

A snapshot of general paediatric services and workforce in the UK

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Introduction

This study into how general paediatric services are run was conducted in September 2019, prior to the COVID-19 pandemic. The results reveal a stretched general paediatric service, with a great deal of variation in services across the UK. This report serves as a useful benchmark and as a prompt to consider the aspects of general paediatric care that should be restored, can be innovated, or that we do not wish to return to.

General paediatric services are the forefront of care for a seriously unwell child or baby. The majority of paediatric trainees qualify in general paediatrics, but only around 42% of paediatric consultants work in general paediatrics, with the remaining in subspecialty rolesⁱ. Emergency paediatric admissions are increasing year-on-yearⁱⁱ, primarily driven by respiratory illnesses in the under 5s and neonatal issuesⁱⁱⁱ. Across all of paediatrics, the Royal College of Paediatrics and Child Health (RCPCH) currently estimates that an increase in 856 (22%) whole time equivalent general paediatric consultants would be needed to meet current demand across the UK^{iv}. As such a gap will not be met easily or rapidly, a multidisciplinary workforce is essential to meeting demand.

A general paediatric service usually consists of a children's inpatient ward alongside outpatient clinics and a neonatal unit. It is sometimes supported by a Children's Assessment Unit (CAU), where patients are kept for short-term observation. Referrals to general paediatrics are made from the Emergency Department (ED), primary care or other routes such as transfers from another hospital. Children are seen with a range of acute and long-term health conditions, such as respiratory illness, nutrition problems, or safeguarding concerns. There is an increasing need for Allied Health Professional (AHP) involvement due to greater numbers of children with medical complexity.

On a given working day, general paediatric staff may have to cover the inpatient ward, outpatient clinics, the CAU, paediatric cases in ED, as well as neonatal services in some hospitals. Staff will regularly liaise with primary care, intensive care, surgical teams, community teams, paediatric subspecialty teams, social care and in some cases (as in the case study 1, below), police and legal professionals. Shortages in these adjacent areas have a knock-on impact on general paediatrics.

The health needs of children have changed drastically over the past 50 years, and paediatrics has had to adapt accordingly. Overall, threats to child health are moving towards complex and comorbid conditions such as diabetes, obesity, mental illness, and safeguarding concerns. Thanks to modern advances, such as vaccines, children more rarely present with infectious diseases like measles and mumps. However, given the COVID-19 pandemic we must be cautious and not forget about the importance of preventing infectious diseases. To address the breadth of child health needs, we must ensure that care is integrated, with close links to primary care, public health, mental health and community services, as highlighted by the NHS Long Term Plan^v. General paediatrics will be key to delivering integrated care for children.

The findings of the current report are considered against a backdrop of a system recovering after the COVID-19 pandemic, NHS-wide workforce pressures, worsening child health outcomes and increasing

i RCPCH. Workforce Census: UK Overview Report. (2019).

<https://www.rcpch.ac.uk/resources/workforce-census-uk-overview-report-2019>

ii NHS Digital. Hospital Episode Statistics. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data>

iii RCPCH. Paediatrics 2040, forthcoming data. <https://www.rcpch.ac.uk/work-we-do/paediatrics-2040>

iv RCPCH. Shortage of consultant paediatricians – report. (2019).

<https://www.rcpch.ac.uk/resources/shortage-consultant-paediatricians-report>

v NHS Long Term Plan. (2019). <https://www.longtermplan.nhs.uk/>

inequality in the UK as reported in the recently released State of Child Health 2020 report^{vi}. Whilst the coronavirus SARS-Cov-2 rarely has a serious clinical impact on children, the COVID-19 response, such as social distancing measures, has had a profound knock-on effect to services and especially vulnerable children.

The current survey was conducted with the aim of getting a snapshot of the current state of general paediatric services in the UK. We surveyed services on two days: Wednesday 18th and Saturday 21st September 2019 to allow comparison between a weekday and weekend. This was done in partnership with NHS England/NHS Improvement initiative Getting It Right First Time (GIRFT)^{vii} who conducted a concurrent survey of neonatal services and will also release a report of their findings. 192 general paediatric units were invited to participate and 124 responded (65%). The response rate in England was much better than in the devolved nations, possibly due to greater awareness of the GIRFT programme in England.

Our primary findings were:

1. Medical rotas and staffing:

- There was an average of 10% of staff missing on the training rotas on weekdays, equivalent to 0.6 people per unit.
- The majority of absences were due to vacancies (weekday 25%; weekend 28%) or short-term sick leave (weekday 19%; weekend 10%).
- A third of the tier 1 medical rota was staffed by GP trainees.
- ST4 to ST8 paediatric trainees were more likely to be on the tier 3 rota on the weekday than the weekend.
- A quarter of units surveyed (25.3%) had at least one locum doctor present.

2. Multi-disciplinary team:

- The general paediatric team is comprised of a wide range of healthcare professionals.
- Non-medical staff tended to be less available at the weekend: 84% of units had a play therapist present on a weekday compared to just 31% on the weekend.
- Similarly, 62% of units had a dietician present on a weekday compared to just 2% on the weekend.

3. Route to accessing care:

- The majority of referrals to paediatric inpatients were via the Emergency Department
- Six percent of acute ward beds were occupied by a child admitted due to a mental health problem.
- The presence of a CAU was associated with a reduction in the number of referrals from an Emergency Department and an increase in the numbers of discharges but had no association with the number of admissions.

vi RCPCH. State of Child Health. (2020). <https://www.rcpch.ac.uk/resources/state-of-child-health>

vii NHS England/NHS Improvement. Getting It Right First Time (GIRFT). <https://gettingitrightfirsttime.co.uk/>

Recommendations

The recommendations in this report are informed by the RCPCH's Reset, Restore and Recover^{viii} principles for child health services following the pandemic. When implementing these recommendations, we call on stakeholders to include children and young people in decisions and consider how plans will affect them. The [Resources section](#) of this report signposts to material that may help in the implementation of these recommendations.

1. Integrated care

Paediatric emergency attendances and admissions are rising year-on-year^{ix}, and greater intervention at the primary and community level is needed to prevent unnecessary hospitalisation of children. Our findings show that beds in general paediatric wards are being occupied by children with mental health problems. This is not an appropriate location for children in acute mental distress and reflects a lack of community resources and a need for better integration of care.

