JMCC Consultation – Consultant Working Environments
Royal College of Paediatrics and Child Health (RCPCH) response

RCPCH is pleased to respond to the JMCC consultation on consultant working environments.

Our mission is to transform child health through knowledge, innovation and expertise with a vision of creating a healthier future for children and young people across the world. We welcome the opportunity to improve working practices with the intention of raising the standard of medical care provided to children and young people and improving their health outcomes.

Paediatrics is the broad term for general paediatrics and 17 subspecialties. For general paediatrics and a number of the subspecialties, paediatrics is an acute hands on consultant led service which means a consultant presence is required at peak times during the week and at weekends so that children and young people can be seen in a timely way.

Paediatrics and child health is recognised as already having embraced new ways of working, with greater involvement of senior clinicians seven days a week, although there is still work to be done, to achieve the RCPCH's own standards.

While this document is focussed on consultants, it is important to be aware that consultants are part of a team and any standards must be aligned across both the team and the wider network.

Lastly this document does not appear to apply to career grade doctors i.e. Staff, Associate Specialist or Specialty (SAS) doctors who may also work on paediatric consultant rotas.

1. Health and safety

Paediatrics is recognised as a specialty with one of the highest on-call and out-of-hours commitments, which are both demanding and stressful.

The RCPCH supports the European Working Time Directive (EWTD) and the UK Working Time Regulations (WTR) which we consider to be health and safety regulations for both patients and staff. EWTD is key to protecting doctors from fatigue; fatigue being a risk to patients. The EWTD and WTR are of even greater importance under seven day working.

We have embedded the Regulations in the development of our standards and recommendations for the working practice of our members. For example, our *Facing the Future* standards[1] which set out 10 key standards for general acute paediatric services.

The RCPCH has also worked on service standards documents with other Royal Colleges and professional groups and it is an expectation that the paediatrician as part of a team will still adhere to the EWTD in his /her working practice. Examples of these documents are *Time to Move On*[2] which recommends a clinical network model wide approach to care and the *Intercollegiate Standards for Children and Young People in Emergency care Settings*[3].

A safe and well supported working environment should align with the RCPCH's service standards as well as the EWTD and WTR. We have set out specific guidance for paediatricians in our paediatricians' handbook (http://www.rcpch.ac.uk/paediatrician-handbook), which is included in this response where relevant.

Our Invited Reviews service has visited over 30 paediatric teams in the last 30 months and has found in these environments high levels of stress-related sickness, particularly in community paediatric services which have been subject to frequent changes in structure and management and which are also largely responsible for child protection examinations. These are however not usually seven-day services but have seen attrition in conditions and increased pressure and caseload in recent years. It would appear in these environments, where there is a significant amount of off-site working and potentially stressful patient/family interactions that there is insufficient support for the consultants (and SAS doctors) in debriefing and ensuring work-life balance.

It is important that travelling time between sites is included within job planning as we have seen examples where this is insufficiently recognised.

2. Comfort breaks and refreshment

As above the RCPCH supports the EWTD and WTR.

Even with the Directive protected rest periods are often impossible to take, furthermore many hospitals have removed on call rooms and rest facilities are poor or non-existent, In addition many doctors work over these hours and mostly this is unpaid.

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[1] RCPCH (2010) Facing the Future http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/service-standards-and-planning/general-paediatrics/facing

[2] RCPCH (2014) High Dependency Care – Time to Move On http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/service-standards-and-planning/general-paediatrics/high-d)

[3] RCPCH (2012) Standards for Children and Young People in Emergency Care Settings http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/service-standards-and-planning/emergency-and-urgent-care

On-call rotas should be no more frequent than one in five, and it is likely that consultant team sizes will need to increase further over the next few years to fully meet the EWTD and to move towards 10-PA job plans.

Predictable activity out of hours in the evenings or during weekends should be agreed as part of the job plan and allowed for as direct DCC PAs. Unpredictable activity, including telephone calls for advice and recalls to hospital, should be assessed by means of diaries, averaged over a time period. Again, this should be agreed and built into the job plan, and assessed annually at the job plan review. Please see also the above comment about time for travelling between sites which needs to be included in job plans.

With the continuing increase in middle grade rota gaps and consultants acting down to fill these, there must be appropriate compensatory rest.

As the expected age of retirement advances, doctors are likely to contribute to clinical care at greater ages. It is inevitable that fewer doctors will do the same clinical work for the whole of their career after completing initial training. Neither paediatricians nor their patients and families would expect a doctor aged 60 years to be providing acute or intensive care at night. There must be ways of supporting staff to work in less hands-on ways e.g. through portfolio careers which is a model which the RCPCH strongly supports.

