

State of Child Health



Short report series:
Paediatric workforce data and
policy briefing

Paediatric workforce data and policy briefing

Key points

- At least 752 whole time equivalent (WTE) more consultant paediatricians are required above the 3757 WTE in the UK in 2015.
- ST1 recruitment needs to be frontloaded to cope with WTE attrition. To maintain the current proportion of trainees on the rota and meet the 10 per rota standard would require 465 trainees in each year of level 1 training. This allows for a conservative participation rate of 90%.
- An over production of paediatric certification of completion of training (CCT) holders is unlikely due to the work-life balance choices of doctors in paediatrics, current rota gaps, and the fact that 47% of licenced doctors in paediatrics are non-UK graduates.

Introduction

The medical workforce is high profile news. Contributing factors have been the imposition of a new junior doctor contract on the basis that this was critical to the provision of seven day services (culminating in industrial action), staff shortages, major financial pressures on the NHS, and concern over the impact of the decision to leave the EU.

In paediatrics, recent years have seen rising hospital admissions, changes in the nature of childhood disease and the impact of stresses in primary care. In 2016, RCPCH highlighted increasing rota gaps in general paediatrics and neonatology, a higher proportion of unplanned cover provided by consultants, and a high level of concern among clinical directors about how their units would cope with workforce shortages.

In 2016, summarising a discussion at Council, the President of the RCPCH posed a series of questions to the RCPCH health policy, workforce, and training teams. This document provides answers to these questions, using data from a wide range of sources including selected results from the RCPCH Workforce Census 2015 (1) .

Because there are many uncertainties in the system, workforce planning needs to be constantly revisited and revised and it is our intention to review this briefing at regular intervals, taking into account changes that occur in all of the child health workforce and wider health workforce.

Purpose of the briefing

- To clarify the current RCPCH position on workforce issues in paediatrics for members and stakeholders.
- To be a reference point for staff and officers who deal with queries from the press and media, Department of Health, providers and commissioners, and RCPCH members.
- To be the basis for calls to action aimed at the Government, workforce planning bodies, child health service providers and commissioners in the UK.

What is included?

- An assessment of the current level of demand for paediatric consultants in the UK taking into account published service standards and UK government policy (1.1).
- An assessment of the number of paediatric trainees required to meet demand (1.2).
- Consideration of how other staff groups can contribute to service delivery (1.3, 2.3).
- An examination of models of care in paediatrics along with RCPCH recommendations drawn from published literature and previous projects (2).
- Key factors to ensure paediatric careers are developed and designed to recognise the need for continued learning, flexibility and transition to different roles (3).

Paediatric workforce supply and demand

1.1. Consultant¹ demand

Summary

At least 752 whole time equivalent (WTE) more consultant paediatricians are required over and above the 3757 WTE in the UK in 2015. This will satisfy current service standards for acute paediatrics and subspecialties. It does not include provision for 24 hour, seven day consultant delivered services. It does not include provision for integrated working with primary care, social services and the third sector as described in Facing the Future Together for Child Health (2).

Calculating the number of consultants required in paediatrics and child health is complex. It is subject to, among other things;

- the changing nature of childhood illness,
- the need to promote good health and wellbeing,
- the rise in admissions to hospital and referrals to specialist services, reorganisation and reconfiguration of services, and
- the nature of services provided by other professionals who work with infants, children and young people.

We base our estimate on:

- RCPCH Facing the Future standards for acute general paediatric services (3)
- British Association of Perinatal Medicine (BAPM) standards for neonatal care (4)
- British Association of Community Child Health (BACCH) recommendations (7)
- Paediatric intensive care guidance (5)
- Paediatric nephrology guidance (9)
- RCPCH 2015 workforce census (1)

How our estimate of demand is calculated:

- We require 201 WTE more general paediatric consultants to support existing consultant rotas in 189 inpatient units to ensure that there are 12 hours of consultant cover each day. This is in order to meet the RCPCH revised Facing the Future Standards for Acute General Paediatric Services (3). This represents an increase from 1660 WTE in 2015 to 1861 WTE. We require a further 50 WTE consultants for planned tier 2 (middle grade) cover as part of sustainable solutions to address the rota gaps. This gives 251 additional consultants for general paediatrics. Not included in this estimate is consultant workforce demand for the 16 standalone Short Stay Paediatric Assessment Units (on sites without paediatric inpatient units) in existence at the time of the 2015 census (6).

