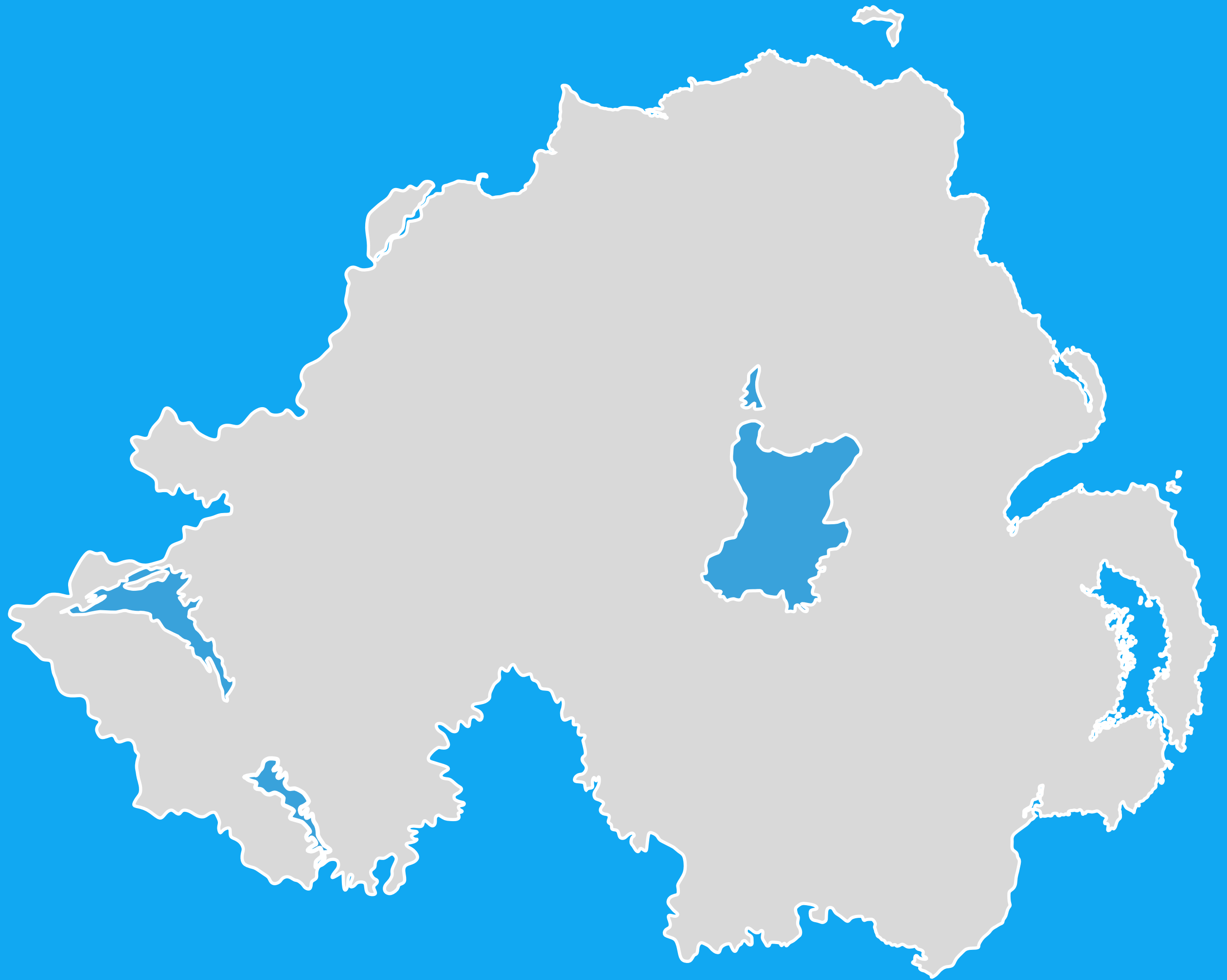

Workforce census: Focus on Northern Ireland

Published November 2019

RCPCH
Royal College of Paediatrics and Child Health
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1. Introduction

This report is a workforce profile for Northern Ireland, supported by the Royal College of Paediatrics and Child Health (RCPCH) census 2017, and other data on the paediatric workforce and services collected by the RCPCH. It follows on from the Workforce Census Overview Report [1] that provides a UK-wide analysis of the census data, and is part of a series of reports focusing on the devolved UK nations in turn.[2,3] A further report focuses on Specialty, Staff Grade and Associate Specialist (SAS) doctors [4].

This report makes recommendations specific to Northern Ireland in five key areas:

1. Plan the child health workforce
2. Recruit, train and retain more paediatricians
3. Incentivise the paediatric workforce
4. Plan for and expand the non-medical workforce
5. Expand paediatric training for the primary care workforce

The reports are supported by the following Census Resources on the RCPCH website:

- An interactive dashboard of paediatric workforce data which allows users to apply filters and customise for their own use and interest.
- A set of detailed tables in Excel format for those who wish to see further breakdowns of the census data.
- An explanation of how we arrived at our estimate of consultant workforce demand and supply of trained doctors.
- The census data collection methodology and response rate.

2. Executive summary

There are five Health and Social Care Trusts in Northern Ireland delivering acute, community and specialist (including neonatal) care for children and young people across 11 hospitals[5]. Northern Ireland has the highest proportion of the population under 18 of the UK nations, and 20.8% of the population are aged 0 to 15 years[6].

Consultant whole time equivalent growth rate in Northern Ireland between 2015 and 2017 was 5.4%; lower than the England growth rate of 8.2% and the UK growth rate of 7.8%. Growth in Northern Ireland slowed compared to the findings of the 2015 census: the number of consultants grew by 17.9% between 2013 and 2015. Furthermore, 11.3% of the total career grade workforce (consultant plus SAS doctor) had posts vacant for longer than 3 months, higher than the overall UK rate of 4.1%.

The shortfall in paediatric trainees across Northern Ireland is also seen in rates of rota gaps and vacancies, which are higher than the UK for Tier 1 and Tier 3 medical staff. To meet the RCPCH standards set out in Facing the Future[7], the number of WTE consultants in Northern Ireland needs to increase by around half, to approximately 172 WTE. The actual increase between the previous census rounds was 5.4%.

There are particular concerns in Northern Ireland about workforce provisions to remote and rural areas. As in the rest of the health service, remote and rural areas face higher costs. Paediatrics faces issues of recruitment and retention, and a reliance on a small number of paediatricians in smaller centres[8]. The Rural Needs Act (NI) 2016 for Public Authorities places a statutory duty on

local authorities to consider rural needs in their plans and policies[9].

As in other specialties and healthcare professions, the number of paediatric trainees and consultants are unlikely to rise by the amount needed to meet demand any time soon[10]; especially as only 6% of Foundation Year 1 (F1) doctors consider specialising in paediatrics[11]. Therefore, workforce planners need to develop non-medical workforces, and see their potential in helping paediatric services meet standards and demand. Advanced Nurse Practitioners (ANPs) are employed across the Trusts in Northern Ireland, and this is a good first step towards diversifying the workforce.