3. Access to ancillary services (e.g. IT, pharmacy, test results etc)

There is a need to differentiate between planned and unplanned work and be clear what is meant be seven day services. Most paediatricians are already in the hospital at the weekends when they are on call and many do formal ward rounds and are present at handover (as specified in the College's *Facing the Future* standards). However, if weekends are to include clinics and other work normally done Monday to Friday (including short term waiting list initiative activity) then all support services in the hospital and community would need to work in a similar fashion.

Good patient care requires good communication between healthcare professionals. The Francis Report emphasised the need for better information and highlighted the risks that increasing service pressures bring to patients[4]. No matter where children and young people are being cared for and whichever day of the week, their basic health information should be available, as needed, to those looking after them. IT systems need to provide an electronic health record accessible at any time and in any setting. Data sharing between primary, secondary and tertiary care in a timely way is crucial to deliver high quality care.

4. Support staff

Consultant paediatricians are part of a team of healthcare professionals providing care to children and young people. Consultants can't be considered in isolation from other members of the team and their working conditions. Other professions also need to align to the same hours of work, for example, Community Children's Nursing Teams, pharmacists, administrative staff and chaperone/healthcare assistants or play workers and sometimes multiagency staff. For example, the College is currently developing (jointly with the Royal

[4] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

College of GPs and the Royal College of Nursing) a new set of standards, Facing the Future Together for Child Health (http://www.rcpch.ac.uk/child-health/standards-care/service-configuration/general-paediatrics/facing-future-together-child-h), to provide more care closer to home and prevent unnecessary attendances at emergency departments or admissions to hospital. This includes a requirement for a 24 hour Community Children's Nursing (CCN) service to provide acute care for children and young people in the community.

The College is also looking at the skills mix and consideration is being given to extended and advanced roles of nurses and the role of Physician Associates in paediatric care.

5. Access to out of hospital community services

The College believes that no child or young person should be in hospital when care can be provided to an equivalent or better standard outside the hospital in their locality and closer to their home if appropriate (right care, right time, right place).

As above the College, together with the Royal College of Nursing, is looking at the role of a 24 hour Community Children's Nursing Team in providing more care in the community, seven days a week. Care in the community by Community Children's Nurses (CCNs) provides a safe and acceptable alternative to hospital care for children and young people with acute medical conditions[5] with high parental satisfaction[6 7].

6. Step up and step down services

The transition to shift patterns of working have significantly reduced the continuity of care that trainee doctors used to provide and increased the number of clinical handovers between medical staff. Consultant presence during the handover both improves patient outcomes and also provides an excellent training opportunity[8]. The RCPCH's revised *Facing the Future* standards will recommend that there are two consultant led handovers every 24 hours.

The *Time to Move On* critical care document sets out recommendations to improve the delivery of safe high quality critical care outside the Paediatric Intensive Care Unit, including stepping up and down between different levels of critical care and guidance on staffing and competencies.

7. Professional development (PDP, SPA, CPD)

In relation to both questions 7 and 8, the RCPCH would reinforce the expectations and requirements set out by the GMC and endorse the provision of sufficient time to allow consultants to maintain compliance and therefore safe and effective practice.

[5] Callery et al (2013) Comparison of the costs of care during acute illness by two community children's nursing teams
[6] Parker et al(2011) Evaluating models of care closer to home for children and young people who are ill
[7] Parab et al (2013) Specialist home-based nursing services for children with acute and chronic illnesses. Cochrane Library 2014
[8] Professor Sir John Temple (2010) Time for Training A Review of the impact of the European Working Time Directive on the quality of training

CPD is a 'must' given regulatory requirements and the College would highlight the importance of employers providing sufficient study leave, as well as balanced access to both internal and external learning opportunities and activities. In this context, it is also key that consultants are released to support national membership exams or other pertinent positions in order to continue to develop the future paediatric workforce. Seven day services may create difficulties for doctors in accessing learning opportunities if days off, for example, are rota'd; external courses are generally run on weekdays and, where departmental CPD/audit/morbidity and mortality meetings etc. are held on fixed days, these may be missed more often.

8. Supervision of educational trainees and multi-professional staff

In relation to question 8 specifically, the College feels there is currently a lack of clarity about the difference between clinical supervision (patient safety) and educational supervision (trainee support and development). Whilst every consultant has a responsibility for the former, not all may wish – or have the required skill set – to take on the latter role. Some consultants may therefore need more time in their job plan to take on the educational supervision role. We would also endorse and encourage application of National Association of Clinical Tutors guidance on recognising educational roles in Job Plans (2009).

Team job planning should be encouraged as individually negotiated agreements can give rise to inconsistency and discrepancies within the consultant body with regard to study leave provision, on-call commitment etc.