¹ Or equivalent staff, associate specialist or specialty doctors trained and assessed as competent to work on the paediatric consultant rota.

- In 2015 there were 59 neonatal intensive care units (NICU) in the UK which need an estimated 71 consultant rotas. There are more rotas than units as larger units require additional consultant rotas). To meet the BAPM standard (4) of 8 consultants per NICU, 568 specialist neonatal consultants are required. The 2015 census recorded 457 WTE, indicating a shortfall of 111 WTE.
- In community paediatrics in 2015 there were approximately 719 WTE filled posts. Based on the British Association of Community Child Health recommendations for 4.6 WTE consultants per 300,000 total population from 1999 (7), over 900 WTE are needed; a further shortfall of 181 WTE.
- Paediatric intensive care is approximately 19% (38 consultants) short of being able to provide 7 WTE consultants in each of the 29 paediatric intensive care units in the UK (8).
- Paediatric nephrology requires 5 consultants (9) for each of the 17 services i.e. 85, the RCPCH census 2015 records only 63, there is therefore a shortage of 22 (25.9%).
- Further detailed work on the remaining subspecialties is required, but assuming a conservative 20% (as per neonatology) shortage across other subspecialties, there is a subspecialty shortage additional to community child and neonatology of 209, making the shortfall 752 WTE.

This analysis does not include in this estimate the potential provision of one WTE consultant for each current inpatient unit for better integration of primary and secondary care using some of the tools examined in Facing the Future Together for Child Health (2).

Potential impact of 24/7 service delivery

NHS seven day services standards entail 24/7 consultant led services, a maximum of 14 hours for initial consultant review, consultant directed ward rounds and twice daily consultant review for high dependency patients (10). This means that the above calculation based on 12 hour consultant presence, 7 days per week will meet the required standards.

Any policy change to provide 24 hour consultant presence in paediatrics would have an immense impact on consultant demand. A move from 12 to 24 hour presence in inpatient units would mean an increase of 9 hours (3 programmed activities - PAs) per day per inpatient unit (4 PAs extra resident duty less reduced need (1 PA) for off-site on-call cover). This equals 663 WTE more consultants across the current 189 inpatient units. Extending this principle to paediatric subspecialty rotas (e.g. neonatal intensive care unit (NICU), paediatric intensive care unit (PICU), and oncology) would lead to an estimated further 300 WTE more consultants required.

If we are to achieve the goal of a sustainable 24 hour, 7 day service, there needs to be full support from other staff such as diagnostic departments, pathology staff, therapists, porters and administrators. We would also need growth in the number and

deployment of advanced clinical practitioners such as physician's associates and advanced nurse practitioners.

Impact of service redesign and reconfiguration on consultant demand

Service redesign and reconfiguration should have the primary aim of improving patient outcomes and it should also provide consistency in practice, deliver safe and sustainable care, and offer continuous quality improvement. It should show that standards of care are met both in clinical outcomes and for patient and staff experience (11). In meeting these aims, reconfiguration may not reduce the number of medical staff required to run a service.

The Making it Better (12) programme reconfigured acute paediatric and neonatal services in Greater Manchester between 2006 and 2012. In this region, paediatric consultant numbers rose from 108 in 2003 to 207 in 2013 to meet the requirements of RCPCH Facing the Future Standards. In Mid Yorkshire, reconfiguration to reduce inpatient services in three sites to one saw consultant numbers rise from 16 to 22 between 2007 and 2016.