We found that a third of junior paediatric rotas were staffed by GP trainees. This is positive as GPs with greater paediatric experience will be better equipped to care for children and young people in their practise. We also found that there is a wide range of healthcare professionals working in a general paediatric team. Allied Health Professionals (AHPs) play a key role in the general paediatric team delivering care for children.

In our findings, the presence of a Children's Assessment Unit (CAU) had no effect on number of admissions, but hospitals with a CAU had higher discharge rates, and lower numbers of referrals from ED. Further research is needed into the best model for acute paediatric services.

- The **RCPCH** commits to supporting implementation of the Long Term Plan, for example via our position on the Children and Young People's Transformation Programme board. The **RCPCH** also commits to supporting integrated care models across the four UK nations.
- **NHS England and NHS Improvement** and other bodies responsible for implementing the NHS Long Term Plan, should continue to prioritise integration in the post-pandemic landscape.
- **Commissioners and workforce planners** should consider the whole multidisciplinary team when commissioning workforce for general paediatrics, as the breadth of experience is essential to delivering integrated care.
- The **RCPCH** will work with the **Royal College of General Practitioners and the Royal College of Psychiatrists** to create opportunities for their trainees to experience placements across paediatrics, general practice, and psychiatry.
- The **RCPCH** will continue to document innovative practises and alternative models of careⁱ, and we call on **all child health professionals** to share their ideas across peer networks and apply a QI mindset to their work.

viii RCPCH. Reset, Restore, Recover: Principles for Recovery. (2020).

<https://www.rcpch.ac.uk/resources/reset-restore-recover-rcpch-principles-recovery>

ix NHS Digital. Hospital Episode Statistics. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data>

2. Workforce and service planning according to need

To deliver quality care to children and young people, paediatric services must consistently have the right number of staff with the right level of expertise. However, we found a 10% shortage of staff on medical training rotas. We also found a high reliance on locums; over a quarter of all services had a locum present on the days surveyed. Employing locums is an expensive and short-term solution to workforce shortages.

Our data show variation in the availability of staff between a weekday and weekend. The average number of staff on medical rotas on a weekend is around half the number on a weekday. The availability of other essential staff, such as dietitians, physiotherapists and play therapists, is also much lower at the weekend.

As well as a variation in provision between days, there was also unwarranted variation between different units and regions of the UK. Regions with high admissions, referrals and higher populations of children, did not necessarily have more paediatric inpatient beds. Individual units with higher levels of demand did tend to have more beds, but there was also wide variation in this. Children must receive the same level of high-quality care whenever and wherever they present.

- The bodies responsible for workforce planning in the UK (**Health Education England; NHS Education Scotland; Health Education and Improvement Wales; and the Northern Ireland Medical and Dental Training Agency**) must plan the child health workforce according to demand.
- This should be supported by local-level workforce planning bodies, for example, in England the **Sustainability and Transformation Partnerships (STPs)** and **integrated care systems (ICSs)**. The **RCPCH** should be involved in these decisions and commits to supporting workforce planning with data, intelligence, and our Ambassadors programme.
- **Medical education bodies**, such as HEE and the devolved nations equivalents, should continue to develop generalist Allied Health Professional (AHP) roles, such as Advanced Nurse Practitioner, psychologist, dietitian, and physiotherapist to support the child health workforce.
- Healthcare providers (**NHS Trusts and Health Boards**) must ensure that child health provision is given parity with adult health, especially in post-pandemic restoration of service.

3. Safety and wellbeing of staff

Our case studies demonstrate that intense workloads can impact staff mental health. During the pandemic, many paediatric staff will have been through an exceptional trial of stress, dealt with unfamiliar and difficult circumstances, and may have been redeployed to adult services. Supporting staff wellbeing during restoration of services is essential.

As part of this, we need to continue to ensure equality for all staff members and better representation at a leadership level. For example, Black and Minority Ethnic (BAME) staff in the NHS are at greater risk to the coronavirus^x,^{xi}, as well as having less access to Personal Protective Equipment (PPE)^{xii}. All colleagues' voices must be listened to and their needs accommodated as we restore services.

x Public Health England. COVID-19 review of disparities in risks and outcomes. (2020).

<https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>

xi Health Services Journal. Exclusive: deaths of NHS staff from covid-19 analysed. (2020).

<https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article>

xii British Medical Association. BAME doctors hit worse by lack of PPE. (2020).

<https://www.bma.org.uk/news-and-opinion/bame-doctors-hit-worse-by-lack-of-ppe>

- Whilst there still is a risk from COVID-19, **healthcare providers** must conduct staff risk assessments, taking into account factors such as ethnicity, age and underlying health conditions. These at-risk groups must be consulted, and their voices taken into account.
- **Service leaders and planners** should ensure staff safety, e.g. the right to refuse to work where they feel unsafe or improperly protected. They should also support staff wellbeing in the long-term by ensuring they have access to appropriate resources and support services.

Case studies

To contextualise the data, following the survey, we contacted RCPCH members to ask them to provide examples of how service pressures impact their work and the children they care for in general paediatrics. In the example below, a consultant describes a typical week in a busy general paediatric service. The example highlights how stretched surrounding services, such as community, social care, and policing, mean that general paediatrics is overwhelmed with cases that have nowhere else to go. With staffing stretched to capacity, there is no room in the system for shortages. This doctor also talks about the emotional impact on staff seeing distressing cases, such as physical abuse. This may contribute to burnout and sick leave^{xiii}.

Case study 1: General paediatric consultant in major acute general hospital in England. January 2020.

“On Monday morning, there was a cardiac arrest of a 3-week old in the Emergency Department and we had to do extensive resuscitation. Simultaneously, we had an 8-month old on the ward with safeguarding concerns, and police and social care wanted a strategy meeting. I hadn’t even seen the child at that point as I was dealing the child in resuscitation. I was also trying to see all the children on the ward for the first time on a ward round.

Furthermore, an 8-month old was referred from community services for a child protection medical after concerns were raised in the community. There were full investigations, and I carried out extensive discussions as I was unhappy for the child to be released home into the same environment. This necessitated three strategy meetings on consecutive days, as social care said it did not reach the threshold. Our legal team had to get involved and full escalation was required.

Concurrently, a 5-year-old presented with worst NAI non-accidental injury I have ever seen. Extensive subcutaneous emphysema air below the skin caused by e.g. rib fracture on face, chest, abdomen, extensive bruising etc.

