RCPCH State of child health: short report series

Workforce briefing winter 2018

Published December 2018

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

1. Introduction

The child health workforce across the United Kingdom is suffering from the same planning problems, underfunding and staffing issues as the rest of the health workforce.[1] There is growing evidence that workforce problems are affecting the delivery of high quality safe paediatric services in each of the UK countries. In England, a recent NHS Improvement Report identified workforce problems as the main contributor to poor ratings of paediatric services by the Care Quality Commission (CQC).[2]

The Royal College of Paediatrics and Child Health (RCPCH) sees ensuring an adequate child health workforce as essential for the safe delivery of care to children and young people (CYP) in the UK. Whilst this is wider than the paediatric workforce, issues in the recruitment and retention of paediatricians threaten the safety of our children's health. To highlight issues and identify solutions, the RCPCH will be releasing a series of reports on the state of the paediatric and child health workforce across 2019, supported by data from the College's 2017 Workforce Census. At the time of writing, we expect that the NHS Long Term Plan and Health Education England's workforce strategy will be published shortly, and it is essential that the RCPCH's workforce findings and recommendations are used to inform workforce and service planners of the key pressures facing paediatrics.

This briefing document highlights some of those key findings and provides a set of recommendations which RCPCH believe are crucial for the future of the paediatric and child health workforce in the UK.

2. Recommendations

2.1 Plan the child health workforce

There has been an incoherent and inconsistent approach to planning for the child health workforce.

NHS Improvement (NHSI)/Health Education England (HEE), Health Education and Improvement in Wales (HEIW), NHS Education for Scotland (NES) and the Department of Health and Social are in Northern Ireland must develop a bespoke child health workforce strategy for their individual countries.

The strategy must include identifying the workforce need for medical, midwifery and nursing staff, as well as allied health professional, pharmacists, health visitors and school nurses.

The strategy must acknowledge and support differential participation rates and the development of portfolio careers.

The strategy must model the paediatric and child health workforce up to 2030 based on existing service demand projections. The strategy must be sufficiently robust to deliver professional and service standards and deliver the right model of service to meet needs.

2.2 Recruit and train more paediatricians

The RCPCH supports the Royal College of Physicians' call [3] to double the number of medical students. In addition, the RCPCH wants to see:

a) The UK government and the governments in Northern Ireland, Scotland and Wales increase in the number of paediatric trainee places in the UK to 600 in each training year for the next 5 years.

b) The UK government and the governments in Northern Ireland, Scotland and Wales fund an additional year of General Practice (GP) training. This additional year must include paediatric and child health training for all GP trainees, as proposed in the RCGP curriculum submission in 2016. The extended programme would be subject to approval by the General Medical Council.

c) The Department of Health and Social Care must expand the Medical Training Initiative scheme, which provides doctors from outside the UK to train and develop their skills in NHS.

2.3 Incentivise the paediatric workforce

Pay premia have been used in other hard to recruit medical specialties. Paediatrics is now facing severe shortages with falling applications and recruitment challenges.

a) The Department of Health should offer flexible pay premia to paediatric trainees as a recruitment incentive into the paediatric specialty and for hard to recruit areas, including remote and rural settings.

b) The Department of Health should offer flexible pay premia to paediatricians who return to clinical practice after successfully undertaking a pre-agreed period of approved academic research and those who take time out of clinical practice to undertake other recognised activities that may be of benefit to the wider NHS.

2.4 Attract more overseas-trained doctors and health professionals

Paediatrics has historically been reliant on the skills and expertise of doctors from outside the UK. Any new migration system needs to take account of the value and contribution the health and social care sector provides to the UK economy and its population, looking beyond pay as a proxy for 'skill' and 'value'. This will enable recognition of the range of roles we might need to recruit to including world class medical researchers, nurses and ACPs.

a) The Home Office must place paediatrics and SAS doctors on to the shortage occupation list.

b) The Home Office must commit to permanently removing the tier 2 cap so that the UK attract paediatricians with the right skills into the NHS.