1.2. How many paediatricians should we be training?

Principles behind supply estimates

To generate more accurate projections for the future supply of paediatric trainees, we need clarity on several factors at national level. This includes the implementation of Shape of Training proposals, the development of physician's associates, future numbers of children's nurses and the development of nurse practitioner roles. We need joined up strategic planning between regional education and training bodies and service commissioners/planners to make more accurate paediatric supply and demand forecasts.

One method of calculating the number of paediatricians we should be training is to determine the number of Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) holders needed each year to meet current and future demand for consultants within the future models of care. To calculate the number of doctors we need to recruit to the training programme, we require factors including attrition from training, participation rates, exam failures, and migration trends.

As paediatric trainees play a pivotal role in service provision, the number of paediatric trainees working in the UK must be enough to support acute rotas of 10 WTE staff as per the Facing the Future standard (3). We therefore need to commission more paediatric specialty trained doctors.

We need to augment the supply of paediatric trainees with alternative workforces to provide support for rotas. There is little evidence of effective national or regional planning to increase the numbers of consultants, general practice (GP) trainees and advanced nurse practitioners working on resident paediatric rotas. There has also been a decline in the numbers of staff, associate specialists and specialty doctors supporting service delivery.

On tier 1 (SHO), for example, paediatric trainees occupied 42% of posts in the UK in 2015. To maintain this proportion of trainees on the rota and meet the 10 per rota standard requires 465 trainees in each year of level 1 training. This allows for a conservative participation rate of 90%. In comparison, the number of ST1 paediatric trainees who accepted posts in the UK in 2016 was 404.

Given the high level of less than full time working, (13) attrition rates (14) and parental leave the number of trainees needed may increase, especially in the light of RCPCH evidence that 20% of tier 2 rota positions are vacant (15).

Evidence for an increasing trainee numbers

There is currently a shortage of CCT holders in paediatrics to meet recommended standards. An over production of paediatric CCT holders is unlikely due to the work-life balance choices of doctors in paediatrics, current rota gaps, and the fact that 47% of licenced doctors in paediatrics are non-UK graduates (13).

Studies of new CCT holders have shown that most have found consultant or other suitable posts in the UK with little delay after qualification (16). There is no sign that this will change soon, given forecast numbers of new CCT holders and current consultant growth rates. In addition to an increase in the number of consultants between 2013 and 2015, the average PAs worked has increased by 0.2 per consultant, equivalent of a further 80 consultants.

Workforce planning must take into account rates of less than full time working, out of programme, parental leave and other factors affecting participation rate.

There were 3779 paediatric trainee doctors in the UK in June 2015 (13). Given estimated participation rates, this equates to approximately 3009 whole time equivalents. This estimate is based on 9% of trainees being out of programme or on parental leave at any given time (17) and 25% of trainees working less than full time at 0.5 WTE. The less than full time estimate is based on General Medical Council (GMC) figures of 21.2% LTFT pro-rated to account for 15% of trainees whose FT/LTFT status was not recorded (13).

The participation rate in training (WTE as a proportion of headcount) has reduced over recent years. In Yorkshire and Humber, the number of doctors training LTFT at level 1 rose from 3% to 16% of female paediatric trainees between 2009 and 2014, and is now at 19.9% for male and female paediatric trainees in 2016. At tier 2 the LTFT rate has risen from 16% to 30% between 2009 and 2014. The participation rate also falls throughout the training programme. RCPCH data show that 6.7% of ST1-3 trainees were out of programme or on parental leave in 2015 and that this figure rises to 13.2% at ST4-5 and 12.6% at ST6-8. These data show that we should frontload ST1 recruitment to cope with WTE attrition.

