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

CCT Class of 2011 and 2012: where are they now?

Findings of a survey carried out between July 2013 and September 2013

November 2013

Introduction

There is great concern that the number of doctors achieving Certificate of Completion of Training (CCT) or Certificate of Eligibility for the Specialist Register (CESR) in paediatrics each year will outweigh the number of new consultant opportunities available to newly qualified paediatricians, thus giving rise to a surplus or a potential exodus from the UK, particularly in the light of NHS budget constraints. Yet at the same time acute paediatric services are struggling to staff middle grade rotas due to shortages of trainees in the ST4-8 stage of their training. There is concern that this staffing crisis could have a negative impact on recruitment to paediatrics, with potential trainees being put off by perceived lack of future consultant job opportunities. Slowing consultant expansion reported in the College's 2011 Medical Workforce Census[i] has exacerbated these concerns about surplus.

The RCPCH plans to undertake sophisticated modelling as part of its ongoing workforce strategy, but current trends have allowed us to develop some generalised assumptions[1] which predict a potential average surplus of 150 CCT holders between 2014 and 2019. This surplus would be reduced by those wishing to work abroad or take up non-consultant positions. More nuanced modelling is required but it is clear that there is a problem on the horizon.

The College continues to advocate for an expansion in the number of consultants in order to provide a consultant delivered service and address issues with staffing middle grade rotas, as per the five interlocking recommendations made in Facing the Future[ii]. In addition to looking at the numbers being trained, it is important that the right types of CCT/CESR holders are available to recruit to specialist posts, and in the right geographical areas.

The journey from graduation to certification as a consultant is a long one, and therefore the system is slow to react to changing economic and political circumstances. Workforce planning needs to be undertaken with a long term view and be robust against short term change and political cycles. In order to influence and inform commissioning and long term workforce planning, it is vital that the College continues to collect relevant and timely data which is shared with national workforce planning bodies and with members.

In 2011/2012 the College undertook a follow up survey of all paediatric trainees who were recommended for entry to the specialist register via the CCT route and the CESR route in 2010. In 2013 this survey has been repeated for those who were recommended for CCT/CESR in 2011 and 2012 and the results are presented in this report.

The College's *Class of 2010: Where are they now?* report[iv] found that approximately 18 months after gaining their CCT or CESR, 89.4% of the cohort were in consultant posts, 31.7% had moved region from their training post, 76.2% had substantive posts, 28.5% undertook resident shift working and 7.2% stated that they were currently working overseas.

The Royal College of Physicians undertook a similar project to look at career progression of new CCT holders from 2009-2011[iii]. The report finds a falling number of CCT holders

[1] a) Current paediatric trainees in the system at ST1-ST6 complete their training with no delays, b) there is 5% attrition each year, c) consultant growth remains at the level recorded between 2009 and 2011 at 2.3%, and d) consultant retirements are set at one-thirtieth of the workforce. Assuming an average consultant works between the ages of 35-65.

gaining substantive posts, and an increase in the number of non-consultant "post CCT" roles[iii].

The data collected in this survey is extremely valuable for workforce planning; information on the number of CCT holders leaving the UK after qualification and the number working in different specialties to their training post input into workforce modelling and required training numbers in each subspecialty. The results can also inform the career advice given to trainee paediatricians and the College position on future training numbers.

It aims to answer the following questions:

- Do CCT holders go on to work in the job they received accreditation for?
- Are new CCT holders obtaining substantive posts?
- Are they full-time (FT) or less than full time (LTFT), and are they working as they intended?
- What do the working patterns of these cohorts of consultants look like; how much educational supervision, resident shift working and general paediatric on call are they undertaking?
- How many SPAs are new consultants being awarded in their contracts? What are they using these SPAs for?
- How do new consultants find the transition from senior trainee, and how can the College support them in this?
- What is the uptake for CPD with the College, and is there anything more we should be offering?

The College intends to repeat this survey biennially to enable the monitoring of trends to influence workforce planning and policy development.

The College has also re-surveyed those who obtained CCT or CESR in 2010 alongside this survey and intends to follow this cohort through the early years of their career to establish a longitudinal dataset. The purpose of this exercise is to establish whether the rates of attrition and working in different specialties continue through the early years of a consultant's career, and to establish how the College can best support these doctors during this transition period. The results of this survey will be available in early 2014.

Methodology

The 494 trainees who obtained a paediatric CCT in 2011 and 2012 and 38 who were recommended to the specialist register via CESR in 2011 and 2012 were identified. A questionnaire was sent to these 532 individuals in July 2013 via SurveyMonkey®, which was open for response until September 2013.

An overall response rate of 63.7% (339/532) was achieved. Among those obtaining CCT in 2011 the response rate was 57.1% (141/247), and among the 2012 cohort it was 69.5% (198/285). Where a response was not achieved, the GMC register was used to confirm whether or not that doctor was on the specialist register and efforts were made to establish their current post and location in order to provide a complete picture of the cohort.

After cleaning and validation of responses, results were analysed and compared where appropriate with the results of the CCT Class of 2010 survey[iv] completed in June 2012 and the RCPCH 2011 medical workforce census[i].

The questionnaire asked 35 questions which covered the following areas:

- GMC registration status, grid training and subspecialties.
- Current post and location.
- Contract type and working patterns, resident shift working and educational supervision.
- Ease of obtaining current post and transition to consultant role.
- CPD and College support.

The full questionnaire is available at: www.rcpch.ac.uk/cct-survey

Key findings

Current post and location

- 96.2% of the 2011 cohort and 81.2% of the 2012 cohort are currently working as consultants.
- In the 2012 cohort, 11.7% are currently working as clinical fellows, compared to 1.5% of the 2011 cohort and 7.6% overall.
- Overall, 10.2% of respondents are currently working overseas. The mostly commonly cited reasons for leaving the UK were family/personal reasons and to gain further experience.
- 85.7% are working for the NHS, 6.5% in public healthcare overseas, and 3.4% in private healthcare overseas. None of the respondents are working in private practice in the UK.
- 33.6% (97) of UK respondents are working in a different region to where they trained but only 18 of these cited the reason for changing region as wanting to move to another area. The majority (63.6%) cited the reason for moving as related to the availability of suitable/subspecialty post.

GMC registration status, grid training and subspecialties

- 97.2% of the 2011 cohort and 98.9% of the 2012 cohort are on the GMC specialist register.
- Across both cohorts, 8.0% of the total cohort (responding and non-responding) took a CESR route to the specialist register. This compares to 3.4% of respondents in the 2010 cohort.
- The proportions of respondents registered in general paediatrics, community and other subspecialty areas are 64.8%, 4.8% and 30.4% respectively, which compares to proportions of 40.5%, 19.2% and 40.3% in the total consultant body.
- Across both cohorts, 88.7% are working in the same specialty/subspecialty as they trained; 10.7% (37) are working in a different specialty/subspecialty, the largest proportion (45.9% or 17 respondents) of whom are registered general paediatricians working in community child health and neonatal medicine.