2.5 Plan for and expand the non-medical workforce

The delivery of paediatric services to children and young people and their families requires a multidisciplinary workforce.

a) The RCPCH will collaborate with the Faculty of Physician Associates and educational funders and providers to develop post qualification fellowships in paediatrics, to emulate the mature model in the USA. This will facilitate career growth and increase workforce options.

b) NHSI/HEE, HEIW, HES and the Department of Health and Social Care (NI) must develop a national career strategy for advanced clinical practitioners including ANPs in neonatology and paediatrics, and Physician Associates.

3. Findings

3.1 Consultant demand

RCPCH currently estimates that demand for paediatric consultants in the UK is around 21% higher than 2017 workforce levels, i.e. an increase of approximately 850 WTE consultants is required. This is to ensure that safe service standards are met, and to cope with increased demand for child health services. Some of the elements driving demand are:

- The growth in emergency admissions. Between 2013/14 and 2016/17, admissions in England rose 12.7%, from 631500 to 711805. In Scotland, over the same period, admissions rose 13.1%, from 49370 to 55862. In Wales, admissions rose 17.2%, from 54627 to 64002***** .

- The number of admissions seen in some units mean that double rotas are increasingly needed.

- The College's 2017 Facing the Future Audit [4] showed that only 48% of children admitted to the paediatric department with an acute medical problem are seen by a consultant paediatrician within 14 hours of admission. Our estimate therefore calculates demand in general paediatrics based on providing consultant resident cover for 12 hours per day and 7 days a week.

- Not all Neonatal Intensive Care Units (NICUs) meet the British Association of Paediatric Medicine standard [5] stating that NICUs should have separate rotas. In 2017, 89.9% of NICUs had a separate tier 3 (consultant) rota, compared to 92.6% in 2015.

- In 2017, the College and the British Association for Community Child Health (BACCH) published Covering all Bases [6] which found that there was a need for substantial increase in the number of community child health medical workforce. This is necessary to meet the current and anticipated demand due to a rising number of co-morbidities, long delays in diagnosis for autism and ADHD, and growing safeguarding concerns.

***** Awaiting data on emergency admissions from Northern Ireland.

3.2 Career grade doctor numbers

The consultant paediatric workforce in the UK grew from 3996 in 2015 to 4306 in 2017, or 3756.9 to 3997.1 in terms of Whole Time Equivalents (WTE). This represents a 7.8% rise in headcount but only 6.4% in terms of WTE in the two years since the 2015 RCPCH Census. This means that for every additional consultant the increase in whole time equivalent is only 0.77 WTE.

Consultant growth between 2015 and 2017 was highest in England at 8.2% (or 6.7% WTE), compared to 5% in Scotland (4.8% WTE), in 5.1% in Wales (2.9% WTE) and 5.4% in NI (5.7% WTE).

Between 2015 and 2017, there was a decline in the average programmed activities (PAs) in consultant contracts for direct clinical care (DCC) from 7.6 to 7.4. This seemingly small reduction is the equivalent of 80 WTE consultants, thus further negating some of the growth in numbers.

Staff, Associate Specialist and Specialty (SAS) doctors continued to decline in number, as seen in every census since 2001, with only 778 (or 646 WTE) reported in 2017. This represents a 3.7% decline in headcount and 3.6% in WTE since 2015. This is a smaller magnitude of decline than in previous censuses, but SAS doctor numbers are now only 51.9% of the total reported in the 2001 RCPCH Census.

3.3 Factors influencing workforce demand

- Less than full time working (LTFT) among consultants in the UK has increased to 24.2% in 2017, from 21.5% recorded in 2015. In 2017, 35.6% of female consultants in the UK worked LTFT and 10.7% of male consultants worked LTFT.

- The proportion of the paediatric consultant workforce who are women continues to increase. In 2017, 53.5% (52% WTE) of consultants in UK were women, an increase from 51.6% in 2015. Three-quarters of paediatric trainees are women, so the proportion of consultants who are women will continue to rise.

- SAS doctors tend to be older than consultants. Age trends indicate that SAS doctors are likely to continue to decline in number as they retire without replacements. The growth in consultant numbers varies according to role. Between 2015 and 2017 paediatric subspecialty consultant numbers grew by 14% whereas community child health (CCH) consultants increased by only 1.9%. Covering all Bases [5] recommended a 25% increase in Community Child Health career grade staffing.