The 2018/19 Draft Commissioning Plan from the Health and Social Care Board and the Public Health Agency sets out priorities for health and social care to improve the experience of people at all stages of their life and healthcare journey. According to the report, the child population is projected to decrease, but conclusions cannot be drawn about service demand based on population, as a decrease does not necessarily mean there will be a reduction in demand for child health services. As the burden of disease becomes more complex, and greater intervention is needed with the advent of technology (such as gene screening), there will continue to be a need for a highly trained workforce. In Northern Ireland, compared to the rest of the UK, there is a higher ratio of people who obtained their Primary Medical Qualification (PMQ) in the UK compared to those who graduated overseas. Given that there are workforce shortages in the nation, it is important to further investigate this pattern and consider whether more could be done to attract overseas graduates.

The average number of Programmed Activities (PAs) in consultant full time contracts was higher in Northern Ireland compared to the rest of the UK. Furthermore, although the rate of less than full time (LTFT) consultants working in Northern Ireland increased compared to 2015, it was lower than the UK as a whole. Paediatrics in the UK has a trainee workforce which increasingly wishes to work LTFT[12]. Therefore modelling will need to consider how the shift towards LTFT in trainees may extend into consultant LTFT working patterns in the future, as this could lead to a fall in the whole time equivalent (WTE) workforce in Northern Ireland.

There is heavy reliance on Specialty, Associate Specialist and Staff Grade (SAS) doctors in Northern Ireland. The rest of the UK may be able to take lessons about how to effectively retain and reinvigorate SAS doctors in paediatrics. The number of SAS doctors in paediatrics has almost halved since the 2001 census across the UK. However, the NHS Long Term Plan[13] contained a commitment to create a new associate specialist or equivalent grade. The RCPCH has recently released a workforce report focusing on SAS doctors in paediatrics using the latest census data[4]. We also welcome a recent report from Health Education England and NHS Improvement, Maximising the Potential[14], which offers guidance to recognise and support SAS doctors.

The general paediatric workload is shifting, and we report a year-on-year upwards trend of admissions. A more effective way of working across primary and secondary care, as described in Facing the Future: Together for Child Health[15], is needed to keep up with the upward trend in admissions. To further investigate this, the RCPCH is conducting a project to determine the role of paediatricians and child health in the future called Paediatrics 2040[16]. This project will develop a shared understanding of what the key issues are likely to be for paediatricians and to better understand what the future may hold for the profession in the UK in 2040.

While this report focuses on paediatricians, it is clear that many other doctors and healthcare professions contribute significantly to the delivery of child health and wellbeing. Therefore, it is vital that a holistic approach will be adopted to meet the gaps in addressing our current needs and concurrently to plan for an integrated child and family focused workforce for the future, as close to home as safely possible.

3. Acknowledgements

The RCPCH would like to thank the clinical directors and clinical leads of Trusts in Northern Ireland who submitted data to the census, conducted from autumn 2017 to summer 2018. Your input is invaluable in allowing the RCPCH to provide evidence-based recommendations and ensure the pressures facing the child health workforce are prioritised.

Marie Rogers, Lisa Cummins and Davide Carzedda currently comprise the RCPCH workforce team which leads the census work. Heather Clark, Wingsan Lok, Martin McColgan, Anita Pau, Donella Williams, Rachel Winch, and Lucas Woodward were also part of the workforce team during the census project and contributed to the work. Furthermore, Melissa Ashe and Grace Brown in the Health Policy team gave valuable input, along with James Clark in the Recruitment and Careers team, and John McBride the External Affairs Manager for Ireland.

Dr Raymond Nethercott, RCPCH Officer for Ireland
Dr Nicola Jay, RCPCH Officer for Workforce Planning and Health Services
Dr Simon Clark, RCPCH Vice President for Health Policy.

4. Recommendations

4.1 Plan the child health workforce

The **Department of Health (Northern Ireland)** must develop a bespoke child health workforce strategy.

- The strategy should take a systematic approach to identify all the child health workforce required to meet the needs of the infant, child and young person population including medical, midwifery, nursing, allied health professionals, pharmacists, health visitors and school nurses.
- A comprehensive plan for the child health workforce should integrate with other services; particularly primary care, obstetrics, and emergency care. The plan must model the paediatric and child health workforce at least up to 2030 based on what future services will look like and existing service demand projections.
- The strategy must be sufficiently robust to deliver professional and service standards that are measurable and comparable across the UK and internationally.
- The strategy must acknowledge and support differential participation rates and the development of portfolio careers to enable retention of staff. RCPCH is prepared to work with all agencies in a constructive and collaborative manner to secure the workforce strategy.

4.2 Recruit and train more paediatricians

The **Department of Health (Northern Ireland)** must fund an expansion of paediatric training places

- Our model shows that to meet demand and safe standards of care, 15 headcount doctors must be appointed at the beginning of paediatric training for the next 5 years in Northern Ireland. In 2017 there were 13 appointments and in 2018 there were 12, therefore a 13-20% rise is needed.

The **Department of Health (Northern Ireland)** must expand the number of medical students.

- The RCPCH supports the Royal College of Physicians' call[17] to double the number of medical students in the UK, with distribution across medical schools to meet local population demand.

The **Royal College of Paediatrics and Child Health** must ensure that paediatrics is an attractive specialty where trainees can thrive.

- The RCPCH recognises that workforce shortages and rota gaps mean that paediatricians feel overworked, stressed and burned out.
- To combat recruitment and retention problems, the RCPCH launched a new Careers Campaign at the end of September 2019 to support our current members and attract more doctors into paediatrics. This will help to close the gap between applicants and paediatric training posts.

4.3 Incentivise the paediatric workforce

The **Department of Health (Northern Ireland)** should consider incentives for paediatricians, such as flexible pay premia.

- Pay premia have been used in other hard to recruit medical specialties, such as General Practise[18]. Paediatrics is now facing severe shortages with falling applications and recruitment challenges.
- This should be considered for paediatric trainees as a recruitment incentive into the paediatric specialty; particularly for hard-to-recruit areas, including remote and rural settings.
- Incentives such as flexible pay premia could be offered to paediatricians who return to clinical practice after successfully undertaking a pre-agreed period of approved academic research or other recognised activities of benefit to the NHS.
- Novel incentive methods that reward innovation and commitment to improving healthcare for deprived communities should be considered.

4.4 Plan for and expand the non-medical workforce

The **Department of Health (Northern Ireland)** must consider how the non-medical workforce can support child healthcare delivery.

- The delivery of paediatric services to children and young people and their families requires a multidisciplinary workforce.
- There must be a national career strategy for advanced clinical practitioners including Advanced Nurse Practitioners in neonatology and paediatrics, and Physician Associates.

4.5 Expand paediatric training for the primary care workforce

The **Department of Health (Northern Ireland)**, along with the **Royal College of General Practise** and the **Royal College of Paediatrics and Child Health** should ensure the expansion of paediatric placements and modules in General Practice specialty training.