1.3. Alternatives to trainees?

Staff, Associate Specialist and Specialty (SAS) doctors

The RCPCH support the contribution Staff, Associate Specialist and Specialty (SAS) doctors make to paediatric services and wish to ensure that the route to the specialist

register, if desired, is facilitated and that these doctors have roles which develop and are fulfilling.

In 2015, there were more than 800 SAS doctors working in paediatrics in the UK. They represent 13% of the WTE career grade workforce in England, 27% in Wales, 28% in Scotland and 39% in Northern Ireland. The number of SAS doctors working in paediatrics has fallen over recent years due to an ageing workforce and changes to immigration rules. Currently fewer than 200 WTE SAS doctors are working on general acute and neonatal rotas.

Whilst entry to the SAS grade may not in general be the initial career choice of these doctors, many have the competencies to work at the level of a consultant. Facing the Future standards recognise this. These doctors should be included in calculations for the number of consultants required which makes planning for this workforce more challenging.

Medical Training Initiative (MTI)

The MTI scheme provides a superb educational opportunity for aspiring paediatricians from overseas to train in the NHS. We support the growth and development of the MTI scheme, but the numbers involved are currently low (127 appointments were made between 2014 and 2016) (18). The nature of the work done by the MTI trainees tends to be more specialised. It would be risky to ascribe to the scheme the potential to provide a sustainable workforce solution.

Regional variation

Workforce planning must take into account regional variation in application rates. Paediatrics faces variation in application rates across the UK. In 2016, the fill rate for ST1 in paediatrics was 100% in Scotland, Wales, Northern Ireland, but was less than 100% in 6 of the 10 English deaneries, falling to just above 70% in Yorkshire and Humber. There is also significant anecdotal evidence regarding difficulties in placing trainees in remote and rural hospitals. Trainees have also been withdrawn from smaller areas to ensure adequate rotas in larger centres e.g. in West Wales and Lothian in Scotland.

2. Models of Care and Workforce Models

2.1. Models of care

Workforce planning needs to be an integral part of the development of all service models. Every clinical service needs to consider their own short and long term workforce plans, with specific focus on the improving the quality of care for infants, children and young people, rather than on policy or cost concerns.

It is important to highlight the length of training required to become a paediatrician, both in terms of programme length and elapsed time. New service models need a long run-in to ensure the right staff groups are trained and available in the right numbers. Services should work with the relevant Colleges and training bodies to ensure that staff are trained in the right competencies to work in new models.

Models of care for paediatric services and the importance of clinical networks

To future proof paediatric services, RCPCH supports the implementation of managed clinical paediatric networks across all paediatric specialties, services at the secondary/tertiary interface, and for secondary care across defined geographical areas. RCPCH also supports the implementation of a range of models of integrated care (19, 20).

Vanguards and Sustainability and Transformation Plans in England aim to support new models of service commissioning and planning across clinical, geographical and professional boundaries. These models must meet the needs of infants, children and young people, and subsequent workforce requirements must be taken into account within regional workforce planning.

Bringing Networks to Life (21) makes the case for the development and maintenance of a range of clinical networks across a range of specialties. For 2017 and beyond, and to ensure the sustainability of our services, we advise that the 'managed network model' is implemented. Networks require a management function to support clinicians delivering the care, and to add quality assurance to the care provided across a defined geographical patch.

The RCPCH supported the findings of the Kirkup review into services at Morecambe Bay (22) for an audit of maternity and paediatric services and a larger national review that focuses on delivering safe services in areas that are rural, difficult to recruit to, or isolated.

Most paediatric subspecialties deal with conditions which have a relatively low incidence and therefore are best delivered in limited numbers of centres where high level skills and competences can be developed. The paediatric nephrology network is an example of this model (9).

Reconfiguration

For secondary acute care, small proximal units should be combined with nearby larger units or converted to assessment units with no overnight admissions where appropriate.