Contract type and working patterns

- 72.3% of consultants in the 2011 cohort had substantive contracts, compared to 63.1% of the 2012 cohort. In the 2010 cohort, this figure was 76.2% and in the 2011 census, 94.9% of the whole consultant body were recorded as having substantive contracts.
- Across both cohorts, 79.1% are working full time (FT) and 20.9% less than full time (LTFT). This reflects the working patterns of the whole consultant body; the 2011 census reported 20% working less than 10 PA contracts[i].
- 21.7% (48) of full time and 25.9% (17) of less than full time workers are not working as they intended.
- Overall, full time respondents have on average 1.90 SPAs in their contract, and less than full time respondents have 1.39 SPAs. The ratio of SPAs to total PAs is much lower among the 2011 and 2012 cohorts (0.19) than the overall consultant body (0.27).

- 18.4% have contracts with 1 or less SPA; this rises to 57.9% in Scotland.

Resident shift working and educational supervision

- Across both cohorts, 21.6% stated their posts involved resident shift working. The 2011 cohort had an average of 2 PAs dedicated to resident shift working, compared to 2.86 for the 2012 cohort.
- 78% of the 2011 cohort and 61% of the 2012 cohort are involved in the educational supervision of trainees.

Transition to consultant role

- 60.8% of respondents started their first post after entering the specialist register; 32.5% started before. Respondents obtained their first post an average of 49 days after entering the specialist register, however there was large variation in the time taken.
- 39.8% of respondents made use of their 6 month grace period after finishing their training programmes.
- Across both cohorts, 26.4% found the transition to a consultant post very easy or quite easy, 43.5% found it neither easy nor difficult, and 20.8% found it quite difficult or very difficult.
- 46.0% wanted support from the College during transition in leadership and management skills development and 41.0% wanted a College-facilitated network for new consultants.

CPD and College support

- Overall 84.0% of respondents are registered with the College for CPD; 90.9% of the 2011 cohort and 79.2% of the 2012 cohort.
- Respondents wanted to see more management (21.2%) and leadership (10.9%) CPD courses/e-learning.
- Several respondents requested that the College develop a CPD application for mobile devices.

Discussion and recommendations

Some of the key areas raised by the survey are set out below along with recommendations for action. This survey has revealed some important trends and it is recommended that it is repeated biennially to ensure that the College has up to date information about the working practices of, and issues affecting new consultants. The findings should be disseminated to key stakeholders, including HEE/DH, Scottish Assembly, Welsh Assembly, Northern Irish government and Centre for Workforce Intelligence in England.

Supporting Professional Activities

One of the most important findings from this survey is the number of programmed activities for SPAs the respondents have in their contracts. There is a clear difference between these cohorts and the total consultant body with evidence that the number of PAs in contracts for new consultants are below the standard 2.5 PAs set in the consultant contract[vii]. These contracts mean that the time available for new consultants to carry out research, supervise and appraise trainees, become involved in trust and College activities is being squeezed. The Academy of Medical Royal Colleges (AoMRC) recommends that 1 to 1.5 PAs is required for continuing professional development alone, and it is clear even this bare minimum is not being achieved for many of our respondents, particularly in Scotland.

With a clear emphasis on the importance of CPD to meet patient and service needs expressed in the recommendations of the Shape of Training Report[v] it appears counter intuitive at this time that employers are reducing opportunity for new consultants at this most important stage of their career.

The RCPCH will raise these issues directly with key stakeholders and will continue to monitor and report on the number of PAs and SPAs in new and replacement consultant contracts and publish trends on the RCPCH website.

Recommendations

- RCPCH to ensure the AoMRC is aware of these findings and propose that the medical professions' concerns are communicated to Health Education England and appropriate bodies in Scotland, Northern Ireland and Wales to ensure that the dangers to future innovation and development of this trend are communicated to provider organisations. This should be raised at the next AoMRC general meeting.
- RCPCH to develop a specific campaign aimed at the Scottish Government and the Scottish Academy to highlight the problem and lobby for change in new contracts. This should be done in conjunction with the release of this report.
- RCPCH to produce a position statement on the need to protect supporting professional activities in new consultant contracts and use influence where possible to ensure contracts contain sufficient PAs. This to be produced by late Spring/Summer 2014.
- Through the RCPCH representatives on the Advisory Appointment Committee, ensure that new contracts are approved with an appropriate amount of SPA time.

Continuing Professional Development

The uptake of registration on the RCPCH CPD scheme post CCT is not as high as would be wished and 14.9% (7) of those not registered are unaware of the scheme. Lack of registration among new CCT holders may be due to the introduction of revalidation and the mandatory nature of employer revalidation and CPD systems and the wish to avoid duplication of data on another system. However, the findings of this survey do not reflect the overall consultant body; there has been an overall increased uptake for the CPD scheme in the last year which is thought to be due to the introduction of revalidation.

Registering with the RCPCH CPD scheme is recommended, and new CCT holders are notified in their CCT recommendation letter about the scheme, but registration is not mandatory and doctors can choose to record their CPD in other systems. Several respondents commented that a CPD mobile application would be more relevant and easy to use. The College is currently developing this and it is expected to be launched in 2014.

The College will continue to promote the value and benefit of the CPD scheme to all career grade members to ensure continued uptake of the scheme in line with the College's current key performance indicator of 65% usage.

Transition to consultant

Many new consultants expressed a need for support in the period of transition to consultant working, particularly the need for management and leadership training. This reflects the GMC findings that taking on more management and leadership responsibilities are often cited as concerns during transition[vi]. This is a theme further explored by Greenaway[v] in which he states that "We expect them [doctors] to provide leadership and management, not only for the patient in front of them, but for the team, unit and system in which they work.

Recommendations

- Strengthen the College's offering and marketing of management and leadership related courses for new consultants and trainees approaching CCT, possibly considering a "new consultant" package of training, which could also encompass guidance on CPD and revalidation.

Specialty matching, especially community child health

The data also highlights a mismatch between the specialty area that new consultants are registered in and the proportion working in this area in the total consultant body. This reflects the data collected from the College's workforce census which has continued to show either a decline or relatively small increases in the size of the community paediatric workforce and a failure to meet the workforce number standards set by BACCH in 1999. It is also important to consider the need to train the right numbers for the desired workforce which may not match the current workforce structure.

Work is currently underway to enter community child health onto the national grid for recruitment in 2014/2015.

Recommendation

- Discuss with British Association for Community Child Health and the CCH College Specialty Advisory Committee (CSAC) options for increasing the number of CCH trained CCT holders.

Regional mismatches between training places and consultant posts

The survey has shown many CCT holders cannot find work in the region they trained and have to move elsewhere. This reflects patterns seen in the 2010 cohort and continued monitoring would be needed to identify any unusual trends. As part of the workforce strategy, the College will continue to advise and work with the workforce planning bodies to ensure that the right number of doctors are being trained and posts are available for the needs of the local population. Through the recruitment process and the College's trainee representatives, the College can ensure that trainees and prospective trainees are aware that there may be a requirement to relocate to obtain their desired post on completion of training.

Decline in appointments to substantive posts

This survey has shown growth in new CCT holders being appointed to non-substantive or locum positions. The results may suggest that some new CCT holders do not immediately get substantive posts, but are moving into them as their careers progress; however they may also suggest an overall fall in the number of substantive posts available for service provider financial or other reasons. Further work is required to look in more detail at the causes of this trend. By repeating this survey the College should continue to monitor this cohort, particularly regarding proportion of non-substantive posts.

As part of the agreed workforce strategy, the College will produce a College position statement on the number of consultants required and the future training numbers.