- Primary care workers need increased confidence to deal with child patients. There is minimal paediatric training opportunities in the General Paediatric specialty curriculum.
- There must be more training opportunities for General Practitioners to maintain, enhance and develop their paediatric skills.

5 Findings

5.1 Consultant demand modelling

There were 113.1 WTE (118 headcount) consultants in 2017 and we estimate that this will need to increase by 53%, to approximately 172 WTE, to meet consultant demand.

The greatest part of this estimated increase is for general paediatricians: 77 WTE are required, there are currently 53.9 WTE. We estimate 28 WTE community child health (CCH) consultants are required to meet demand, an increase of around 40%. This is a minimum predicated on the number of SAS doctors working in CCH increasing at the same rate as consultants.

To calculate consultant demand, we use standards that outline best practice in paediatric care, including the RCPCH Facing the Future standards[19], which state there should be 12-hour consultant presence 7 days a week in inpatient units. In addition, the British Association of Perinatal Medicine (BAPM) standards[20] which state that there should be 8 consultants per NICU, and the RCPCH Covering all Bases report[21] which calculated demand for consultants in community child health (CCH) on the basis of population and referrals.
We have based our modelling on these assumptions:

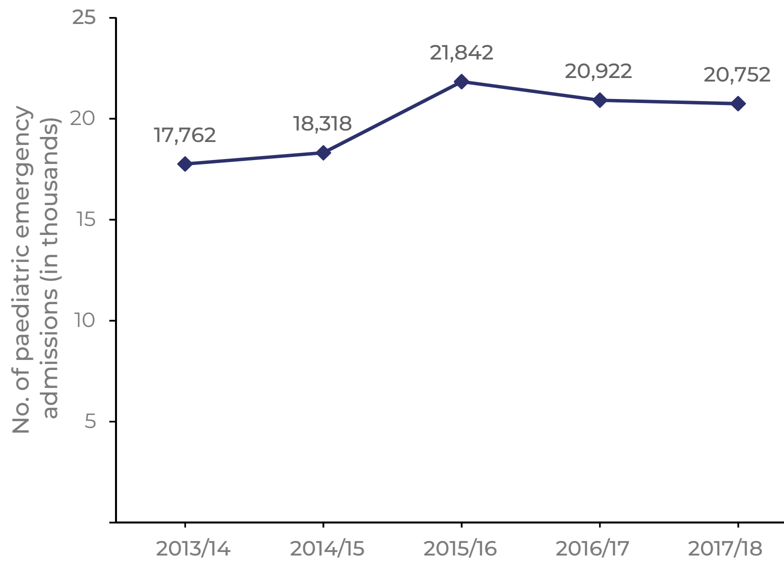
- Service structure remains as it was in 2017-2018 in terms of the number of inpatient units, neonatal units, paediatric intensive care units (PICUs), number of community child health services.
- The number of SAS doctors will not increase significantly.
- The number of GP trainees, nurses and other workforce groups who can work on rotas will not grow under current workforce policies operated by governments in the four UK nations.

The area with greatest difference between demand and actual consultant numbers is general paediatrics, accounting for around 60% of the increase needed.

The key factors influencing current demand levels are:

- Between 2013/14 and 2016/17 paediatric emergency admissions in Northern Ireland have risen 17.8%. Note that the numbers do not include children seen and treated in Short Stay Paediatric Assessment Units (SSPAU), but the same workforce covers these areas. See Figure 1.
- The level of paediatric admissions in some units mean that double rotas are increasingly needed (i.e. two trainees in service at one time).
- The RCPCH's Facing the Future Audit [22] shows continued challenges to meet standards for presence throughout all hours of peak activity and consultant review within 14 hours of admission.
- In 2017, the RCPCH and the British Association for Community Child Health (BACCH) published Covering all Bases [23] which found that there was a need for substantial increase in the 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.

Figure 1. Number of paediatric emergency admissions to Trusts in Northern Ireland, 2013/14 to 2017/18.



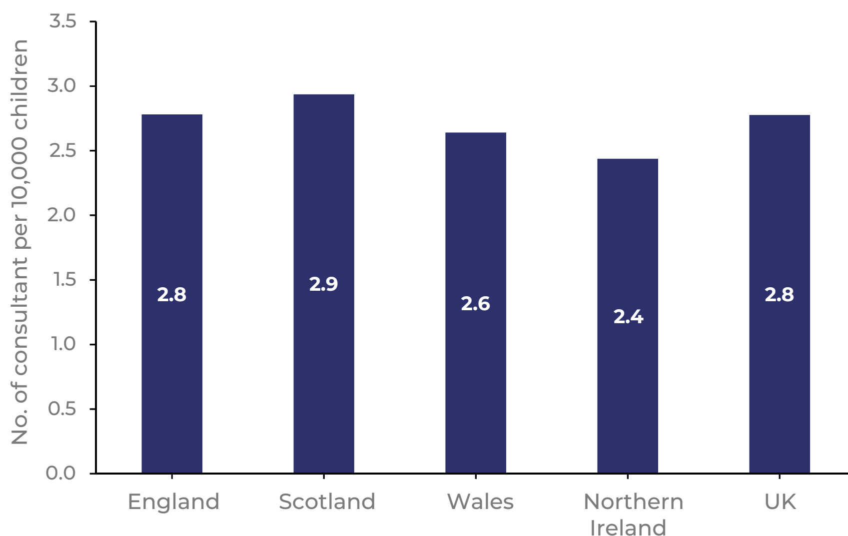
5.2 Career grade paediatric workforce

In 2017, there were 118 headcount paediatric consultants in Northern Ireland; a 5.4% increase from 2015 when there were 112 paediatric consultants. Consultant growth in England over the same time period was 8.2%.

Consultant growth in Northern Ireland is slowing: between 2013 and 2015 there was a 17.9% growth in consultant headcount.

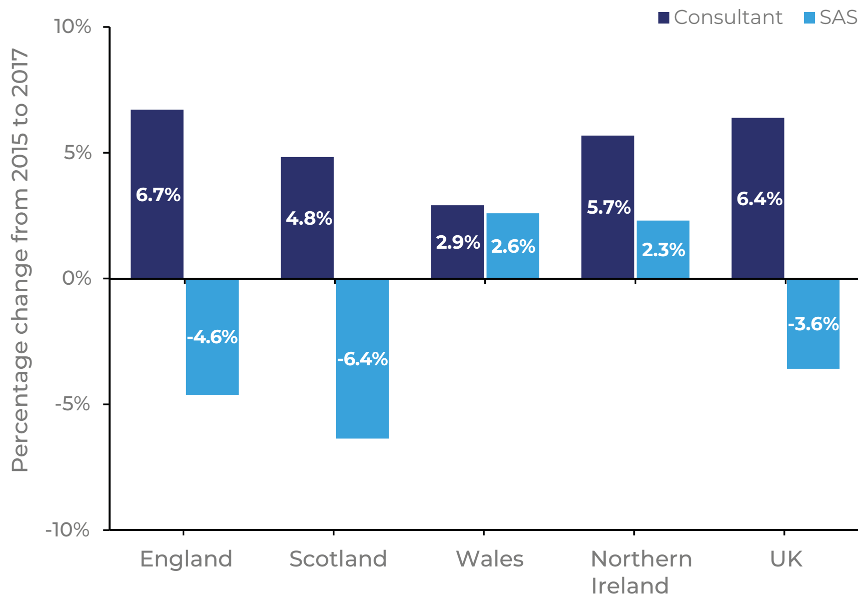
Northern Ireland has 2.4 headcount consultant paediatricians per 10,000 children, lower than the UK rate of 2.8, see Figure 2.