- Of paediatric consultants working in the UK, 38.1% obtained their primary medical qualification from overseas, and 62.0% graduated in the UK. The majority of SAS paediatric doctors (51%) obtained their primary medical qualification outside of the UK (7.8% from the EEA and 42.8% from other non-UK countries). The paediatric workforce is heavily reliant on doctors educated overseas, and uncertainty around immigration will impact on this group.

- The number of applicants to paediatric training from the EEA fell from 97 in 2015 to 41 in 2017; a 58% fall in two years [7].

3.4 Rota gaps and vacancies

Vacancy rates in the UK recorded in the 2017 census were 11.1% on tier 1 (junior) rotas and 14.6% on tier 2 (middle grade) rotas; these have increased since the 2015 census which showed 6.3% and 13.7% respectively. The 2017 Census rates were not as high as those recorded in the RCPCH rota gaps and vacancies report of early 2017 [8], when we estimated 23.7% gaps on tier 2. This difference in findings may be due to different samples of units responding to each survey, or the timing of the surveys (the Census data relates to autumn, whereas the rota gaps survey is undertaken in winter). Respondents may also have been uncertain whether to record gaps due to out of programme activity (particularly maternity leave). Despite these reservations, the vacancy rates found are still cause for considerable concern.

The GMC National Training Survey for 2018 shows that paediatrics is one of the specialties with greatest pressures, e.g. approximately 48% of paediatric trainees consider intensity of work heavy or very heavy, this is only exceeded by Emergency Medicine and Medicine. Approximately 65% of paediatric trainees feel somewhat, to a high degree or a very high degree, burnt out by their work, placing it 4th of 11 specialties [9].

The proportion of vacant posts on rotas filled by locums on tier 2 rota declined from 58.2% in 2015 to 42.8% in 2017. On the tier 1 rota, this fell from 56.5% to 55.6% indicating that organisations are less able to find locum cover.

Vacancy rates for District General Hospitals (DGHs) are higher than those for tertiary/training hospitals, highlighting where shortages are most keenly felt. Facing the Future [10] states that there should be 10 whole time equivalent posts on training rotas. Our 2017 census shows that although tier 1 rotas are on average close to meeting this standard, tier 2 rotas only have an average of 9 staff, and that shortfalls are worse on separate neonatal rotas.

60% of all rotas have fewer than 10 WTE; 68% on tier 2. Having fewer doctors and other staff on the rota inevitably means there is less time for trainees for teaching, research and carrying out audit and other quality improvement work.

3.5 Other workforce groups in paediatrics and child health: Advance Nurse Practitioners, Physician Associates and GP Trainees

RCPCH is supportive of an increased skill mix where other types of appropriately trained and competent non-medical and other medical groups can support paediatric services. Our census shows that only 60.6% of organisations employed Advanced Nurse Practitioners (ANPs) in 2017, unchanged from 60.3% in 2015. The RCPCH support ANPs to use e-portfolio for their training at reduced membership rates.

Only 5 of the 160 responding organisations (3.1%), all in England, employ Physician Associates; the same number as in 2015. There was a total of 7.6 WTE Physician Associates recorded in 2017, down from 9 WTE in 2015.

The proportion of GP trainees recorded as working on junior paediatric rotas has remained virtually identical between 2015-2017 at approximately 28%.

3.6 CCT holders and applicants for consultant posts

There has been little change in the number of new paediatric CCT and CESR holders each year, indeed numbers have fallen slightly every year since 2014. Findings from the paediatric CCT and CESR Class of 2016 survey indicate that that it is becoming a buyer's market for new certificate holders in paediatrics. Meaning, CCT holders are in general able to obtain jobs in the specialty and location they want to work in, and the average number of job applications to obtain their first post has reduced.

Data from Advisory Appointment Committees show that there is considerably less competition for community child health consultant posts with an average of only 1.3 applicants compared to 3.1 for general and 3.8 for other specialist posts.

There are also concerning national and regional differences: average applicants per consultant post is only 1.3 in Northern Ireland and 1.4 in East Midlands and rises to 7.0 in North West London.

3.7 Doctors in training

According to GMC data [11] the headcount number of doctors in training in paediatrics and child health increased by 2.7% between 2012 and 2018. As 37.7% of paediatric trainees are now working LTFT this represents a whole time equivalent fall of 2.5%.