Results

1. Current post and location

Table 1 breaks down respondents' current grade at the time of the survey by cohort. Overall, 96.2% of the 2011 cohort and 81.2% of the 2012 cohort are currently in consultant posts. When the 2010 cohort were surveyed, 89.4% were in consultant posts[iv]. In the 2012 cohort, 11.7% were working as clinical fellows at the time of the survey, compared to 1.5% of the 2011 cohort. The distribution is similar across those taking the CCT and CESR route; however the CESR 2012 group are slightly more likely to have consultant posts (87.5%) than the CCT group (80.5%).

Table 1: Current grade group, 2011 and 2012 cohorts

	2011		2012		Overall	
	No.	%	No.	%	No.	%
Consultant	129	96.3%	160	81.2%	289	87.3%
SAS doctor	1	0.7%	7	3.6%	8	2.4%
Clinical fellow	2	1.5%	23	11.7%	25	7.6%
Other non-training grade	2	1.5%	2	1.0%	4	1.2%
Not currently employed as a doctors	0	0.0%	5	2.5%	5	1.5%
Total	**134**	**100.0%**	**197**	**100.0%**	**331***	**100.0%**

*8 respondents did not provide a grade.

Overall, 10.2% of respondents stated that they are currently working overseas; this was slightly higher among the 2011 cohort (11.9%) than the 2012 cohort (Table 2). Only 7.2% of the 2010 cohort stated that they were currently working overseas[iv]. In the 2012 cohort, a higher proportion of those working as clinical fellows stated that they were overseas (31.8%). This reflects the findings of the 2010 cohort survey, when 36.4% of clinical fellows were working overseas. It is possible that these respondents are working in short term research posts straight after completion of training before taking up a consultant post.

Of the 5 respondents who stated they were not currently employed as a doctor, 3 were on maternity leave, 1 was applying for posts and 1 was overseas, having secured a substantive post for their return.

Table 2: Location of current post by grade group and cohort

		Current post location		
Grade		**UK**	**Overseas**	**Total**
2011				
Consultant	No.	115	14	129
	%	89.2%	10.9%	
Clinical Fellow	No.	1	1	2
	%	50.0%	50.0%	
SAS doctor	No.	1	0	1
	%	100.0%	0.0%	
Non-training grade	No.	1	1	2
	%	50.0%	50.0%	
Total	**No.**	**118**	**16**	**134**
	%	**88.1%**	**11.9%**	
2012				
Consultant	No.	150	8	158
	%	94.9%	5.1%	
Clinical Fellow	No.	15	7	22
	%	68.2%	31.8%	
SAS doctor	No.	6	1	7
	%	85.7%	14.3%	
Non-training grade	No.	1	1	2
	%	50.0%	50.0%	
Total	**No.**	**172**	**17**	**189**
	%	**91.0%**	**9.0%**	
Overall	**No.**	**290**	**33**	**323**
	%	**89.8%**	**10.2%**	

Table 3: Destination country of those moving overseas

	2011	2012	Total
Australia	4	6	10
India	4	5	9
Canada	2	2	4
New Zealand	1	1	2
United States	1	1	2
Gambia	0	1	1
Kenya	1	0	1
Kuwait	1	0	1
Malaysia	0	1	1
Singapore	1	0	1
United Arab Emirates	1	0	1
Total	**16**	**17**	**33**

Table 3 indicates that the most popular destination countries for those moving overseas are Australia (10) and India (9), accounting for 57.5% of all those now working overseas in the cohort.

The most common reasons for leaving the UK (Table 4) were family/personal (27.3%) and to gain further experience (27.3%). 21.2% (7) cited negative "push" factors, which included limited job availability, lack of training clarity, bureaucracy, recession and negative feelings about the NHS.

Table 4: Reasons for leaving the UK, 2011 and 2012 cohorts

	No.	% of those leaving the UK
Family/personal	9	27.3%
Gain further experience	9	27.3%
Negative "push" factors	7	21.2%
New challenge	3	9.1%
Job opportunity	3	9.1%
Immigration restrictions	2	6.1%
Better quality of life	2	6.1%
Temporary overseas work	1	3.0%
Didn't apply for UK posts	1	3.0%
Total	**37**	

Overall, 85.7% of respondents are currently working in the NHS, 6.5% working in public healthcare overseas and 3.4% in private healthcare overseas (Table 5). None of the respondents are working in private healthcare in the UK. This is slightly lower than the 2010 cohort, when 90.5% reported they were working in the NHS[iv].

Table 5: Type of organisation currently working in, by cohort

Organisation working in	2011		2012		Overall	
	No.	% of cohort	No.	% of cohort	No.	%
NHS	114	85.7%	161	85.6%	275	85.7%
Public healthcare system overseas	9	6.8%	12	6.4%	21	6.5%
Private healthcare overseas	7	5.3%	4	2.1%	11	3.4%
University	2	1.5%	4	2.1%	6	1.9%
University and NHS	1	0.8%	2	1.1%	3	0.9%
Overseas (organisation not specified)	0	0.0%	1	0.5%	1	0.3%
Non healthcare organisation overseas (e.g. local authority, charitable body)	0	0.0%	2	1.1%	2	0.6%
Non healthcare organisation in the UK (e.g. local authority, charitable body)	0	0.0%	2	1.1%	2	0.6%
Total	**133**	**100.0%**	**188**	**100.0%**	**321***	**100.0%**

*18 respondents did not answer this question.

Respondents were asked whether they are currently working in the same region as they trained, or in a different region (Table 6). Overall, 33.6% are working in a different region to their training region, and there is little difference between the two cohorts. This is

similar to the 2010 cohort (31.7%), indicating that based on these three cohorts, movement between UK regions is at a constant rate.

Table 6: UK respondents - working in a different region to where trained, 2011 and 2012 cohorts

	2011		2012		Overall	
	No.	%	No.	%	No.	%
Working in a different region	38	32.2%	59	34.5%	97	33.6%
Working in the same region	76	64.4%	110	64.3%	186	64.4%
Not applicable	4	3.4%	2	1.2%	6	2.1%
Total	**118**	**100.0%**	**171**	**100.0%**	**289**	**100.0%**

Respondents were asked why they had moved from their training region (Table 7). The majority stated that there were no suitable posts available (37.3%) and that there were no subspecialty posts available in their training region (26.3%). In 2010, the availability of suitable posts was also the most cited reason (38.7%), however the desire to move to another area was the second most common (33.3%)[iv], compared to 15.3% in this survey.

Table 7: Reasons for working in a different region, 2011 and 2012 cohorts

	2011		2012		Overall	
	No.	%	No.	%	No.	%
There were no suitable posts available in my training region	17	37.0%	27	37.5%	44	37.3%
There were no subspecialty posts available in my training region	15	32.6%	16	22.2%	31	26.3%
I wanted to move to another area	5	10.9%	13	18.1%	18	15.3%
Attractive job offer in a different region	3	6.5%	4	5.6%	7	5.9%
Family reasons	2	4.3%	2	2.8%	4	3.4%
Post is in a different deanery but close to training region	0	0.0%	3	4.2%	3	2.5%
Previously worked/trained in the region	1	2.2%	2	2.8%	3	2.5%
Unable to obtain a post in my training region	1	2.2%	2	2.8%	3	2.5%
Left area for grid post, wanted to return	1	2.2%	1	1.4%	2	1.7%
Short term relocation	0	0.0%	2	2.8%	2	1.7%
To work in a larger unit	1	2.2%	0	0.0%	1	0.8%
Total	**46**	**100.0%**	**72**	**100.0%**	**118***	**1**

*The total number of reasons is higher than the number working in a different region as respondents could provide more than one reason.