Figure 2. Headcount number of consultants per 10,000 children (0 to 18 years inclusive, ONS mid 2017 population estimates) in 2017 by nation.



In terms of Whole Time Equivalent (WTE), in 2017 in Northern Ireland there were 113.1 WTE compared to 107.0 WTE in 2015; an increase of 5.7%.

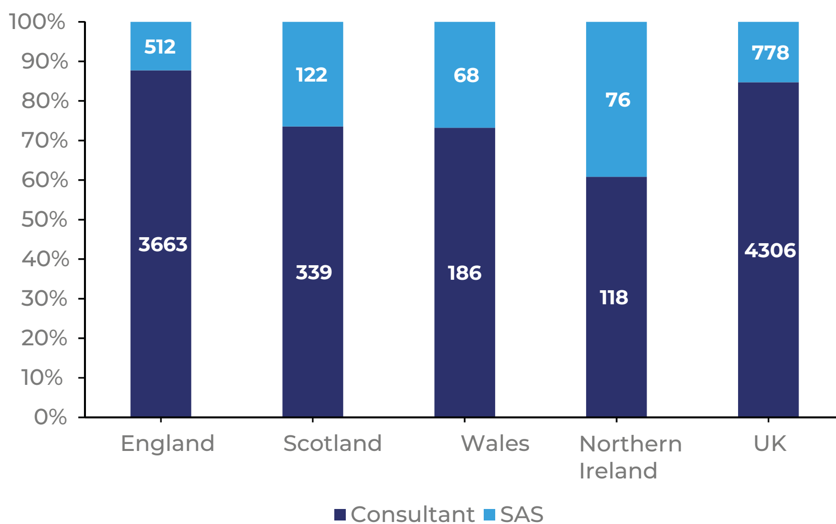
Figure 3. Percentage change from 2015 to 2017 in WTE of consultant and SAS grade doctors



There were 78 headcount (59.7 WTE) SAS doctors in 2017, 1.3% increase in headcount (2.3% increase in WTE), compared to 2015 when there were 75 headcount (58.4 WTE). The RCPCH workforce censuses, starting in 1999, show that SAS doctor numbers have decreased dramatically across the UK.

Northern Ireland's career grade workforce has the highest proportion of SAS doctors of all the UK nations. Across the UK, 15.3% of the career grade workforce are SAS doctors, whereas in Northern Ireland 39.2% are SAS doctors, see Figure 4.

Figure 4. Headcount consultant and SAS grade doctors by nation, 2017.



5.3 Factors influencing workforce demand

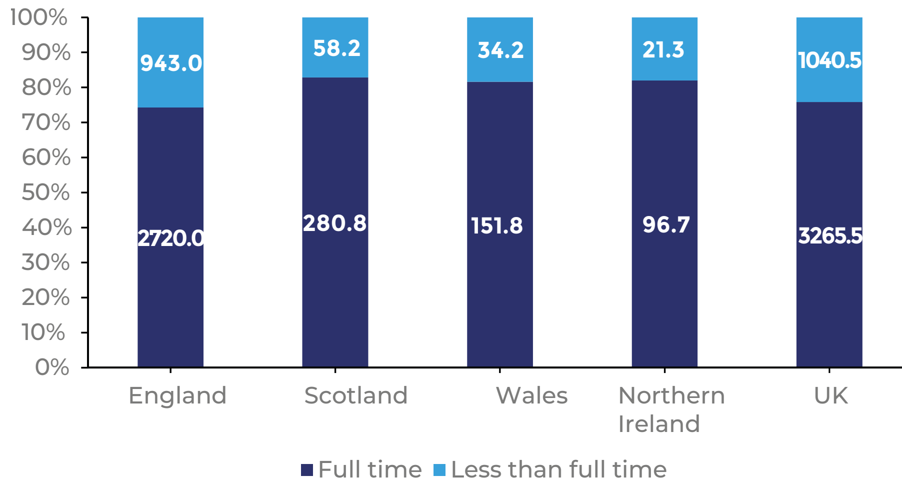
5.3.1 Less than full time working

Consultants in Northern Ireland have a lower rate of less than full time (LTFT) working compared to the UK as a whole (see Figure 5). In 2017, 18.0% of consultants worked less than full time, compared to 25.7% in England and 24.5% overall in the UK. This has increased since 2015 when 16.9% of consultants worked LTFT in Northern Ireland. This rise in LTFT working has reduced the effect of the increase in consultant headcount. This trend is likely to continue given the

percentage of less than full time working amongst doctors in the training programme (17.5% in NI according to GMC data [12]).

Rates of LTFT working for SAS doctors are higher than consultants in Northern Ireland, at 55.4% The overall UK rate of SAS doctor LTFT working in 2017 was 45.8%.

Figure 5. Proportion of full time vs less than full time consultants by nation in 2017. Data labels show WTE.

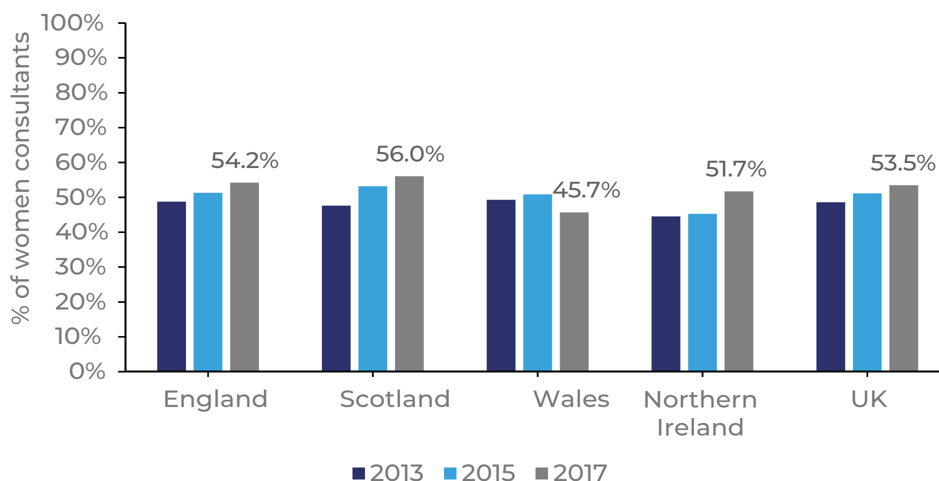


Rates of LTFT working varies widely between job type, which should be considered when workforce planning. For example, in Northern Ireland 35.7% of community child health consultants worked LTFT compared to 20.8% of generalists and 11.4% of specialists.

