Facing the Future:
Standards and modelling for Paediatric Services

Summary / Trainees Guide - April 2011

Introduction

The current UK paediatric workforce (both consultants and trainees) is facing huge pressures. The harsh reality is that it is impossible to do all of the following:

1. Staff in a safe and sustainable way all of the inpatient paediatric rotas that currently exist
2. Comply with the European Working Time Regulations (EWTR)
3. Continue with the present numbers of consultants and trainees

This situation must be addressed - 'doing nothing' is simply not an option. It is time to face the future.

RCPCH have developed 10 **Service Standards** as minimum requirements for all general / inpatient paediatrics. These standards are **not** all deliverable with the current paediatric service provision in the UK. "Facing the Future" sets out those standards and models what might happen to the workforce and structure of inpatient paediatrics if all units are commissioned in future to comply with the standards whilst continuing to deliver a quality service for children.

Note - the changes envisaged will generally be local decisions, as CQC and clinical commissioning groups are in future likely to require all paediatric services to be complaint with the College-defined minimum standards. This modelling document provides paediatricians with the resources and data to shape decision making and take responsibility for modernising services and ensuring that quality and safety is maintained within the reformed NHS

Potential Reconfiguration

The report considers hospitals on the following basis (ref 2009 activity):

- Very small: <1500 emergency admissions/year
  - Proximal-within 30 mins drive to another unit (Currently 10 units)
  - Distal-not within 30 mins drive to another unit (Currently 20 units)
- Small: 1500-2500 emergency admissions/year
- Medium: 2501-5000 emergency admissions/year
- Large: >5000 emergency admissions/year

Within the new standards there would be **no** middle grade rotas in the very small units. It is thought that all of the proximal and some of the distal units would close or convert to short-stay paediatric assessment units (SSPAUs)

with no inpatients. Geography may lead to some of the distal units needing to continue to have inpatient facilities.

There are 38 units which are small and proximal, and 37 units which are small and distal. Implementing the Service standards could lead to loss of middle grade trainees in some of these hospitals. Some of these may consequently convert to SSPAUs, but it is imagined that fewer would do so due to the larger size of these units compared with very small units.

Medium and large units would continue to have 3 paediatric staffing tiers (Level One Trainees, Middle Grades and Consultants).

Workforce: Consultants

There are currently 3264 (3084 WTE) consultant paediatricians in the UK, including 1331 General Paediatricians, plus sub-speciality and academic paediatricians.

In whole time equivalents (WTE) for moderate reconfiguration (very small proximal units all close) there would be a need for 1647 General Paediatric Consultants (1331 currently), or 1510 if there was maximal reconfiguration (10 distal very small units become SSPAUs). This is modelled assuming the SSPAUs created would be nurse led; if they were consultant led, then these numbers would need to increase. Consideration of the impact of the standards on current neonatology and community services predicts that for a consultant delivered, high quality, and safe standard of care to be reached, then an expansion of consultant numbers between 50-60% is needed

	Current consultant WTEs (persons)	**Required consultant WTEs**		
		No change	**Moderate reconfiguration**	**Maximum reconfiguration**
General	1331 (1395)	1875	1647	1510
Neonatology	357 (369)	863	863	863
Community	591 (662)	915	915	915
Other specialist	804(838)	1200	1200	1200
TOTALS	**3084 (3264)**	**4853**	**4625**	**4488**

Workforce: Trainees

There are currently 3461 trainees, with 2544 WTE participating on acute rotas. The difference between trainee numbers and WTE is mainly due to LTFT trainees, OOPE/OOPR, maternity leave and sick leave. To staff current units in accordance with standard 8 (10WTE on a rota) would require a trainee expansion. Should there be enough trainees to support this there would be considerable unemployment at consultant level as there would not be enough consultant positions available per year. (Ideally there should be 3-4 consultants

per trainee to ensure sustainable workforce planning). The current ratio is 1.21 consultants per trainee therefore the current problem is there are too few trainees to staff rotas, and too many trainees for currently expected consultant numbers.

The proposal is to reduce trainee numbers to 1720 WTE. This reduction is only possible with a significant expansion in paediatric nurses to staff SSPAUs, and increasing the

number of GP trainees participating on level one rotas. There are currently 10,000 GP trainees and currently less than a quarter of these will undertake any paediatric placement. It is hoped that in line with the Kennedy report that more GPs will have paediatric rotations built into their training.

	Current number of trainees	**Proposed number of trainees**
Grid Trainees (exc neonates)	270	270
General Trainees on specialist rotas	250*	250*
Grid Trainees (neonates)	70	70
General Trainees available for tier 1 general / neonatal rotas	1072	500
General Trainees available for tier 2 general / neonatal rotas	1267**	630
Total	**2929**	**1720**

Career Pathways

General Paediatric Consultants: The recommendations would mean those in small units, with no middle grade, spend more of their on-call as resident (but less intense) whereas those in medium/large units with middle grade support will spend much less time resident (but more intense). This appears to match current feedback from consultants already in those roles.

Neonatal Consultants and Subspecialty Services: Resident consultant cover will be dependant on the numbers of level 3 units or specialist services and the degree of separation of resident and non-resident duties. Leads for subspecialties are being encouraged to develop models for their services.

Nurses and General Practitioners

The proposals have been prepared with the support of the Royal Colleges of Nursing and General Practitioners. Providing increased opportunity for GP trainees to experience paediatrics, for example in the SSPAUs is extremely helpful in shaping the skills of the future GP workforce, but modelling also needs to acknowledge that there is currently a significant shortfall in nurses with Advanced skills in Neonatology and children's nursing .

Assumptions

- A constant attrition rate for paediatric trainees (four % per annum)
- That the current number of grid trainees will remain the same, and that all grid trainees will be supernumerary
- That the requirement to meet EWTD remains
- No current trainee would be affected by the planned changes.

Conclusions

- The modelling predicts a reduction in the number of inpatient sites from 218 to approximately 170 with 32 new nurse led SSPAUs (the moderate reconfiguration

option) and increase the number of consultants from 3,084 to 4,625 WTEs whilst changing working practices with increasing use of resident consultants.

- There will need to be an Increase in the number of advanced children's nurse practitioners, the number of advanced or enhanced neonatal nurse practitioners and the number of GP trainees working paediatrics.

This summary was compiled by members of the RCPCH Training committee

More details - if you have any queries or comments on this document please contact health.policy@rcpch.ac.uk

* This figure is an informed estimate
** This figure represents the number of tier 2 trainees on general / neonatal rotas minus the neonatal grid trainees and minus half the number of other grid trainees, assuming that only half are supernumerary (1472-70-135=1267)

Royal College of
Paediatrics and Child Health
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Service Standards for Paediatric Units

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1. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.

2. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.

3. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.

4. All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.

5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).

6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.

7. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.

8. All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant.

9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

10. All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment, and the timely provision of an appropriate medical opinion, supported with a written report