an area that has its own GMC approved curriculum; completion leads to the award of a sub-specialty certificate and recording on the GMC Specialist Register. Paediatric sub-specialities are managed by the RCPCH through a national training scheme, known as the 'Grid.' Sub-specialty training includes the acquisition of acute paediatric competences and the achievement of Certificate of Completion of Training is in paediatrics and the relevant sub-specialty. The entry on the specialist register is e.g. Paediatrics (Paediatric Emergency Medicine).

Appendix 2

Current RCPCH training programme

The current “run through” paediatric specialty training programme in the UK is competence-based and can be completed in a minimum of 5 years but is rarely completed in less than 8 years.

Paediatric training in the UK currently includes mandatory elements of general paediatrics, neonatal medicine and community child health. Paediatric trainees undertaking sub-speciality training through the National Grid Training Scheme spend approximately 30% of their level 3 training gaining acute paediatric competences to deliver safe care on out of hours acute paediatric rotas. Currently termed “out-of-programme” activity normally counts as a maximum of one year towards training although the competences gained result in some trainees achieving their Certificate of Completion of Training (CCT) sooner.



Appendix 3

Current Academic Training Pathway

The Academic Training pathway is a recognised pathway leading to CCT