5.3.2 Gender changes in the workforce

There was an increase in the proportion of female consultants in Northern Ireland between 2015 (45.3%) and 2017 (51.7%), so that women now make up the majority of the consultant workforce. This in line with the UK as a whole which has seen a steady increase in the proportion of female consultants (see Figure 6).

Figure 6. Proportion of women consultants by country, from 2013, 2015 and 2017 census data.

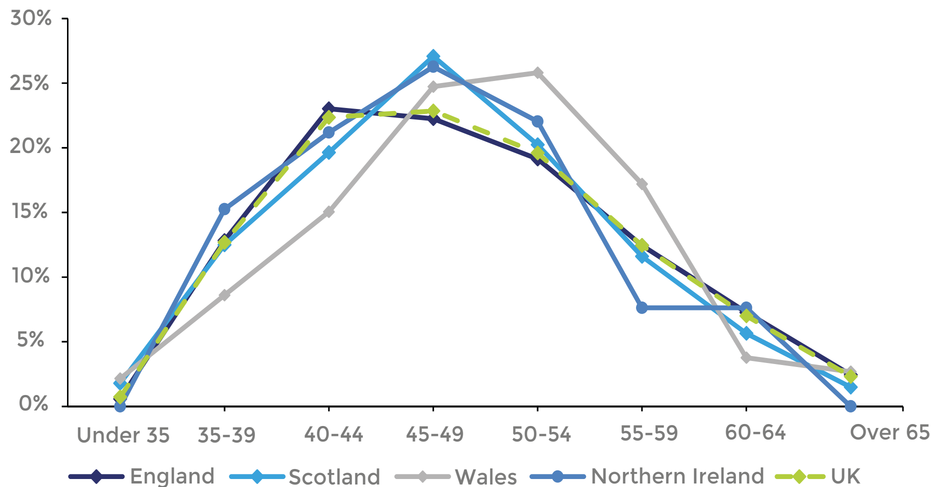


Women account for a higher proportion of SAS grade doctors in Northern Ireland compared to the rest of the UK. In 2017, 89.5% (68/76) of SAS grade doctors were women in Northern Ireland.

5.3.3 Age characteristics of the workforce

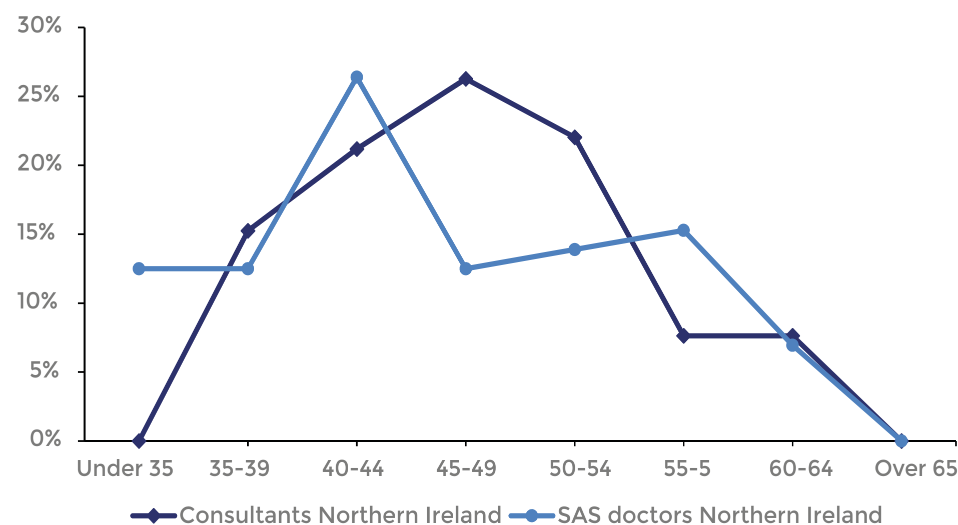
Northern Ireland has a slightly older paediatric workforce compared to the UK as a whole; combined with the slow rate of workforce growth this is a serious concern. Figure 7 shows that the highest proportion of consultants in Northern Ireland are in the age group 45-49 (26.3%), closely followed by 50-54 (22.0%). Fifteen percent 15.3% (18/118) of consultants in Northern Ireland are aged 55 or over.

Figure 7. Proportion of consultants in each age group by nation, 2017.



In the UK as a whole, SAS doctors tend to be older than consultants. In Northern Ireland the age profile of SAS doctors is varied; likely due to the small numbers involved. Figure 8 shows that the highest proportion of SAS doctors aged 40-44, and 22.2% of SAS doctors in Northern Ireland are aged 55 or older.

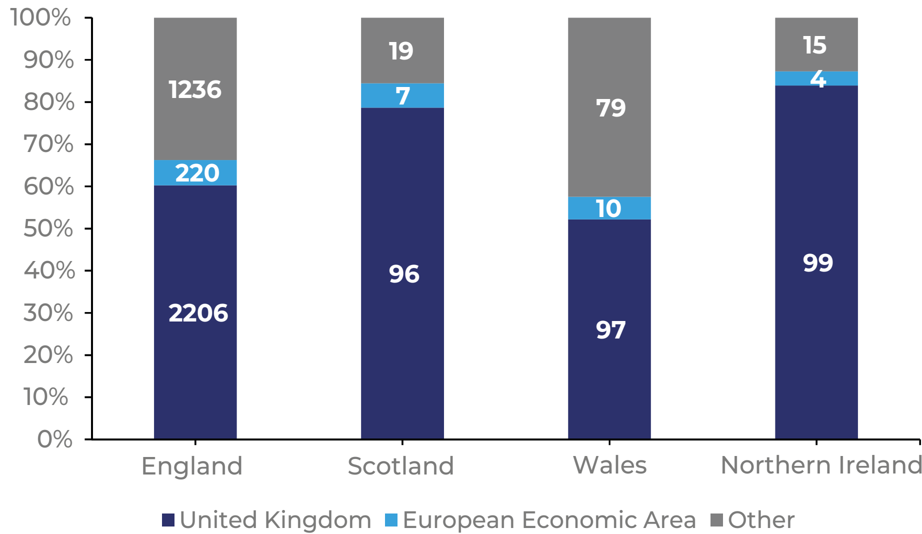
Figure 8. Proportion of consultants and SAS doctors in Northern Ireland in each age group, 2017.



5.3.4 Place of Primary Medical Qualification (PMQ)

Of the UK nations, Northern Ireland has the highest proportion of consultants who obtained their primary medical qualification in the UK. In 2017, 12.7% obtained their primary medical qualification (PMQ) from a European Economic Area (EEA) country and 3.4% from outside Europe and 83.9% of consultants gained their PMQ in the UK (see Figure 9). Whereas in the UK overall, 61.1% of consultants obtained their PMQ in the UK.

Figure 9. Consultant PMQ[i] by nation, 2017.