A review of paediatric services (23) sets out the case for reducing the number of inpatient units, either by closing small proximal units or converting to assessment units with no overnight admissions, according to population needs. Facing the Future makes it clear that we must tackle reduction of inpatient units with four other proposals simultaneously:-

- **Reduce the number of inpatient units:** This has progressed more slowly than anticipated. In the four years following publication of Facing the Future the number of inpatient units reduced from 211 to 189, compared to the RCPCH moderate reconfiguration proposal for a reduction to 170.
- **Increasing the number of consultants:** Consultant WTE rose from 3084 in 2009 to 3767 in 2015. This is significantly lower growth than the Facing the Future proposal for an increase to 4625 WTE.
- **Expanding significantly the number of registered children's nurses:** The WTE of paediatric nurses in England rose from 15,122 in April 2011 to 16,176 in April 2016 (24). This has not translated into a significant rise in the number of advanced nurse practitioners in paediatrics and neonatology. The WTE of nurse practitioners working on paediatric and neonatal rotas increased from 170 in 2011 to 189 in 2015.
- **Expanding the number of GPs trained in paediatrics:** This has not occurred in a systematic national manner. The number of GP ST doctors included on paediatric and neonatal training rotas fell from 764 in 2011 to 711 in 2015.
- **Decreasing the number of paediatric trainees:** These fell 2% from 3878 to 3779 between 2011 and 2015.

There has been a small reduction in the number of trainees despite the other elements of the proposals not occurring as proposed. This has contributed to the crisis we are witnessing on tier 2 rotas. Increased less than full time working, parental leave and out of programme activity has had a well-documented effect on trainee participation rates. Therefore there is currently a need to increase the number of doctors in training in paediatrics. Any reduction should not be considered before completion of the other elements as proposed by Facing the Future (23).

Integration

Care should be integrated across primary and secondary care, with the goal of reducing unnecessary hospital admissions and increasing the provision of care closer to home.

The balance of the nature of childhood disease has been shifting from acute care to long term condition management. The vast majority of children's illnesses are minor

requiring little intervention, but the presentation of serious illnesses can mimic non-serious illness. Primary care services must be better equipped to identify children with early signs of serious illnesses. The RCPCH publication *Facing the Future Together for Child Health* (2) sets out standards and best practice for joint working between paediatric secondary care, general practice and community nursing to reduce the number of hospital admissions and provide care closer to home.

Children and young people's participation

We should involve children and young people, parents and carers in the design and development of services to ensure that they deliver the outcomes that matter most to patients. For example, a project in Bromley-by-Bow aimed to provide parents and carers of children under the age of five with the knowledge and skills to manage their children's health at home confidently and to know when to seek further help (25). We should be measuring services against these outcomes. We must consider the life course of the child at all times, and commission and deliver services around the pathway of the individual child and family.

2.2. Consultant delivered and consultant led care

We define a consultant delivered service as one where the consultant is clinically responsible for the care the patient receives and will either provide hands-on care or closely supervise all aspects of a patient's care in the clinical setting. Other members of the team deliver care but only under the supervision of the consultant (26).

We recommend both consultant delivered and consultant led services. Care is effectively consultant delivered in specialties such as paediatric intensive care, paediatric surgery, and paediatric anaesthesia. We describe other examples of consultant delivered services in general paediatrics in the RCPCH Consultant Delivered Care report (26).

A consultant led model may better suit other services. Upskilling other health care workers, as recommended by a recent Nuffield Trust report (27), will enable some services to be consultant led and delivered by allied health professionals with the necessary skills and competencies.

2.3. Further workforce options to support models of care

Physician associates

Physician associates (PAs) are healthcare professionals with a two year (approximately 90 week) postgraduate generalist healthcare/ medical education who are dependent practitioners. It is not yet clear whether current or future training programmes will provide the competencies for them to work on paediatric and neonatal rotas.

Physician associates are currently unregulated and not registered. The Royal College of Physicians has launched a Faculty of Physician Associates (FPA) to support the development of these roles. The RCPCH has a representative who attends faculty

board meetings to ensure that it considers possible benefit or risk of these unregulated roles in caring for infants, children and young people.