The following day, the team had a “hot debrief” for the 5-year-old due to the emotional impact on staff involved.

Finally, there were two new diagnoses of malignancies cancerous growths in a 2-year-old and 9-year-old that required back-to-back discussions with the families to break the news.

I highlight these cases as these are the ones that were extremely time consuming and complicated. This is in addition to all the other children on the ward, investigations that they need, supporting junior staff emotionally due to what we were dealing with etc... Even I felt pretty broken by the end of this.”

xiii McKinley N, McCain RS, Convie L, et al. Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study. BMJ Open. (2020). <https://bmjopen.bmj.com/content/10/1/e031765>

In a second example, a consultant clinical lead working in a large, geographically remote district general hospital (DGH) reported how the themes from the data reported here are reflected in their job. Despite ambition from NHS England to have Seven Day Hospital Services^{xiv}, support staff are often not available at the weekend. The doctor also reports the negative impact of cuts to child mental health services on general paediatrics as well as the positive impact of a CAU for her service.

Case study 2: General paediatric consultant and clinical lead for geographically remote DGH in England. March 2020.

“There are significant differences at weekends, there are fewer medical staff, no dieticians, less physios, no occupational therapists, paediatric pharmacists only sometimes, lack of support from community paediatrics with safeguarding, and less social care support. No outpatient clinics are run at weekends except occasional catch ups due to wait times.

We have a CAU and it really made a difference having a single point of entry for acute emergencies (oncology still goes straight to ward). It was clear what the workload was, had staff in one place and enabled better triage and flow. Furthermore, we now have a dedicated consultant on the unit 09:00-21.30hrs and this has further improved flow, taken pressure off wards, helped with wait times and is also going to help with GP communication and support of primary care in the future.

Children are still being seen in inappropriate settings. Child and Adolescent Mental Health Service (CAMHS) support has improved with out of hours support and a tertiary unit within the region and a dedicated Eating Disorders team. But tertiary beds not always available so we can end up keeping a patient on an acute ward. Further responsiveness of social care and CAMHS for support in the community still doesn't meet demands and patient discharge can be delayed.

We have seen year on year increases in referrals and a fall in bed base such that the on-call consultant can get tied up managing bed issues instead of being able to focus on sick children. Pressures on Paediatric Intensive Care Unit in nearby urban centre can mean we hold patients on our adult Intensive Care Unit for longer than we would wish in some cases. My impression is that workforce numbers has not kept pace with demand including population expansion, increased complex cases and more exacting standards and demand for peer review reports and audit.

Attempts to increase workforce is limited due to need for services to save money, getting new roles agreed. For example, getting nurse practitioners and nurse consultants is very longwinded and a medium-term solution not a short-term solution. Middle grade gaps have increased, and this has meant consultants acting down, locums are not easy to find.

Locum use is expensive especially what we have to pay for out of hours work. They are not easy to find often let us down at the last minute and some we have had have been of very poor standard, one I referred to the GMC.”

xiv NHS England. Seven Day Hospital Services: Our Ambition.

<https://www.england.nhs.uk/seven-day-hospital-services/our-ambition/>

Findings

1. Who is available to deliver children’s care?

Medical staff

We asked respondents to indicate the number of staff who had been scheduled to work in advance compared to the number of staff who actually worked, on each day. The difference between these two figures then gives an indication of staff shortages on the day of the snapshot.

The highest shortages during the week were on the tier 1 rotas (0.9 people short on average, or 10.7% of the total tier 1 staff who were scheduled to work); whereas there were higher gaps on tier 2 during on the weekend (0.4 people short on average or 10.9% of the total tier 2 staff who were scheduled to work). The shortages on tier 1 and tier 3 were higher on the weekday compared to the weekend.

On the weekday, there was an average of 9.7% of staff missing on the training rotas overall (equivalent to 0.6 people per unit), on weekend they were 8.8% short on average (or 0.3 people per unit).