2. GMC registration status, grid training and subspecialties

Table 8 indicates how many of the total cohort is on the GMC specialist register. Overall 98.1% are currently registered. Those not registered includes those who have been previously, but are not currently licensed to practice, so is likely to reflect those that have moved overseas to work.

Table 8: Registration on the GMC specialist register, responding and non-responding doctors

	Responding doctors		Non responding doctors		Total	
2011 cohort	**No.**	**%**	**No.**	**%**	**No.**	**%**
On specialist register	138	97.9%	102	96.2%	240	97.2%
Not on specialist register	3	2.1%	4	3.8%	7	2.8%
Total	**141**	**100.0%**	**106**	**100.0%**	**247**	**100.0%**
2012 cohort						
On specialist register	198	100.0%	84	96.6%	282	98.9%
Not on specialist register	0	0.0%	3	3.4%	3	1.1%
Total	**198**	**100.0%**	**87**	**100.0%**	**285**	**100.0%**
Overall						
On specialist register	336	99.1%	186	96.4%	522	98.1%
Not on specialist register	3	0.9%	7	3.6%	10	1.9%
Total	**339**	**100.0%**	**193**	**100.0%**	**532**	**100.0%**

Figure 1 indicates the route taken to get on the GMC specialist register for both responding and non-responding doctors. Across both cohorts, 92.0% took the CCT route and 8.0% took one of the certificate of eligibility for the specialist register (CESR) routes. In 2010, only 3.4% of the cohort took the CESR route[iv]. There were a higher number of CESRs awarded in 2011 than in 2010 and 2012 which is thought to be due to timing of applications rather than a trend; however continued monitoring is required to identify any long term trends.

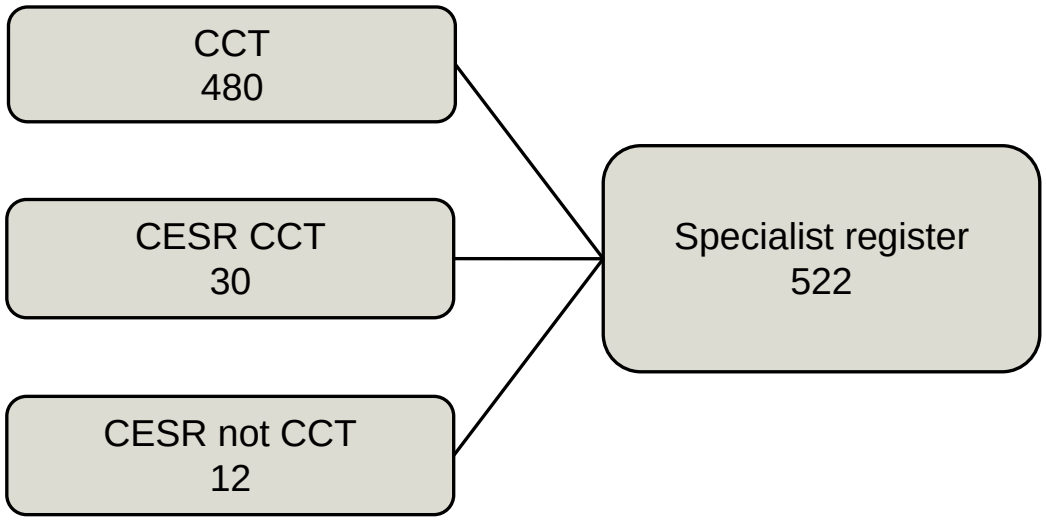

Figure 1: Route to GMC specialist registration, total 2011 and 2012 cohorts

2.1 GMC registration and grid training

Table 9 gives a breakdown of the total cohort and survey respondents by subspecialty registered. 65.2% of survey respondents and of the total cohort were registered in general paediatrics; likewise 9.7% of respondents and 9.6% of the total cohort were registered as neonatal medicine subspecialists. Comparing the number of respondents in each subspecialty to the total cohort suggests that the survey results are fairly representative of the whole cohort, with responses from all subspecialty areas.

Table 9: Total cohort by and survey respondents by registered subspecialty

	Total cohort		Survey respondents	
	No.	%	No.	%
Clinical pharmacology & therapeutics	2	0.4%	2	0.6%
Community child health	31	5.8%	16	4.7%
Diabetes and endocrinology	4	0.8%	4	1.2%
Emergency medicine	11	2.1%	6	1.8%
Gastroenterology, hepatology & nutrition	6	1.1%	2	0.6%
General paediatrics	347	65.2%	221	65.2%
Immunology, infectious diseases & allergy	11	2.1%	10	2.9%
Inherited metabolic medicine	1	0.2%	1	0.3%
Intensive care medicine	14	2.6%	9	2.7%
Neonatal medicine	51	9.6%	33	9.7%
Nephrology	3	0.6%	2	0.6%
Neurodisability	12	2.3%	10	2.9%
Neurology	15	2.8%	8	2.4%
Oncology	4	0.8%	3	0.9%
Palliative medicine	2	0.4%	1	0.3%
Respiratory	12	2.3%	8	2.4%
Rheumatology	6	1.1%	3	0.9%
Total	**532**	**100.0%**	**339**	**100.0%**

Figure 2 shows that all of the respondents who are registered for emergency medicine, gastroenterology, hepatology and nutrition, inherited metabolic medicine, nephrology, neurodisability and palliative medicine have trained through the grid. However, there are several subspecialties with new CCT holders who did not train on the grid. Not including general paediatrics, overall 74.6% of responding subspecialists trained this way.