The FPA plan to start an accreditation programme to address concerns about the standard of education within each of the courses. The ultimate aim of the FPA is for regulation of the role. The FPA currently recommend that courses should comprise a total of 3150 hours, with 1400 in clinical practice of which 90 are spent in paediatric acute settings.

Physician associates are not covered under legislation to prescribe, including the prescription of ionising radiation which means they are unable to request X-rays. They can order other investigations and imaging tests. The FPA is aware it needs to provide more guidance and support to members and employers about these concerns.

Children's nurses, who are regulated and registered professionals, can undertake all the above functions through completion of two years of postgraduate nursing education. Closer examination of the comparative cost effectiveness of developing physician associates should be undertaken.

There is a proven track record of nurses extending their roles and becoming nurse practitioners with established pay banding and governance arrangements. The development of physician associates is less well-defined, with limited exposure to paediatrics in their training. We are circumspect about the introduction of physician associates in paediatric services, the impact on care to children and the potential return on investment. At the end of 2016, there were only 287 qualified PAs and 465 student members in the UK, although 29 centres will run programmes in 2017. To date, physician's associates do not have a significant impact on paediatric and neonatal tier 1 and 2 rotas, which employed over 4600 WTE staff in 2015.

Nursing and nurse practitioners

We support the continued development of advanced nurse practitioner roles in paediatrics and neonatology. Any increase in the number of advanced nurse practitioners should not be at the expense of reducing children's nursing numbers.

There is a need to maintain a children's field of practice on the Nursing and Midwifery Council (NMC) register. This is due to the specific knowledge, skills and attitudes required to care safely and effectively for infants, children and young people in every care setting. RCPCH will continue to support existing guidance and work closely with colleagues at Royal College of Nursing (RCN) and the NMC.

The WTE of children's nurses in England has risen by only 7% in five years between April 2011 and April 2016 (24). RCPCH support nursing levels and standards as set out in the RCN document "Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers (2013)" (28). A further increase in nursing numbers is required to meet these standards.

It is concerning to learn that of the £50.5 million reductions planned for 2016-17 by local authorities, the biggest single area was a £7 million reduction to services aimed

at improving the health of ICYP, such as health visiting, school nursing and childhood obesity programmes (29).

We support BAPM standards for neonatal nursing (4) and remain concerned about the shortfalls highlighted in the Bliss baby report of 2015 (30).

It has been confirmed that applicants for children's nursing would not apply to enter general or adult nursing. There are approximately 12 applicants for every place, but there is concern that the policy to replace bursaries with loans may impact recruitment. Number limitations will be due to placement availability and costs.

3. The paediatric career pathway: trainee to retiree

3.1. The training pathway

It takes between five and eight years to complete paediatric training. The RCPCH three-level training programme can be completed in five years, but in practice most trainees take eight years or more of actual training time to gain CCT (31). Of 270 trainees gaining their CCT between July 2015 and June 2016 0.3% (1 individual) spent less than 6 years in whole time training, 10% spent 6-7 years, 42.2% 7-8 years and 47% more than 8 years. Considering elapsed time from start to finish, the RCPCH found that paediatricians who obtained their CCT in 2014 did so on average 10.2 years after full registration with the GMC.

Currently paediatric trainees, particularly middle grade doctors, play a significant role in service provision. In winter 2015, consultants worked resident night shifts in only 15.2% of units, resident weekends in 23.6% and resident twilight shifts in 28%. This means that doctors who are in training spend a high proportion of their time providing the service, often as the most senior opinion present in the hospital.