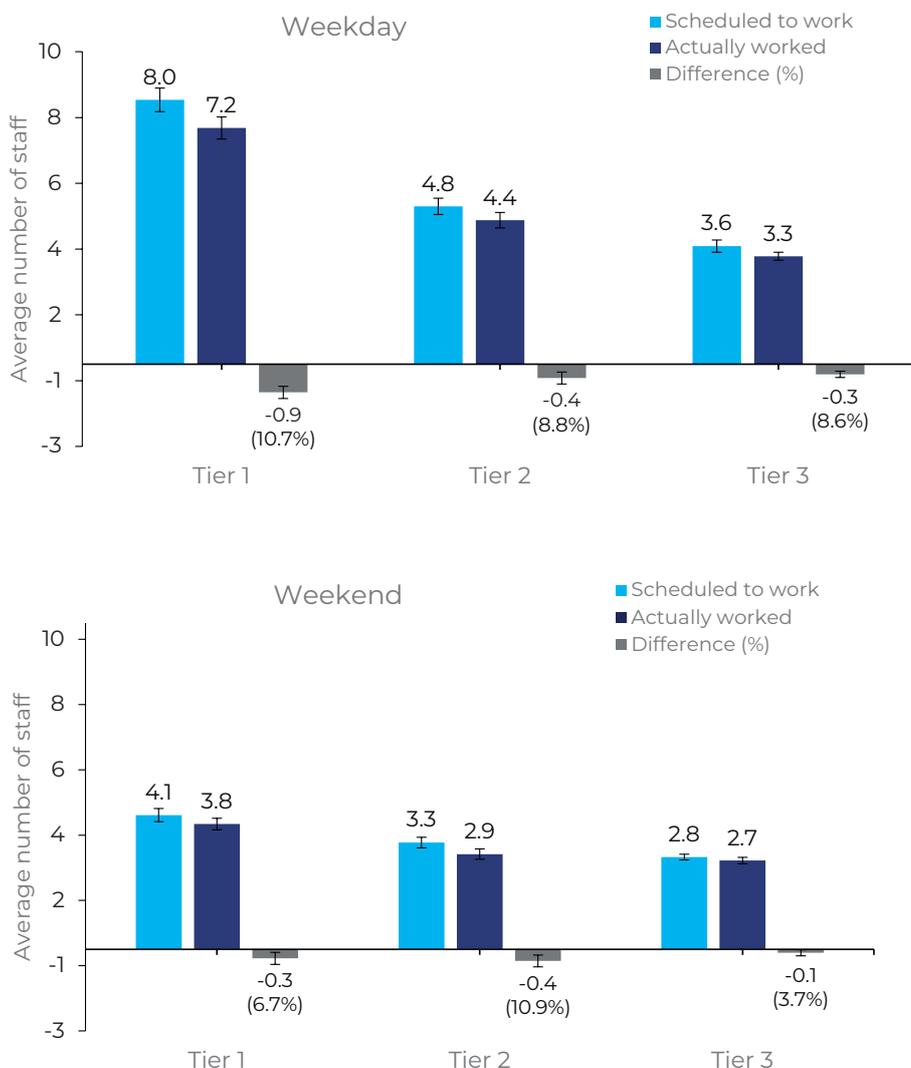


Figure 1. Average number scheduled compared to average number that actually worked on weekday and weekend by tier. Error bars show Standard Error of the Mean (SEM).^{xv}

^{xv} Twenty-two units were removed from weekday rota analysis, and 17 units were removed from weekend analysis. due to missing data or errors.

The main reasons for shortages were vacancies (24.6% on the weekday and 28.1% on the weekend) followed by short term sick leave (18.6% on the weekday and 9.9% on the weekend). None of the shortages were due to parental leave.

A range of staff are employed to support paediatric services. These are essential to delivering high quality care to children. Table 1 shows the grades of staff employed, by proportion of each tier. Across weekend and weekday, the majority of the tier 1 is staffed by GP trainees (33.8% and 32.1% respectively), followed by ST1 to ST3 paediatric trainees (25.8%, 30.9%), and then Foundation Year (FY) doctors (25.8%, 22.8%). ANPs and nurse practitioners collectively 8% of tier 1 across weekend and weekday.

Locally Employed Doctors (LEDs)^{xvi} or Trust doctors comprise 16% of tier 2 rotas whereas Specialist and Associate Specialist (SAS) staff only 9%.

The majority of the tier 3 rota is staffed by consultants (97.1%, 99.1%), with a small proportion of ST4 to ST8 paediatric trainees stepping up. The higher rates of stepping up on the weekday (2.6%) compared to the weekend (0.9%) may reflect the fact that trainees feel more supported on the weekday due to better staffing rates (Figure 1) and non-medical staff support (Figure 2).

Table 1. Grades on rota by proportion of each tier, weekday (WD) and weekend (WE)

Grade	Tier 1		Tier 2		Tier 3	
	WD	WE	WD	WE	WD	WE
GP trainees	33.8%	32.1%	-	0.3%	-	-
FY doctors	25.8%	22.8%	0.8%	-	-	-
ST1 to ST3 paediatrics	25.3%	30.9%	5.5%	3.4%	-	-
Locally Employed/ Trust doctors	7.2%	4.4%	15.4%	16.1%	-	-
Advanced Nurse Practitioners	4.5%	4.4%	2.5%	1.4%	-	-
Nurse Practitioners	2.0%	3.6%	0.6%	0.6%	-	-
ST4 to ST8 paediatrics	1.3%	1.0%	63.4%	67.7%	2.6%	0.9%
Trained GPs	0.1%	0.6%	-	-	-	-
SAS doctors	0.1%	0.2%	10.7%	9.1%	-	-
Consultant	-	-	1.2%	1.4%	97.4%	99.1%

Non-medical staff

The type of non-medical staff present on the unit varies between weekday and weekend. On the weekday, 83.9% of units had play therapists compared to 30.6% on the weekend, 61.9% had dieticians (only 1.7% at the weekend) and 59.3% had physiotherapists, almost double the 28.9% recorded at the weekend.

Non-medical staff were notably more present on the weekday than weekend overall.

xvi The Locally Employed Doctor group covers a wide range of contracts and job titles often of fixed term duration. Many (but not all) have recently completed their foundation training and will return to formal training, and some may move onto a SAS contract in the future. (Specialty, associate specialist, and locally employed doctors' workplace experiences survey: initial findings report, GMC, 2020, p.3. <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>.)