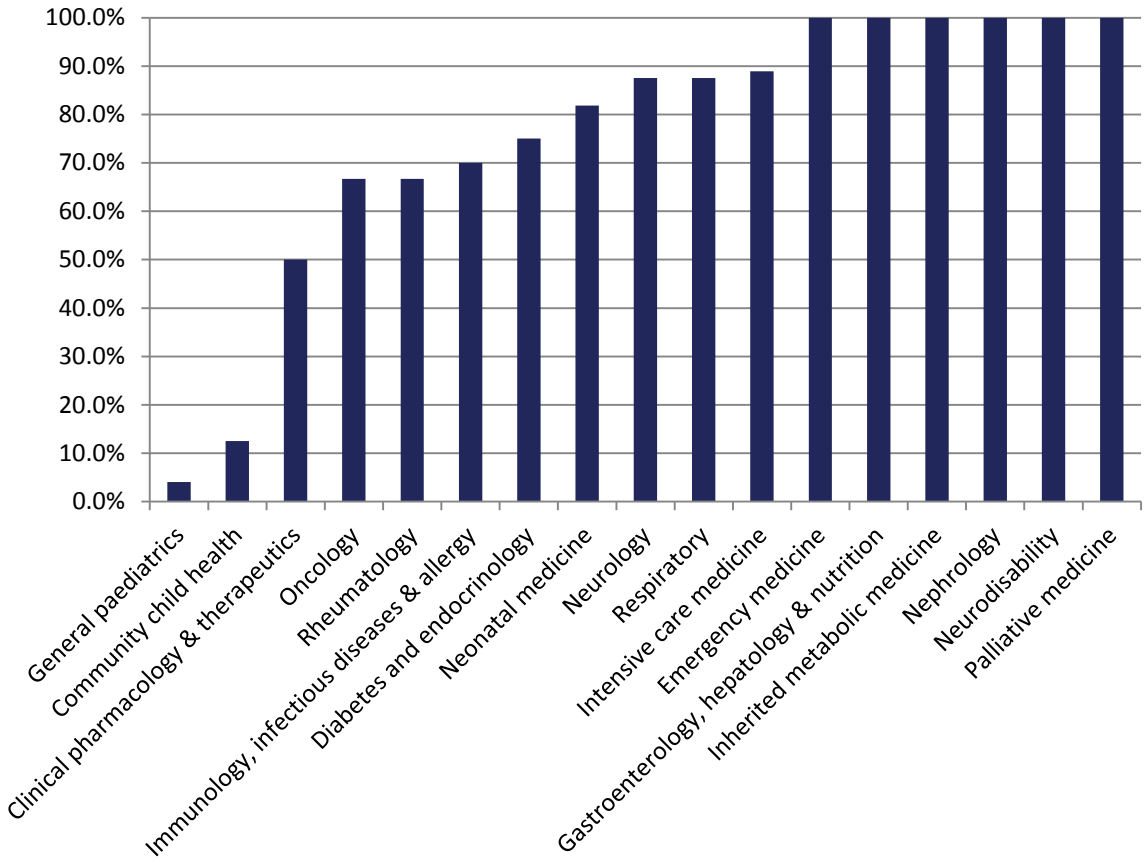

Figure 2: Percentage of respondents trained on the national grid, by registered subspecialty

2.2 Registered subspecialty

Table 10 groups respondents by their registered subspecialty into general paediatrics, community or specialist. The proportions in each of these groups can be compared to the overall workforce recorded in the 2011 RCPCH census[i]. The number registered for community child health in the 2011 cohort (6.5%) and 2012 cohort (3.5%) is much lower than the proportion of the total consultant body working in this subspecialty (19.2%).

This shortfall should also be considered in light of a community child health workforce that has an older age profile than acute general paediatrics and other specialist areas and is therefore likely to see a higher number of retirements in the coming years[i]. Similarly, the number registered for other subspecialties is lower (26.8% in 2011 and 32.8% in 2012) than the overall consultant body (43.3%). While comparisons with the current consultant body are informative, there is a need to train the correct numbers for the desired workforce structure for the long term.

The data from the 2010 cohort shows a similar pattern as the 2011 and 2012 cohorts, with 62.7% registered for general paediatrics, 4.7% for community child health and 33.6% for other subspecialty areas[iv].

Table 10: Registered specialty group of the 2011 and 2012 cohorts compared to the working specialty groups of the whole consultant body, Census 2011

	Registered subspecialties of 2011 cohort		Registered subspecialties of 2012 cohort		Consultants in 2011 census	
	No.	%	No.	%	No.	%
General Paediatrics	92	66.7%	126	63.6%	1325	40.5%
Community	9	6.5%	7	3.5%	627	19.2%
Specialist	37	26.8%	65	32.8%	1317	40.3%
Total	**138**	**100.0%**	**198**	**100%**	***3269**	**100.0%**

*excluding 50/50 and non-paediatric doctor subspecialties

Respondents were asked whether or not they are currently working in the same specialty/subspecialty as their GMC registration (Table 11). Overall 88.7% are working in the same role as their registration; this is slightly higher in the 2012 cohort (89.6%) than in the 2011 cohort. Among the 2010 cohort, 91.2% were working in the same subspecialty as their registration[iv].

Table 11: Working in the same subspecialty as GMC specialty registration?

		2011	2012	Total
Yes	No.	117	172	289
	%	87.3%	89.6%	88.7%
No	No.	15	20	35
	%	11.2%	10.4%	10.7%
Not on the specialist register	No.	2	0	2
	%	1.5%	0.0%	0.6%
Total	**No.**	**134**	**192**	**326***

*13 respondents did not answer this question.

Those responding that they were not working in the same subspecialty were asked about the main subspecialties of their current post, and how many months' training they had undertaken in that subspecialty (Table 12).

Table 12: Subspecialty working in if different to registered subspecialty, and average number of months training

	Subspecialty trained in			
Subspecialty working in	General paediatrics	Neurodisability	Total	Average months training
Paediatrics (community child health)	8	2	10	14.8
Paediatrics (neonatal medicine)	9	0	9	21.2
Paediatrics (intensive care medicine)	4	0	4	18.0
Paediatrics (respiratory)	3	0	3	15.0
Paediatrics (neurology)	2	0	2	15.0
Public health medicine	2	0	2	29.5
Medical oncology	1	0	1	20.0
Paediatric Sleep Medicine	1	0	1	N/A
Infectious diseases	1	0	1	12.0
Paediatric Cardiology	1	0	1	24.0
Research - Medical Informatics	1	0	1	6.0
Paediatrics (diabetes and endocrinology)	1	0	1	36.0
Total	**35**	**2**	**37**	**17.85**

The majority of those who are not working in the same specialty are currently working in community child health (10), followed by neonatal medicine (9). Apart from 2 trained in neurodisability, all others had a general paediatric background. Those working in community child health had an average 14.8 months training in this area, and those in neonatal medicine 21.2 months. When the subspecialties are considered without community child health, the average number of months spent training is 19.0.

3. Contract type and working patterns

3.1. Contract type

Table 13 indicates the type of contract currently held by respondents, broken down by grade group. Overall, 70.4% of the 2011 cohort and 55.7% of the 2012 cohort currently have substantive contracts. A considerably higher proportion of the 2012 cohort (25.6%) are working as locum consultants compared to the 2011 cohort (14.6%). Of the 2010 cohort, 14.5% of consultants were in locum posts[iv].

Table 13: Contract type by grade group, by 2011 and 2012 cohort

	Fixed term		Honorary		Locum		Substantive		Overall
2011	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**
Clinical fellow	2	100.0%	0	0.0%	0	0.0%	0	0.0%	2
Consultant	14	10.8%	1	0.8%	19	14.6%	94	72.3%	130
SAS doctor	0	0.0%	0	0.0%	0	0.0%	1	100.0%	1
Non-training grade	2	100.0%	0	0.0%	0	0.0%	0	0.0%	2
Total	**18**	**13.3%**	**1**	**0.7%**	**19**	**14.1%**	**95**	**70.4%**	**135**
2012									
Clinical fellow	18	78.3%	2	8.7%	1	4.3%	1	4.3%	23
Consultant	15	9.4%	0	0.0%	41	25.6%	101	63.1%	160
SAS doctor	1	14.3%	1	14.3%	1	14.3%	4	57.1%	7
Non-training grade	1	50.0%	0	0.0%	0	0.0%	1	50.0%	2
Total	**35**	**18.2%**	**3**	**1.6%**	**43**	**22.4%**	**107**	**55.7%**	**192**
Overall	**53**	**16.2%**	**4**	**1.2%**	**62**	**19.0%**	**202**	**61.8%**	**327**

This suggests that many new CCT holders do not immediately get substantive posts, but are moving into them as their careers progress. However, the overall number of consultants in substantive posts in these two cohorts (67.2%) is lower than reported in the 2011 census for the whole consultant body (94.9%) and this could indicate a trend toward less permanent work.

The RCP's annual survey also indicates a low number of substantive consultant posts for new CCT holders, although the figure rose slightly in 2012 to 63.2% after 3 years of decline[iii].