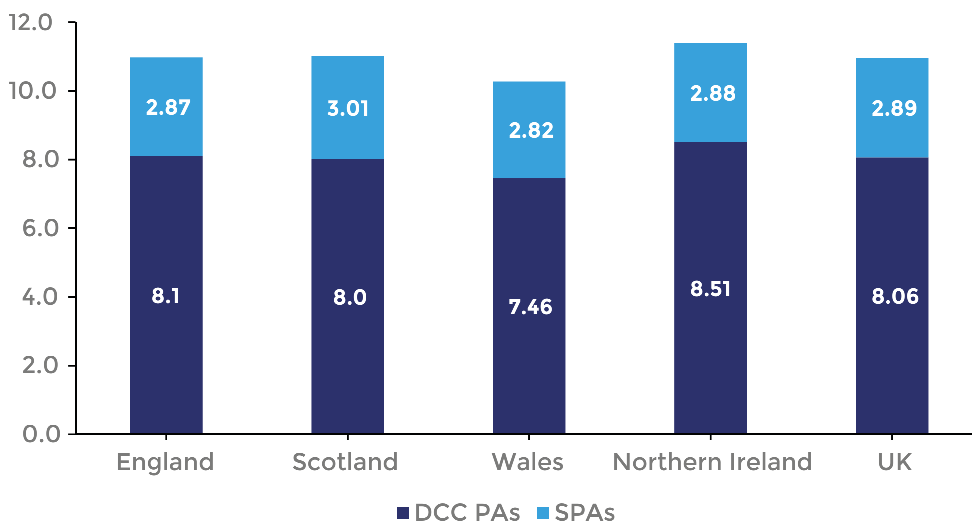


5.3.5 Consultant programmed activities (PAs)

Northern Ireland has the highest average number of contracted PAs for full time consultants: 11.4, compared to the UK average of 11. The British Medical Association (BMA) recommends that full time contracts should be 10 PAs[23].

Programmed activities in a contract are broken down into time for Supporting Professional Activities (SPAs) and time for Direct Clinical Care (DCC). For full time consultants in Northern Ireland, the average number of DCCs is 8.5 and the average number of SPAs 2.9.

Figure 10. Average number of Direct Clinical Care (DCC) PAs and Supporting Professional Activities (SPAs) in full time consultant contracts by nation, 2017.



5.3.6 Job type breakdown of workforce

Northern Ireland has a higher proportion of generalist career grade paediatricians (41.8%) and a lower proportion of specialist career grade paediatricians (27.3%).

i PMQ data missing for 218 consultants across the UK; none were missing for consultants in Northern Ireland.

Figure 11. Headcount numbers of all career grade doctors by job type and nation in 2017.

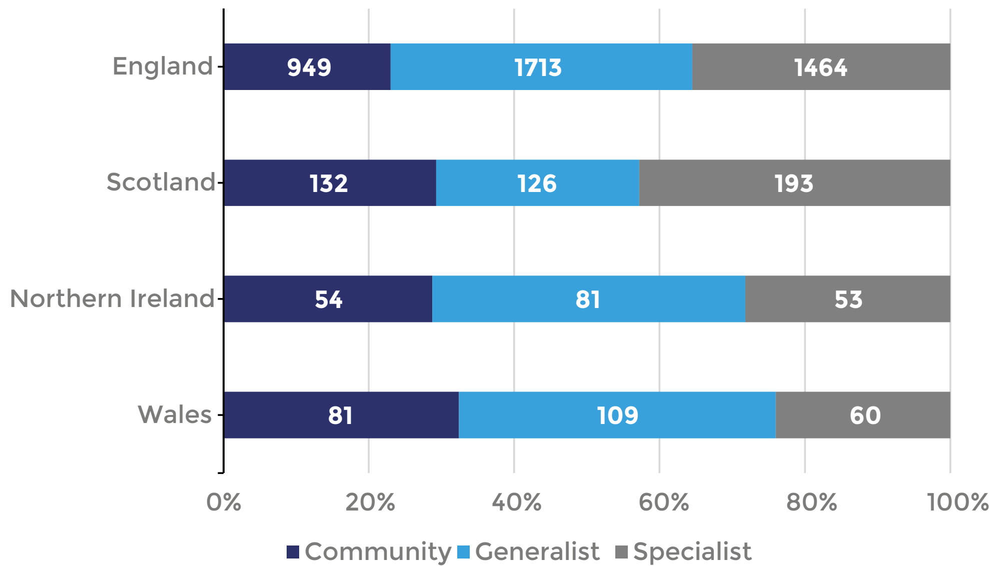
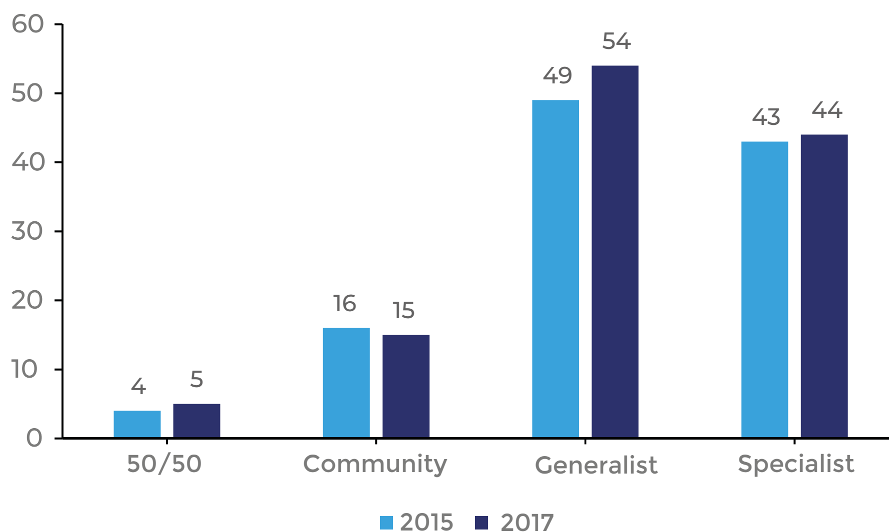


Figure 12 shows that the expansion in the consultant workforce in Northern Ireland has mainly been driven by a modest expansion in generalists, whereas there has been little change in the number of specialists or community child health consultants (50/50 consultants not reported due to numbers lower than 5).

Figure 12. Headcount number of consultants by job type group in Northern Ireland, comparing 2015 to 2017.



5.3.7 Consultant vacancies

There were 22 WTE career grade (consultant plus SAS doctor) posts vacant for longer than 3 months across the Trusts in Northern Ireland, according to the 2017 census data. This represents 11.3% of the total workforce in Northern Ireland, much higher than the overall UK rate of 4.1%. See Table 1.

The vacancies reported in this section reflect the established posts not filled. They do not give an indication of the shortfall against the RCPCH standards, rather they are the shortfall against the workforce establishment of the organisation. The gap between the 2017 workforce and that required to meet standards is considerably larger (see section 5.1 Consultant demand).