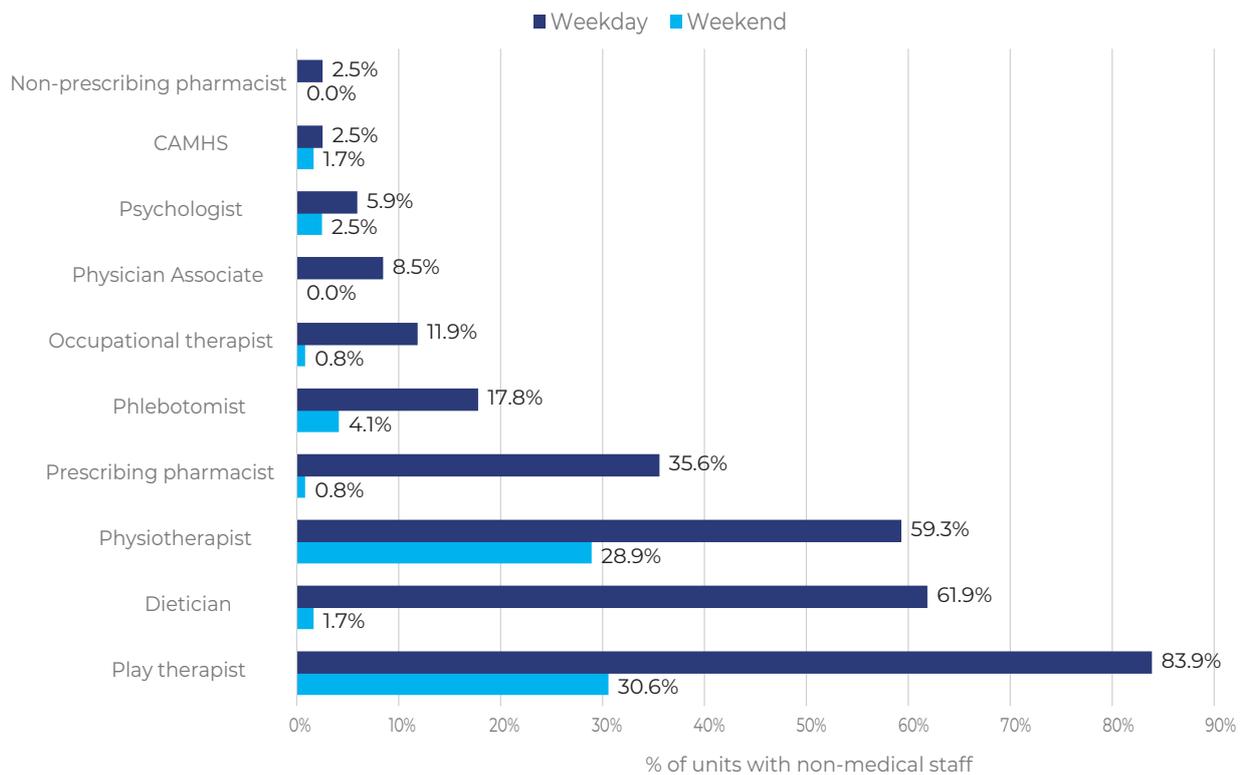


Figure 2. Percentage of units with non-medical staff by type, weekend and weekday.

Locums

Where locum staff were used, the number of external locums was higher than the number of internal locums both on weekday and weekend. 27% of units hired locums on the weekend, and 23.5% hired locums during the weekday. Overall, a quarter of units surveyed (25.3%) had at least one locum present.

Figure 3 shows the average number of locums present on the weekday and weekend per unit. There is an average of roughly one locum (internal or external) per unit surveyed.

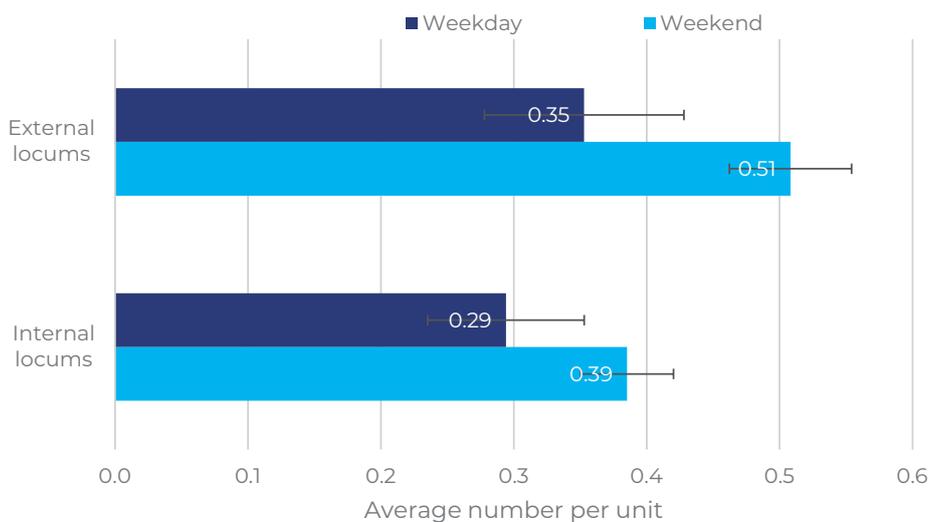


Figure 3. Average number of external and internal locums per units on the weekday and weekend.

2. How are patients accessing services?

Respondents recorded the number of admissions to, and discharges from, general inpatient wards for the 24-hour period (defined as the beginning of the morning shift to the end of the night shift) over the weekday and weekend day. They also recorded number of GP and ED referrals.

GP referrals were lower during the weekend, and ED admissions were, conversely, lower during the weekday (Figure 4). Whilst admission figures were similar across weekend and weekday, there were significantly less discharges on the weekend than on the weekday.

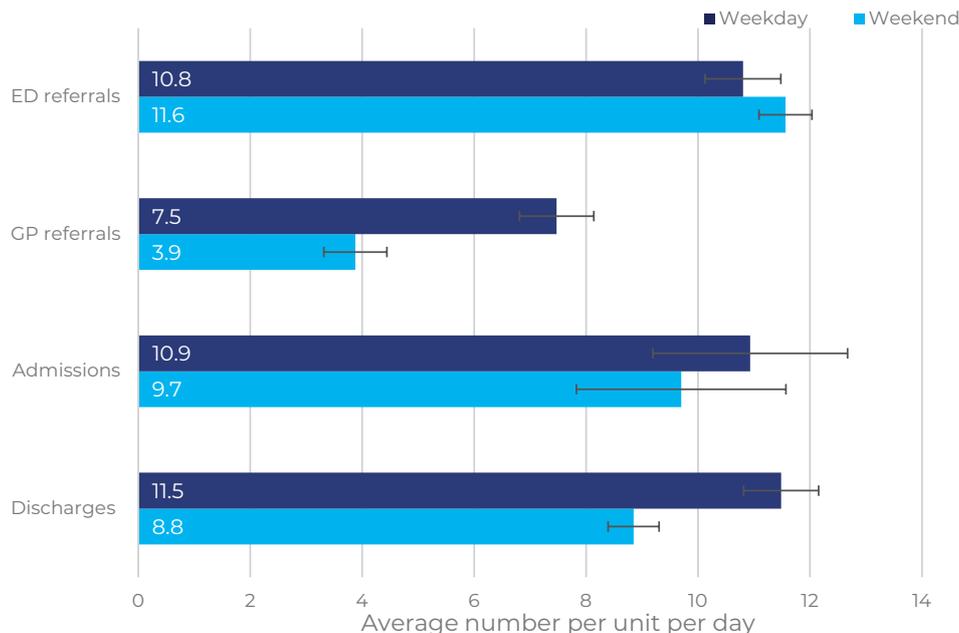


Figure 4. Average number of ED referrals, GP referrals, admissions, and discharges to general acute inpatients on weekday and weekend

Admissions due to a mental health issue

In the 122 responding hospitals in the UK, there was an average of 23.1 beds available per hospital across both the weekday and weekend. Six percent of beds during the weekday were occupied by children and young people admitted due to a mental health issue. On the weekend the percentage was slightly less, 5.8%.

However, there is wide regional variation with percentages reaching 12% in the East of England on weekdays (11% on the weekend) and 9% in the South West (consistent on both weekday and weekend).