3.2. Working preferences

Respondents were asked whether they were currently working full time or less than full time, whether this was the way they preferred to work, and if not, how they would prefer to work. Information about current and preferred ways of working is important to feed into workforce planning models.

Table 14 indicates that overall, 79.1% of respondents are working full time and 20.9% less than full time. For consultants, the proportion working less than full time is slightly higher at 22.1%. This reflects the working patterns of the whole consultant body; the 2011 census reported 20% working in contracts with fewer than 10 PAs[i].

Table 14: Respondents working full time and less than full time by grade and cohort

	Full time		Less than full time		Total
	No.	%	No.	%	No.
Consultant	222	77.9%	63	22.1%	285
Clinical fellow	23	95.8%	1	4.2%	24
SAS doctor	6	75.0%	2	25.0%	8
Non training grade	3	75.0%	1	25.0%	4
Overall	**254**	**79.1%**	**67**	**20.9%**	**321***

*18 respondents did not answer this question.

Across both cohorts, 52% are female and 48% are male (Table 15). The proportion of women obtaining CCT in these cohorts (52%) is as would be expected given the gender balance amongst trainees in the later stages of their training. However, in future years, this balance is likely to change. In January 2012, 76% of ST1-3 trainees were female[i]. Overall, 64.7% of female respondents work full time, compared to 94.8% of male respondents.

Table 15: Respondents working full time or less than full time by gender and cohort

	Full time		Less than full time		Overall	
	No.	%	No.	%	No.	%
Female	108	64.7%	59	35.3%	167	52.0%
Male	146	94.8%	8	5.2%	154	48.0%
Total	**254**	**79.1%**	**67**	**20.9%**	**321***	**100.0%**

*18 respondents did not answer this question

Overall, 21.6% (65) of respondents are not working the way they intended, whether that is full time or less than full time (Table 16). 21.7% (48) of those working full time and 25.9& (17) of those working less than full time did not intend to work in those ways.

Table 16: Proportion of respondents working as they intended, by current way of working and cohort

		Reflects intention?		
Currently working		Yes	No	Total
Full time	No.	189	48	237
	%	78.4%	21.7%	
Less than full time	No.	47	17	64
	%	74.1%	25.9%	
Overall	**No.**	**236**	**65**	**301**
	%	**78.4%**	**21.6%**	

3.3. Programmed activities and supporting professional activities

The number of programmed activities (PAs) being allocated in new consultant contracts for supporting professional activities (SPAs) has been raised as an issue of concern amongst College members. The 2003 consultant contract sets out that with a 10 PA job plan, typically 7.5 PAs are allocated for direct clinical care (DCC) and 2.5 for SPAs[vii]. Those working part time will have a higher proportion of their total PAs dedicated to SPAs, reflecting the need to partake in the same amount of CPD as their full time colleagues[viii], so someone on a 6 PA contract should have 4 DCC PAs and 2 SPAs.

This survey asked respondent how many PAs they are contracted to work in total, and of that total how many are for SPAs. The results are shown in Table 17 and Table 18.

Table 17: Average PAs by specialty group

Specialty group	2011	2012	Overall av. PAs	Average PAs in 2011 census
Full time respondents				
Community	10.25	10.00	10.14	
General	10.19	10.24	10.22	
Specialist	10.36	10.31	10.33	
Overall av. PAs	**10.25**	**10.26**	**10.25**	**11.1**
Less than full time respondents				
Community	7.85	7.33	7.66	
General	7.18	7.93	7.64	
Specialist	6.25	6.70	6.50	
Overall av. PAs	**7.16**	**7.68**	**7.46**	**7.0**

Table 18: Average SPAs by specialty group

Specialty group	2011	2012	Overall av. SPAs	Average SPAs from 2011 census
Full time respondents				
Community	2.13	2.17	2.14	
General	1.85	1.96	1.91	
Specialist	1.83	1.87	1.85	
Overall av. SPAs	**1.86**	**1.94**	**1.90**	**2.84***
Less than full time respondents				
Community	1.10	2.00	1.44	
General	1.27	1.47	1.39	
Specialist	1.13	1.46	1.31	
Overall av. SPAs	**1.21**	**1.52**	**1.39**	**1.95**

*For those with total contracts of 10-12 PAs.

Of those working full time (10 or more PAs), the average number of PAs worked overall is 10.25. Specialists have a slight higher number of PAs on average compared to general paediatrics and community child health. Amongst less than full time respondents (less

than 10 PAs), the average is 7.46. This is marginally higher in the 2012 cohort for both full time and less than full time respondents. The average SPAs for full time respondents is 1.90, and for less than full time respondents it is 1.39. Again, the number of SPAs is slightly higher in the 2012 cohort.

Based on the 2003 consultant contract[vii], the ratio of non DCC SPAs to total PAs should be 0.25 for a 10 PA contract, rising to 0.33 for a 6 PA contract. Overall, all three specialty groups fall short of this recommendation, with general paediatrics and specialist paediatrics faring worse (see Table 19). The 2011 census reported an overall ratio of 0.27 (2.71/10.2) for the consultant body[i]. It is possible that older consultants have more SPAs for management, service development and lead clinician roles, however these data support the concerns expressed by members over a reduction of SPA time in new contracts.

Table 19: Ratio of non DCC SPAs to total PAs, all respondents

	2011	2012	Overall	Total consultant body
Community	0.17	0.24	0.20	
General	0.18	0.19	0.19	
Specialist	0.18	0.19	0.18	
Overall	**0.18**	**0.19**	**0.19**	**0.27**

Of particular concern is the fact that 44 consultant respondents report have 1 SPA or less in their contracts. Looking at this issue regionally indicates that 57.9% of consultant respondents in Scotland have contracts with 1 or less SPAs, 37.5% in Kent, Surrey and Sussex, and 25.0% in the East of England, compared to an overall average of 18.4%. The overall average number of SPAs is also lower in Scotland; 1.43 compared to the UK average of 1.78 (full time and less than full time combined).

The BMA and NHS Employers state that a typical weekly split is 7.5 programmed activities to 2.5 SPAs, and the Academy of Medical Royal Colleges estimates that 1 to 1.5 SPAs per week is the minimum time required for a consultant to meet the needs for CPD for revalidation purposes[ix].

Respondents were also asked what they used their SPA time for, and average SPAs spent on each activity per total UK consultants are shown in Table 20 (full time respondents) and Table 21 (less than full time respondents).

For full time respondents, most SPA time is spent on CPD (0.47 PAs) followed by management (0.37), and quality improvement (0.27).

Table 20: Average SPA time spent per activity, full time respondents

	No. spending time on activity	Average SPAs per all UK consultants working FT*
Continuing professional development (CPD)	164	0.47
Management	142	0.37
Quality improvement	122	0.27
Teaching/training/examination - postgraduate	116	0.21
Teaching/training/examination - undergraduate	103	0.17
Appraisal preparation	94	0.11
Research	47	0.08
Revalidation preparation	74	0.08

*N = 203

For less than full time respondents, most SPA time is also spent on CPD (0.39 PAs), management (0.24) and quality improvement (0.21).