Table 1. Headcount (HC) vacancies and vacancy % levels, by nation and grade group. Percentages as a proportion of each nation's overall workforce.

	England		Scotland		Wales		Northern Ireland		UK total	
	HC	**%**	**HC**	**%**	**HC**	**%**	**HC**	**%**	**HC**	**%**
Consultant	130.1	3.6	9	2.7	8	4.3	13	11.0	160.1	3.7
SAS doctor	32.8	6.4	5	4.1	3	4.4	9	11.8	49.8	6.4
Total	163	3.9	14	3.0	11	4.3	22	11.3	210	4.1

5.4 Factors influencing workforce supply

5.4.1 New Certificate of Completion of Training (CCT), holders

Across the UK, there has been minimal change in the number of new paediatric CCT, CESR and CESR(CP) holders each year. There was a gradual increase between 2011 and 2014, where the

number of new certificate holders went up from 247 to 332. But numbers have fallen slightly each successive year, down to 300 in 2017.

Overall, the number of new CCT-holders who trained in Northern Ireland ranged from four to ten per year between 2011 and 2017. Due to small numbers, the breakdown of new CCT-holders cannot be reported. However, the current level of supply of new CCT holders in Northern Ireland would not be enough on its own to satisfy RCPCH calls for demand for consultants.

The RCPCH conducts a yearly survey of new CCT, CESR and CESR(CP) holders, one year on from their certification, to identify career pathways and views on transition to consultant posts. Findings from the 2016 cohort survey indicate that it is becoming a buyer's market for new CCT and CESR holders[24]. Across the UK, there has been an increase of those who are working in the same specialty as their specialist registration with the GMC, from 77% in 2015 to 89.2% in 2016. Furthermore, fewer doctors are working in a different region from their training region after CCT: 31.7% of 2015 cohort respondents and 27.7% of 2016 cohort respondents.

5.4.2 Paediatric trainees

According to GMC data[12] the headcount number of doctors in training in paediatrics and child health increased by 2.7% between 2012 and 2018 across the UK. The ratios for first preference applications to posts are shown in the Table 2.

- 12/16 (75%) of ST1 places filled for 2018
- 13/14 (93%) of ST1 places filled for 2017

Table 2. Application ratio data from 2017 in Northern Ireland

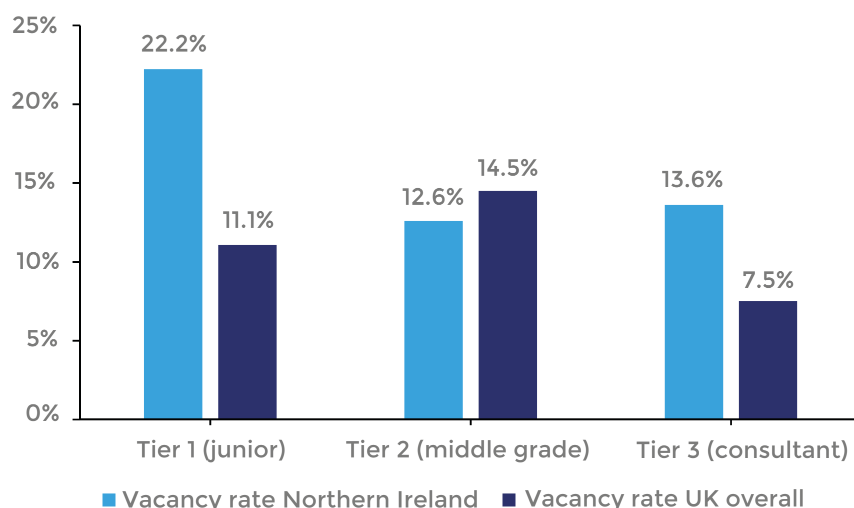
	Northern Ireland	UK overall
ST1	1.2:1	1.4:1

The fill rate for the UK overall in 2019 was 85%. Applicants can keep changing their preferences right up until the very last set of offers have been made, therefore the numbers stated here are a snapshot.

5.4.3 Rota gaps and vacancies

The census asks clinical leads to provide information about the number of rota vacancies for each service tier. It also asks for vacancies broken down by the main types of rota: general paediatrics, neonatal and for combined general/neonatal (depending on the set up in each unit).

Figure 13. Vacancy rate by rota tier, comparing Northern Ireland to whole of UK, 2017.



RCPCH's report Facing the Future: Standards for Paediatric Services [19] states that there should be 10 whole time equivalent posts on general paediatric training rotas. The standard of 10 WTE is used because of analysis undertaken by the Academy of Medical Royal Colleges for how many doctors are required to protect adequate daytime training time and comply with European Working Time Regulations [25]. Ninety percent (88.9%) of training rotas in Northern Ireland do not meet this standard. Table 3 shows that the average WTE for training rotas fails to meet the standard for every rota service.

Table 3. Average WTE by rota tier and service.

	General paediatrics	General / neonatal	Neonatal medicine	Total
Tier 1 (Junior)	8.5	7.8	8	8
Tier 2 (Middle grade)	8	7.3	8	7.4
Tier 3 (Consultant)	12	6.5	6	7
Total	**9.3**	**7.1**	**7.3**	**7.5**

5.4.5 Other paediatric and child health workforce groups.

There were 22.0 WTE advanced children's or neonatal nurse practitioners (ANPs) reported as employed to work within the hospital setting with children and young people across the five Trusts in Northern Ireland. All units employed ANPs in Northern Ireland in 2017, see Table 4.

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. For example,

RCPCH supports ANPs by providing e-portfolio for their training at reduced membership rates. Northern Ireland could be considered a best practise model for this.

Table 4. Units employing advanced children's or neonatal nurse practitioners (ANPs) by country

	Count of units with ANPs	% of units with ANPs	Estimated total WTE of ANPs	Average WTE of ANPs per unit
England	81	58.7	378.3	3.8
Northern Ireland	5	100.0	22	4.4
Scotland	9	81.8	72.8	8.1
Wales	2	33.3	7	3
Total	**97**	**60.6**	**491.3**	**4.2**

However, Table 5 shows that there is not even distribution and the majority of ANPs are employed in Northern or Southern Health and Social Care Trust.

Table 5. Paediatric inpatient units in Northern Ireland employing ANPs.

Name of Trust	Advanced Nurse Practitioners (WTE)
Belfast Health & Social Care Trust	2
Northern Health and Social Care Trust	7
Southern Health & Social Care Trust	9
South Eastern Health & Social Care Trust	2
Western Health and Social Care Trust	2
Total	**22**

5.4.6 Trainee supply requirements

With a consultant demand figure of 172 WTE, we can estimate reasonably accurately how many new CCT holders in paediatrics are needed to meet demand.

We estimate there will be six WTE expected leavers each year (mainly retirements) and nine CCTs are needed to replace these based on current LTFT working and because one in ten new CCT holders either go abroad or go into non-clinical roles. This factor has been fairly constant across the UK since 2010/2011 [24].