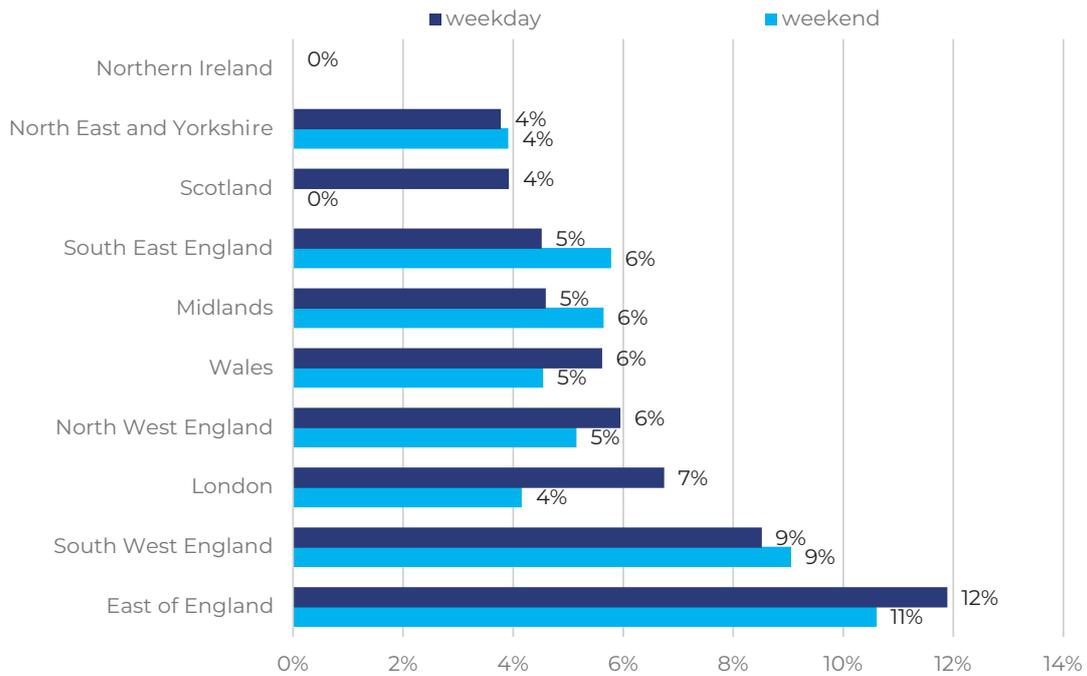


Figure 5. Proportion of general paediatric inpatient beds occupied by patients admitted due to a mental health issue

3. How do Children’s Assessment Units complement general paediatric services?

The definition of a Children’s Assessment Unit (CAU) is “a dedicated facility providing assessment, observation and treatment of an illness, without the need for immediate inpatient admissions for the acutely presenting infant/child/young person.”^{xvii}

However, in reality, CAUs can be more complex, as some have “inpatient admissions” who are patients awaiting bed on paediatric ward, and some classify an inpatient admission even if admitted for less than 24 hours. Therefore, measuring the impact of a CAU on service pressures is difficult. This should be taken into account when interpreting the following findings.

Of the 124 unique responses, 94 units had a CAU (75.8%) and 45 did not (36.2%). This survey found that the presence of a CAU had no impact on the average number of admissions to general paediatric inpatients. However, presence of a CAU was associated with more GP referrals and less referrals from ED on average. Units with a CAU also were able to make more discharges on the days surveyed.

xvii Standards for Short-Stay Paediatric Assessment Units (SSPAU), RCPCH, March 2017. <https://www.rcpch.ac.uk/resources/standards-short-stay-paediatric-assessment-units-sspau>

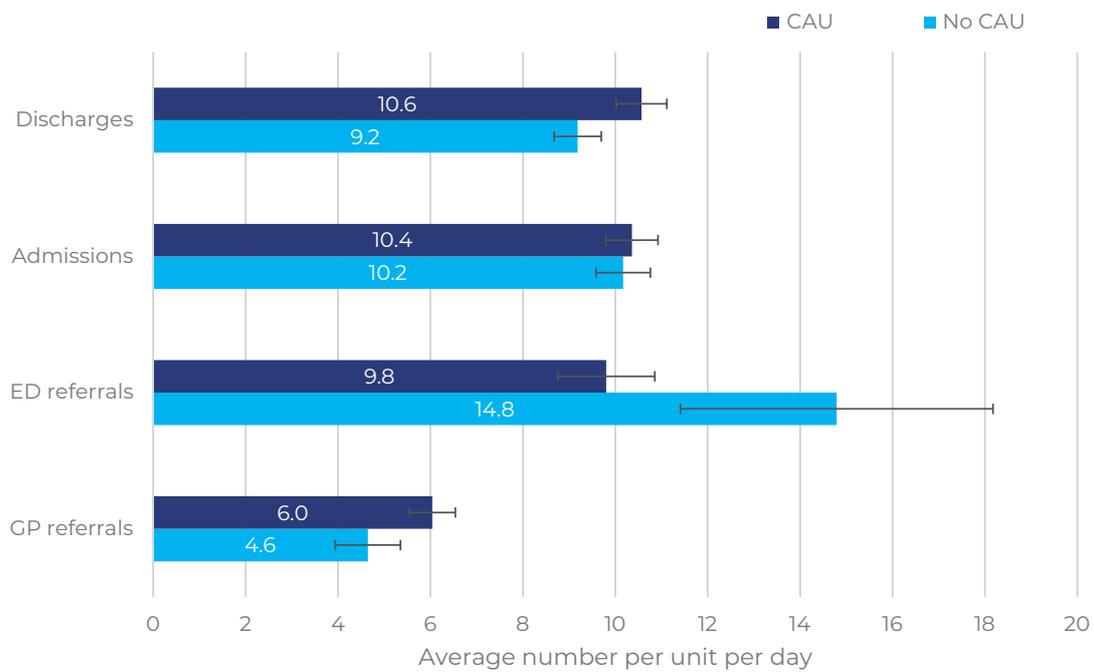


Figure 6. Average number of ED referrals, GP referrals, admissions, and discharges to general acute inpatients in services with a CAU and without a CAU.

Over half of all CAUs were open for 24 hours: 50.6% during the week and 57.9% on the weekend. The average number of children and young people (ICYP) assessed in the 24-hour period was also higher during the week, 18.2 ICYP compared to 13.6 ICYP seen during the weekend.

The RCPCH standards for Children’s Assessment Units state that 24/7 opening times might not be viable for smaller units; they should open in times of peak demand “which usually includes the afternoon and evening, including Saturdays and Sundays^{xviii}. Units should review times of peak demand and adjust opening hours accordingly.