Table 21: Average SPA time spent per activity, less than full time respondents

	No. spending time on activity	Average SPAs per all UK consultants working LTFT*
Continuing professional development (CPD)	43	0.39
Management	34	0.24
Quality improvement	31	0.21
Teaching/training/examination - postgraduate	29	0.17
Teaching/training/examination - undergraduate	23	0.14
Appraisal preparation	29	0.14
Revalidation preparation	16	0.07
Research	8	0.05

*N = 60

3.4. Participation in general on call rotas

Respondents were asked whether they participated in general paediatric on call rotas in order to identify whether subspecialists are providing this type of cover. The data supports the view that in comparison with general paediatricians, on call cover is not provided extensively by these groups. Only 12% (3/22) community child health consultants and 11% (12/107) other subspecialists in the cohort do so. This compares to 70% (126/180) of those working in general paediatrics who participate in general on call rotas, which is lower than expected, even after 12 out of the 54 not working on call can be discounted because they work overseas or as a clinical fellow. It is possible that some respondents misinterpreted this question; therefore we urge caution in using this finding.

4. Resident shift working and educational supervision

4.1. Resident shift working

There is a consensus across the medical profession that a 24/7 service is required, with more consultant presence in the hospital at times of peak activity[x],[xi],[xii]. The College continues to monitor the number of trained paediatricians participating in resident shift work, and to advocate the consultant delivered care model.

Overall, 21.6% of respondents stated that their post involves resident shift working; this figure is slightly higher among the 2012 cohort (22.6%) and represents a fall against the 2010 cohort; 28.5% of whom were in posts involving resident shift working.

Table 22: Respondents who stated their post involved resident shift working (RSW), by cohort

	2011		2012		Total	
	No.	%	No.	%	No.	%
Post involves RSW	25	20.2%	40	22.6%	65	21.6%
Post doesn't involve RSW	95	76.6%	122	68.9%	217	72.1%
Not applicable	4	3.2%	15	8.5%	19	6.3%
Total	**124**	**100.0%**	**177**	**100.0%**	**301***	**100.0%**

*38 respondents did not answer this question.

Respondents were asked how many PAs in their contracts are dedicated to resident shift working. The 2011 cohort had an average of 2.00 PAs dedicated to resident shift working, and the 2012 cohort, 2.86, giving an average of 2.54, which is comparable to the 2.88 reported by the 2010 cohort[iv] and 2.88 in the rota compliance and vacancies survey carried out in Winter 2012/2013[xiii]. Of the 65 who do resident shift working, 9 have more than the RCPCH recommended total of 4 PAs dedicated to this way of working for a 10 PA contract[xiv].

4.2. Educational supervision

Table 23 indicates the number of respondents responsible for educational supervision of trainees by grade and cohort. Among consultants, 80.5% of the 2011 cohort has these duties compared to 65.8% of the 2012 cohort. The difference between the two cohorts may reflect the fact that the 2011 group are further into their consultant career and taking on additional duties.

Table 23: Respondents involved in educational supervision of trainees, by grade and cohort

Grade	No. supervising	%	Total
2011			
Clinical fellow	1	50.0%	2
Consultant	95	80.5%	118
Non-training grade	0	0.0%	2
SAS doctor	0	0.0%	1
Total	**96**	**78.0%**	**123**
2012			
Clinical fellow	7	35.0%	20
Consultant	98	65.8%	149
Non-training grade	0	0.0%	1
SAS doctor	3	42.9%	7
Total	**108**	**61.0%**	**177**
Overall	**204**	**68.0%**	**300***

*39 respondents did not answer this question.

5. Transition to consultant role

This section looks at the transition from senior trainee or equivalent to consultant post, particularly the time taken to gain a first post after specialist registration, making use of the grace period, job applications, and the support the College could provide over this period.

5.1. First post

Respondents were asked if they were in their first post since registration, and when that post started, in order to calculate the average time taken to obtain that first post. The results are summarised in Table 24.

Table 24: First post start in relation to registration, and average number of days between registration and start of first post

	2011		2012		Overall		Average no. of days between*
	No.	%	No.	%	No.	%	
First post start before registration	20	26.7%	49	35.8%	69	32.5%	-131
First post start after registration	47	62.7%	82	59.9%	129	60.8%	153
First post start at same time as registration	8	10.7%	6	4.4%	14	6.6%	N/A
Number and % in first post	**75**	**59.5%**	**137**	**72.9%**	**212**	**66.5%**	**49**

*3 respondents who took more than 3 years to obtain their first post were removed from the average calculation as they were considered to be anomalies.

Of the 2011 cohort, 75 (59.5%) were in their first post since registration, compared to 137 (72.9%) of the 2012 cohort. Overall, 60.8% started their first post after registration, 6.6% at the same time, and 32.5% before registration. There was a slightly higher percentage in the 2011 cohort (62.7%) who obtained their post after registration that in the 2012 cohort (59.9%), and in 2012, 35.8% obtained their first post before registration, compared to 26.7% in the 2011 cohort. The first post was obtained on average 1.6 months after registration, however this disguises a large variation, with those obtaining the post after registration doing so on average 5.1 months later, and those who had already obtained a post did so on average 4.4 months before.

5.2. Job applications

Respondents were asked how many job applications were made before obtaining their current post. The overall average was 1.8; this was higher in the 2011 cohort (2.1) than in the 2012 cohort (1.5). It was also higher among males (2.1) than females (1.5).

5.3. Grace period

Trainees are given six month period of grace after the end of training during which they can retain their NTN if a consultant post has not been secured. Across both cohorts 39.8% of respondents made use of their grace period and 52.8% did not. Table 25 indicates that greater use is made of the grace period by those in general paediatric roles (37.6%) and in specialist roles (33.3%) compared to community roles (18.8%).

Table 25: Respondents making use of grace period by specialty group working in, 2011 and 2012 cohorts

		Yes	No	Not applicable	Total
Community	No.	3	12	1	16
	%	18.8%	75.0%	6.3%	100.0%
General	No.	82	91	19	192
	%	42.7%	47.4%	9.9%	100.0%
Specialist	No.	34	55	2	91
	%	37.4%	60.4%	2.2%	100.0%
Total	**No.**	**119**	**158**	**22**	**299***
	%	**39.8%**	**52.8%**	**7.4%**	

*37 respondents did not answer this question.

The most common reasons for making use of the grace period were cited as waiting for an appropriate consultant job (34.5%), to gain more experience/training (29.4%) and waiting for a job in the right area (10.1%). These results broadly reflect those of the 2010 cohort, when the most common reasons given related to waiting for an appropriate consultant post, followed by to gain more experience/training[iv].

Table 26: Reasons for making use of grace period, 2011 and 2012 cohorts

	No.	% of respondents who used grace period
Waiting for an appropriate consultant job	41	34.5%
To gain more experience/training	35	29.4%
Waiting for a job in the right area	12	10.1%
Working notice period	10	8.4%
Waiting for new job to start	8	6.7%
Going on maternity leave	4	3.4%
To finish research	4	3.4%
To complete training rotation	2	1.7%
Other	8	6.7%
Total	**131***	

*Respondents could provide more than one reason for using their grace period.

5.4. Ease of transition

Respondents were asked to rate how they found the transition from trainee to consultant (see Figure 3). Across both cohorts, 26.4% found the transition to a consultant post very easy or quite easy, 43.5% found it neither easy nor difficult, and 20.8% found it quite difficult or very difficult.