From our previous cohort studies of training [26] we have seen that somewhere between 3% to 5% of trainees leave the programme permanently each year. This is supported by comparing the number of trainees starting paediatrics and CCT outputs. Therefore, attrition from training is expected to account for 9% doctors from each cohort of trainees. To meet demand, 15 headcount doctors must be appointed at the beginning of paediatric training for the next 5 years. In 2018 there were 12 appointments and in 2017 there were 13, therefore a 13-20% rise is needed.

5.5 The structure of paediatric services in Northern Ireland

There are five Health and Social Care Trusts in Northern Ireland providing child health services: Belfast, Northern, Southern, South Eastern, and Western. These are comprised of eleven hospitals

that employ paediatricians to deliver acute, community and specialist (including neonatal) care for children and young people in Northern Ireland.

Figure 14. Location of hospitals with child health services in Northern Ireland. See Table 6 for further details.

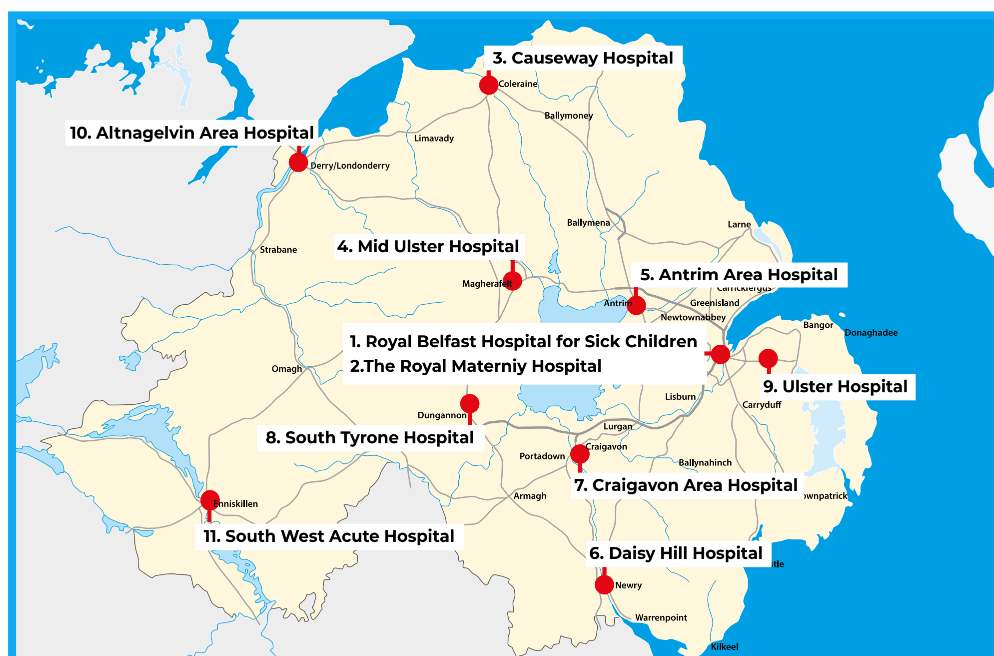


Table 6. Hospitals in Northern Ireland and services provided in each.

	Hospital name	Trust	Paediatric inpatients	Paediatric Critical Care (PCC) Neonatal care	
1	Royal Belfast Hospital for Sick Children	Belfast Health & Social Care Trust	Yes	Level 3 PCC	Neonatal intensive care unit
2	The Royal Maternity Hospital	Belfast Health & Social Care Trust	No	-	Neonatal intensive care unit
3	Causeway Hospital	Northern Health and Social Care Trust	Yes	Level 1 PCC	No neonatal unit
4	Mid Ulster Hospital	Northern Health and Social Care Trust	No	-	No neonatal unit
5	Antrim Area Hospital	Northern Health and Social Care Trust	Yes	Level 1 PCC	Local neonatal unit
6	Daisy Hill Hospital	Southern Health & Social Care Trust	Yes	No critical care provision	Special care unit
7	Craigavon Area Hospital	Southern Health & Social Care Trust	Yes	No critical care provision	Local neonatal unit
8	South Tyrone Hospital	Southern Health & Social Care Trust	No	-	No neonatal unit
9	Ulster Hospital	South Eastern Health & Social Care Trust	Yes	No critical care provision	Neonatal intensive care unit
10	Altnagelvin Area Hospital	Western Health and Social Care Trust	Yes	Level 1 PCC	Local neonatal unit
11	South West Acute Hospital	Western Health and Social Care Trust	Yes	Level 1 PCC	Special care unit

5.5.1 Paediatric inpatient units

Of the eleven hospitals in Northern Ireland providing paediatric services, eight have a paediatric inpatient unit. Ten have a paediatric outpatient unit (only The Royal Maternity Hospital does not). See Table 6. One unit has a dedicate adolescent ward (Ulster Hospital); the RCPCH report Bridging the Gap: Healthcare for Adolescents [27] recommends that units should have a separate facility for adolescents.

Northern Ireland has the lowest paediatric inpatient unit maximum age of the UK nations, ranging from 14 to 16, with an average of 14.5. However, since data collection, all units now take children up to 16. This compares to 12 to 25 in England, with an average of 17.1.

Table 7. Maximum age of admission to paediatric inpatient units by nation.

Nation	Max age for paediatric inpatients (average)		
	Mean	Min	Max
England	17.1	12	25
Scotland	15.9	14	18
Wales	17.2	16	18
Northern Ireland	14.5	14	16
Total	**16.9**	**12**	**25**

Paediatric inpatient units in Northern Ireland had to close to new admissions for 8 days in total in the previous year to 30th September 2017. See Table 8.

Table 8. Paediatric inpatient unit closures to new admissions by country, year to 30 September 2017

Nation	No. units closed 1 or more times	Average No. times unit closed	Max No. times closed	Total responses
England	27	1.6	30	117
Northern Ireland	2	1.8	8	8
Scotland	5	9.8	85	14
Wales	5	3.3	15	12
Total	**39**	**2.5**	**85**	**151**

5.5.3 Workforce pressures

Census respondents were asked to "select the service and workforce pressures or issues that you feel pose a significant risk to your service or to children, young people and their families." Respondents could select more than one response to the question.

In Northern Ireland, the most frequently selected pressure was "Paediatric training post vacancies and gaps" (100%) followed by "Clinical workload" (83%) and "Difficulty recruiting paediatric non-consultant, non-training grade staff" (83%).

6 Methodology and response rate

The RCPCH workforce census 2017 asked the clinical leads or directors at all 191 organisations providing paediatric services in the UK to respond on behalf of their service. Across the UK as a whole, 80.6% (156 /191) of core hospital and staffing information was completed or validated by the clinical lead/ director.

In Northern Ireland, four of the five Trusts gave a complete response to the census. The Trust that did not fully complete their response validated data collected by the RCPCH workforce team. Some responses were missing to individual questions within the census, for example information on the number of unit closure days was difficult to obtain. Response rates to individual questions are reported in footnotes beside the relevant analysis throughout the report. See Census Resources for further detail.

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

www.rcpch.ac.uk

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