4. Are services and workforce planned according to demand?

This survey was conducted on just two days in September 2019, so the data only give a snapshot of services at one point in time. However, if services and workforce are planned according to demand we would expect to find a close relationship between amount of resources, such as number of beds, and demand. The two graphs below do show this positive relationship between service and demand, but there is wide variation between units, indicated by the spread of datapoints.

Hospitals with more beds have more admissions and discharges, although there is considerable variation (Figure 7) indicating that some units with relatively few beds experienced high admissions..

xviii RCPCH. Standards for short stay paediatric assessment units. (2017). https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

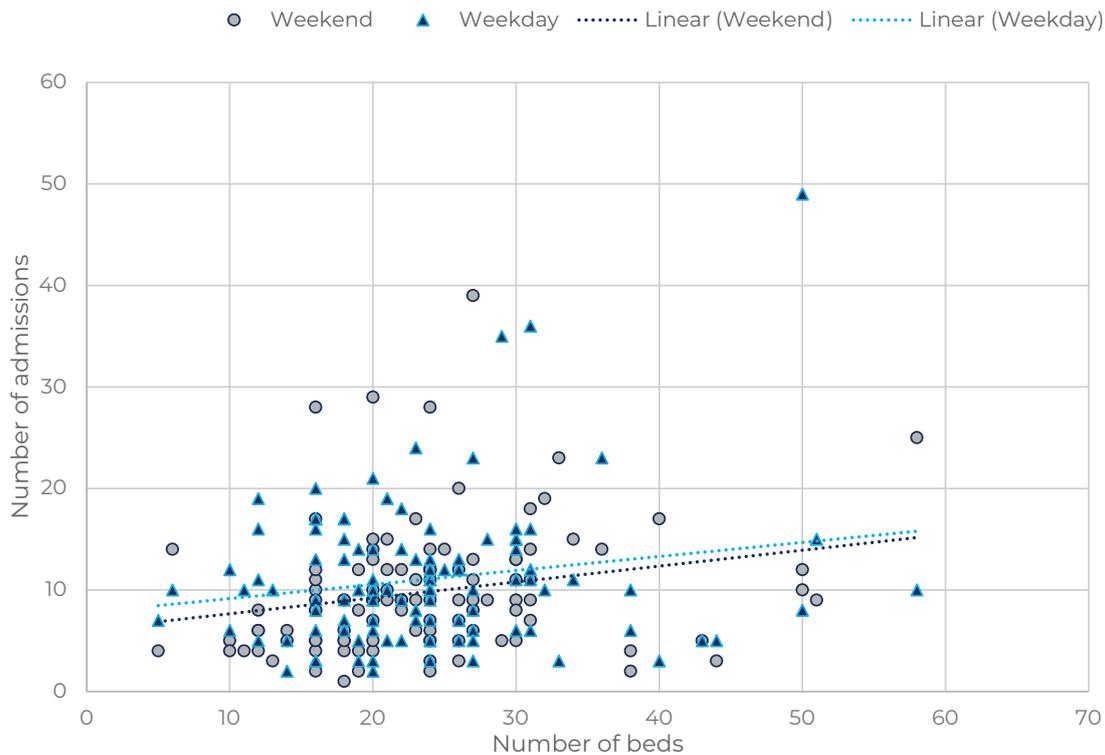


Figure 7. Number of beds in each unit compared to number of admissions in each unit; weekend and weekday.

Figure 8 shows that there is a positive relationship between the number of bed available and the number of children seen per hour in a Children’s Assessment Unit, as would be expected. However, again there is wide variation. Units above the trendline had a higher workload than units of a similar size (in terms of number of beds) on the days surveyed.

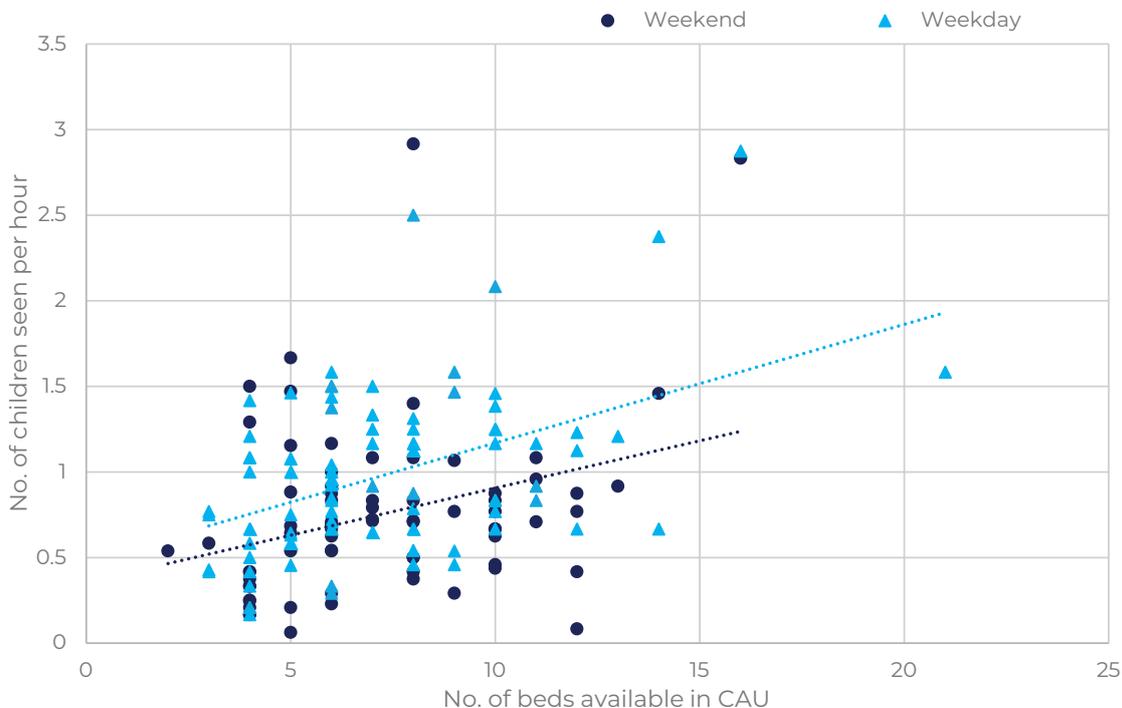


Figure 8. Number of available beds per unit and patients seen per hour, weekend and weekday

Regional variation

With greater devolution of health service planning to the local level, it is essential that services and workforce are planned according to population demand. However, we found apparently unwarranted variation between regions.