The RCPCH 2015 Workforce Census shows that over 1300 paediatric ST4-8 and grid trainees worked on tier 2 rotas in the UK; i.e. 63.3% of all staff on those rotas. The acute clinical service is heavily dependent upon trainees, but acute service pressures impact upon training. If there are future changes to training, such as a reduction in training time, this will lead to a reduction in the number of trainees able to work on the tier 2 rota. Also, we can only achieve a reduction in training time if increased demands of the acute service are not allowed to impact on learning opportunities. We could achieve this by either by increasing the number of trainees available for the tier 2 rota or by training other professional groups to perform this role and contribute to the tier 2 rota.

3.2. Transition to consultant roles

The RCPCH curriculum and assessment strategy trains doctors for the award of a paediatric CCT or CESR (CP). If we recommend a doctor for the award they have met the standard required to become a consultant. Doctors who can show they are able to achieve the competences in the paediatric curriculum are also able to apply for entry to the specialist register through the CESR process.

The RCPCH 2014 CCT holders' survey records that only 9.8% of new CCT holders found transition from senior trainee to consultant post difficult.

We have implemented the RCPCH Start assessment at ST7 to assess managerial and leadership skills, and the RCPCH continues to develop other training programmes to prepare new consultants for the demands of their future career, particularly in the areas of management and leadership.

3.3. Resident shift working

RCPCH supports resident shift working as part of balanced job plan. We encourage units to undertake team job planning so that resident shifts are shared in an equitable way among team members, with opportunities for consultants providing resident shifts to develop a less hands-on career over time.

Resident shift working has become more common; a quarter of all new paediatric consultants undertaking such work. Those doctors spend on average 2.4 programmed activities (PAs) per week (15). These shifts can be either on the consultant or tier 2 rota. If Facing the Future standards are to be met, this will inevitably lead to increased consultant presence, therefore increasing the numbers of consultants required. Consultants working a 10 PA contract, for example, should undertake no more than 4 PAs of resident shift working per week, and should have opportunities to take a less 'hands on' career over time (32).

The PICU in Birmingham Children's Hospital (33) employs a model where the intensity of resident shift working is reduced for more senior consultants by using a sliding scale for on-call and resident shifts.

RCPCH representatives on Advisory Appointments Committees AACs for consultant posts and regional advisers check job plans to ensure the correct balance between traditional consultant duties and the number of PAs for resident shift working. However, not all trusts/boards are required to conform to the AAC process. There are concerns that some employers are not complying with RCPCH recommended practice for new consultant posts. In particular, concerning the number of resident PAs and clinical sessions scheduled immediately after nightshifts which may lead to potential breaches in working time legislation.

Working resident shifts does not only mean dealing with emergency admissions. For example, in remote and rural units where only two tiers of medical cover exist, the "on shift" consultant will be leading a multi-disciplinary team of junior doctors, nurses and allied health professionals.

More about models of consultant delivered care can be found in the RCPCH report *Consultant Delivered Care: An evaluation of new ways of working* (26).

3.4. Consultant careers

In the RCPCH Guidance on the Role of Consultant (32) we encourage portfolio careers. As a consultant's career progresses they may take on greater managerial duties, RCPCH roles and trainee supervision, and reduce the intensity of clinical work.

We should recognise that learning and professional development continues throughout a paediatrician's career. Support needs to be available to all consultants as they develop in their roles. We need to design careers around the extended age of working and flexible working, and to make optimal use of the available workforce to drive and maintain high clinical standards. Many doctors will move from 'running

around posts' to more 'sit down posts' as their careers progress. This may mean roles with greater management responsibility, or national and Royal College roles (34).

The RCPCH is keen to support paediatricians in developing their career by providing management and leadership training. We offer special interest (SPIN) modules to help consultants develop new special interests throughout their career.

If there is a substantial change in the pattern of work, and particularly in field of clinical practice, training will be needed. These career models acknowledge the need to provide training during the senior doctor career, preparing the doctor for new demands in a later career phase. For the experienced clinician, many skills, such as communication, teamwork, management and leadership and training, will be transferrable. Other more specific competencies will require focused training over a period of crossover or change over (34).

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