Recruitment into paediatric training

Rota shortages have not been helped by difficulties in recruiting and falling rates of applications for paediatric specialty training. Overall, across the UK 87.5% of ST1 were filled in 2018 compared to 89.6% in 2017. These are the first 2 years in which recruitment fill rate has fallen below 90% and where posts have needed to be re-advertised. Allowing recruitment only once a year limits the ability to fill gaps as they arise, and this is compounded by decreasing numbers of SAS doctors and the visa rules which make it difficult to fill such posts.

When Paediatric Clinical Directors were asked about workforce pressures 84% of respondents in the UK said that unfilled paediatric training posts and gaps pose a significant risk to their service or to children, young people and their families.

3.8 Trainee requirements

The GMC's report, the State of Medical Education and Practice in the UK 2018 [11] recognises the workforce shortages across professions working in the NHS. For the paediatric consultant workforce to reach the RCPCH's calculated demand level, increases are needed in trainee numbers to ensure greater levels of less than full time working and attrition from training are mitigated. Importantly, we need to increase the recruitment of trainees to ensure compliance with Facing the Future Standards [10], to alleviate rota shortages.

Given the current lack of growth in other workforces to support paediatric services and little expected changes in configuration of services, we estimate that there is a need to recruit approximately 600 doctors into ST1 training posts each year for approximately the next 5 years.

This estimate accounts for the growth in less than full time working, prevailing rates of out of programme activity and also reflects the high level of attrition we have seen throughout the training programme.

References

1. The Health Foundation, The King's Fund, and Nuffield Trust, *The health care workforce in England. 2018:* https://www.nuffieldtrust.org.uk/files/2018-11/health-foundation-king-s-fund-and-nuffield-trust-the-health-care-workforce-in-england.pdf.
2. NHS Improvement, *Improvement and assessment framework for children and young people's health services*. 2018: https://improvement.nhs.uk/documents/2456/Improvement_and_assessment_framework_for_children_and_young_people_FEB_2018_version_3.pdf.
3. Royal College of Physicians, *Double or quits: calculating how many more medical students we need*. 2018: https://www.rcplondon.ac.uk/news/double-or-quits-calculating-how-many-more-medical-students-we-need.
4. Royal College of Paediatrics and Child Health, *Facing the Future Audit 2017*. 2018. https://www.rcpch.ac.uk/resources/facing-future-audit-2017
5. British Association of Perinatal Medicine, Service Standards for Hospitals Providing Neonatal Care. 2010, British Association of Perinatal Medicine: https://www.bapm.org/sites/default/files/files/Service_Standards%20for%20Hospitals_Final_Aug2010.pdf.
6. Royal College of Paediatrics and Child Health and British Association for Community Child Health, *Covering all bases - Community Child Health: A paediatric workforce guide*. 2017: https://www.rcpch.ac.uk/sites/default/files/2018-03/covering_all_bases_community_child_health_-_a_paediatric_workforce_guide.pdf.
7. Royal College of Paediatrics and Child Health. *The State of Child Health: The Paediatric Workforce*. 2017. Available from: http://www.rcpch.ac.uk/workforce.
8. Royal College of Paediatrics and Child Health, *Paediatric Rota Gaps and Vacancies 2017*. 2017: https://www.rcpch.ac.uk/sites/default/files/2018-02/paediatric_rota_gaps_and_vacancies_survey_wingsan_final.pdf
9. General Medical Council, *Training environments 2018: Key findings from the national training surveys*. 2018: https://www.gmc-uk.org/-/media/documents/training-environments-2018_pdf-76667101.pdf.
10. Royal College of Paediatrics and Child Health, *Facing the Future: Standards for Acute General Paediatric Services*. 2015: https://www.rcpch.ac.uk/sites/default/files/2018-03/facing_the_future_standards_for_acute_general_paediatric_services.pdf
11. General Medical Council, *The state of medical education and practice in the UK 2018*. 2018: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

RCPCH State of child health: short report series
Workforce briefing winter 2018

© RCPCH 2018

Royal College of
Paediatrics and Child Health,
5–11 Theobalds Road,
London, WC1X 8SH

www.rcpch.ac.uk

The Royal College of Paediatrics and Child Health is a registered charity
in England and Wales (1057744)and in Scotland (SCO38299)