Table 2 shows activity and resources by NHS England (NHSE) Regions. The regions are ordered by child population (from smallest in the South West to the largest in the Midlands). Resources such as 24-hour acute beds should correspond to demand, as shown by population and average admissions. However, this is not always the case.

The average number of general acute admissions varies from 8.9 in the East of England to 13.6 in North East and Yorkshire. This does not correspond to the child population size, highlighting that populations have characteristics (such as deprivation) other than size that determine their need. Also, although North East and Yorkshire has the highest average admissions, they have the second lowest average number of beds (20.9) per unit.

Table 2. Regional variation in activity and resources (England only^{xix}), averaged across weekday and weekend.

NHSE Region	Population 0-16 years old ^{xx}	Admissions (mean per unit)	24-hour acute beds (mean per unit)	CAU beds (mean per unit)	GP referrals (mean per unit)	ED referrals (mean per unit)	Discharges (mean per unit)
South West	804,857	11.3	27.0	6.6	11.9	6.5	12.1
East of England	1,322,067	8.9	20.6	7.0	5.4	5.8	7.4
North West	1,518,011	10.9	23.5	7.2	6.7	7.7	11.9
South East	1,763,342	10.4	22.1	9.9	6.3	7.0	10.6
North East and Yorkshire	1,844,901	13.6	20.9	9.8	7.9	14.1	12.9
London	1,906,413	9.9	22.6	6.8	5.3	14.0	9.4
Midlands	2,084,104	12.8	28.2	7.7	9.2	18.9	15.2
England	11,243,695	11.3	23.5	8.2	7.4	11.5	11.6

xix Other nations not reported due to low response rate

xx Office of National Statistics. Population estimates.

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates>

Methodology and response rate

We contacted 192 general paediatric services in the UK, 116 (60.2%) responded to both the weekday and weekend questionnaire and a further eight responded only to either weekend or weekday (64.5%). There was a lower response rate from the devolved nations than in England.

Nation	Did not respond	Responded	Total services	Response rate
England	52	106	158	67.1%
Northern Ireland	7	1	8	12.5%
Scotland	9	5	14	35.7%
Wales	8	4	12	33.3%
Grand Total	76	116	192	60.4%

Resources

The data and case studies show that some general paediatric services in the UK are struggling due to poor national planning or rapidly increasing demand. Below we signpost to resources from the RCPCH that provide support.

1 **Reset, Restore, Recover: Principles for paediatric services**

<https://www.rcpch.ac.uk/resources/reset-restore-recover-rcpch-principles-recovery>

This page outlines how we should plan and deliver healthcare for children and young people in the wake of the pandemic. Particularly thinking about how we harness innovation and learning so that it can be shared and maintained and to use this as a basis to train and educate our paediatricians and broader child health workforce.

2 **Where to go for help and support for staff wellbeing**

<https://www.rcpch.ac.uk/resources/where-go-help-support-doctors-wellbeing>

Links to health, support, and wellbeing resources for doctors.

3 **Invited Reviews service**

<https://www.rcpch.ac.uk/work-we-do/workforce-service-design/invited-review-service>

The College's Invited Reviews service provides clinically led peer review and consultancy to healthcare providers. It advises teams and supports them to resolve any concerns about paediatric provision, safety, team dynamics, compliance with standards or proposals for reconfiguration.

4 **RCPCH Ambassadors**

<https://www.rcpch.ac.uk/get-involved/volunteering/rcpch-ambassadors>

The Ambassadors programme is a network of volunteers who advocate locally for children, young people and the staff that care for them. They aim to raise the profile of child health by campaigning, particularly within ICS/STPs. If you are looking to connect with your local ambassador, or are interested in getting involved, please find contact details on the webpage linked above.

5 **QI central**

<https://www.qicentral.org.uk/>

This is an online resource that brings together examples of quality improvement (QI) interventions submitted by child health professionals. It also has tools to aid data collection and improvement interventions.

6 **Workforce data and service modelling**

<https://www.rcpch.ac.uk/resources/workforce-census-2017-resources>

At the bottom of the linked page, you can download the latest data about paediatric workforce and services in the UK, including an interactive Excel dashboard. You can also download a spreadsheet that allows you to model the consultant workforce needed for a general paediatric service to meet Facing the Future standards.

7 **Contact your Area Officer or National Officer**

<https://www.rcpch.ac.uk/membership/regions>

The RCPCH has 7 Area Officers for England and an Officer for each of the devolved nations. Their job is to advocate for their locale, by speaking to decision makers. They are closely linked to RCPCH Ambassadors.

8 **Facing the Future standards, tools and service models**

<https://www.rcpch.ac.uk/resources/facing-future-standards-paediatric-care>

The RCPCH has standards for general paediatrics in the document, "Facing the Future: standards for general acute paediatric services". On the page linked above, you can find

9 Clinical leadership development programme

<https://www.rcpch.ac.uk/resources/clinical-leads-development-programme>

10 RCPCH &Us - CYP engagement

<https://www.rcpch.ac.uk/work-we-do/rcpch-us-children-young-people-families>

Getting the voice of patients is essential to providing an excellent service.

11 Get ready for Shape of Paediatric Training

<https://www.rcpch.ac.uk/education-careers/training/shape-of-paediatric-training>

Shape of Training will change the way paediatricians are changed, with greater emphasis on generalisation and flexibility

Glossary and abbreviations

Acronym	Meaning
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
CAU	Children's Assessment Unit
CYP	Children and Young People
DHSC	Department of Health and Social Care
ED	Emergency Department
GIRFT	Getting It Right First Time
GP	General Practice
HEE	Health Education England
HEIW	Health Education and Improvement Wales
ICS	Integrated Care System
ICYP	Infants, Children and Young People
LWAB	Local Workforce Action Board
NES	NHS Education Scotland
NHSE	NHS England
PA	Physician Associate
SSPAU	Short Stay Paediatric Assessment Unit
STP	Sustainability and Transformation Partnership
WTE	Whole Time Equivalent

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A snapshot of general paediatric services and workforce in the UK

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