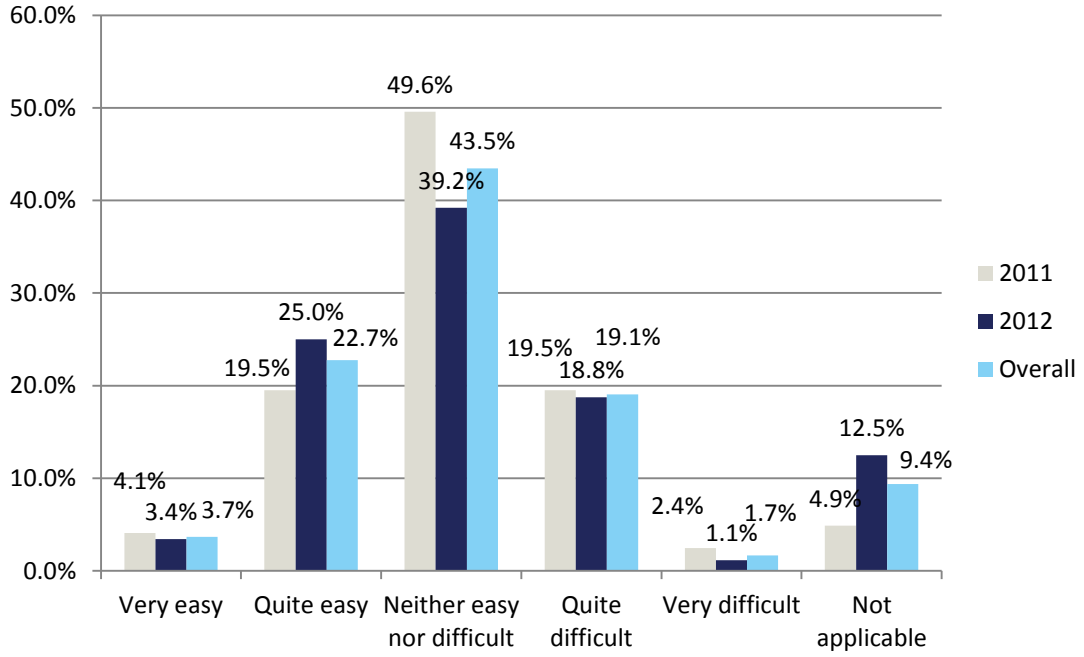

Figure 3: How found transition to consultant role, by cohort and overall

Respondents were asked what support the College could provide to help with the transition process (

Table 27). They were given a number of options to select from but could also provide their own responses.

Table 27: Support from the College for transition to consultant role, by cohort

	2011		2012		Overall	
	No.	% of cohort responding	No.	% of cohort responding	No.	% of total respondents
Leadership and management skills development	74	52.5%	82	41.4%	156	46.0%
College-facilitated network for new consultants	62	44.0%	77	38.9%	139	41.0%
Mentoring	58	41.1%	69	34.8%	127	37.5%
Educational supervision skills development	57	40.4%	60	30.3%	117	34.5%
Careers progression advice after gaining CCT or CESR	49	34.8%	67	33.8%	116	34.2%
Continuing professional development (CPD) courses/e-learning	43	30.5%	67	33.8%	110	32.4%
Clinical supervision skills development	32	22.7%	33	16.7%	65	19.2%
Help with finding a consultant post	24	17.0%	29	14.6%	53	15.6%
Guidance on CPD	0	0.0%	4	2.0%	4	1.2%
Job planning advice	0	0.0%	3	1.5%	3	0.9%
Revalidation training	0	0.0%	3	1.5%	3	0.9%
Advice/preparation for consultant role	0	0.0%	3	1.5%	3	0.9%
Local courses/support already available	0	0.0%	3	1.5%	3	0.9%
I did not need any further support	10	7.1%	20	10.1%	30	8.8%
Grand Total	**409**		**520**		**929**	

Of the options provided in the survey, the most commonly selected was leadership and management skills development, selected by 46% of the respondents, followed by a College-facilitated network for new consultants (41.0%) and mentoring (37.5%). Similar priorities were identified by the 2010 cohort, 54.1% of which asked for leadership and management skills development and 49.3% for a College-facilitated network for new consultants. The least popular of the options was help with finding a consultant post (15.6%).

Several more suggestions were made by one or two respondents and have not been included in the table above. These included child protection/safeguarding training, support over new consultant contracts and resistance over 1 SPA contracts, recognition of CESR CP in Europe, advice about NHS changes, structure and management concepts and a training route with a public health year.

6. CPD and College support

The College's CPD system is open to all career grade paediatricians and supports the maintenance and development of knowledge, skills and competence for clinical practice. It is important that the system and the support offered remains relevant, and that members are well informed of what is available to them. This survey is an opportunity to monitor uptake and relevance to trained paediatricians.

Table 28: Registration with the College for CPD, by cohort

		2011	2012	Overall
Registered for CPD	No.	110	137	247
	%	90.9%	79.2%	84.0%
Not registered for CPD	No.	11	36	47
	%	9.1%	20.8%	16.0%
Total	**No.**	**121**	**173**	**294***

*45 respondents either did not answer or are not on the specialist register.

Table 28 indicates that 90.9% of the 2011 cohort and 79.2% of the 2012 cohort are registered for CPD. The difference suggests that uptake is not immediate after gaining CCT or a new consultant role. The decreased uptake does not reflect uptake among the whole consultant body; the College has seen an increase in members using the CPD scheme in the last year, which is thought to be due to the introduction of revalidation.

The reasons for not being registered are given in Table 29. The most common reason, cited by 25.5% was that they had not got round to it yet, followed by being overseas (17.0%) and being unaware of what is offered (14.9%).

Table 29: Reasons for not being registered for CPD, 2011 and 2012 cohorts

Reasons why not registered	No.	% of not registered
Not got round to it yet	12	25.5%
Overseas	8	17.0%
Unaware	7	14.9%
Use another system	5	10.6%
Didn't know I needed to	5	10.6%
In the process of applying	4	8.5%
No information	2	4.3%
Not started consultant post yet	2	4.3%
Didn't know I was eligible	1	2.1%
Too busy	1	2.1%
Not needed	1	2.1%
Total	**48***	

*Respondents could provide more than one reason for not being registered for CPD.

Respondents were asked what type of course and e-learning they would like the College to offer for continuing professional development (Table 30). Similar to comments made about transition, the most commonly asked for courses were management (21.2% of respondents) and leadership (10.9% of respondents). There were many more suggestions made by one or two respondents which are not listed in Table 30, including dealing with

difficult situations, conflict resolution and communication skills, job planning, project and risk management skills, finances and transition care.

Table 30: Types of course/e-learning respondents would like to see offered by the College

Type of course/e-learning	No.	% of total respondents
Management	72	21.2%
Leadership	37	10.9%
Education/supervision	29	8.6%
Subspecialty specific	19	5.6%
General paediatrics updates	16	4.7%
Child protection/safeguarding	13	3.8%
Quality improvement	11	3.2%
New consultant course	10	2.9%
Recording CPD	10	2.9%
Business case preparation	9	2.7%
How the NHS works	7	2.1%
Medicolegal	7	2.1%
Clinical updates	6	1.8%
Revalidation	6	1.8%
Service development	6	1.8%
Consultant contracts	5	1.5%
Appraisal	5	1.5%
Courses held outside London	4	1.2%
Managing complaints	4	1.2%
Interview skills	4	1.2%
E-learning	3	0.9%
Total	**283**	

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