Association for Paediatric Palliative Medicine

Position statement on training in Paediatric Palliative Medicine

The Royal College of Paediatrics and Child Health College Specialist Advisory Committee (RCPCH CSAC) for Paediatric Palliative Medicine and the Association of Paediatric Palliative Medicine (APPM) seek to highlight the ongoing concerns around the gaps in medical workforce in paediatric palliative medicine.

Currently there are fewer than 20 consultants in paediatric palliative medicine (PPM) scattered throughout the UK. Becoming a consultant in PPM, like all other subspecialities, is a supervised and regulated educational process overseen by the RCPCH through GMC approved training. A consultant in PPM has either completed GRID training (a competitively appointed national 2 year training programme) and is on the subspeciality GMC register or has confirmed equivalent training. A PPM consultant has expertise working with neonates, infants, children and young people with life-limiting conditions and life-threatening illnesses, and their families. Consultants in PPM must rigorously demonstrate capability in providing specialist symptom management, advance care planning, end of life care and support with complex ethical decisions.

Specialist PPM consultants lead specialised multidisciplinary paediatric palliative care teams. These specialised teams may be based in a hospital or hospice setting and offer clinical leadership across the paediatric palliative care network. These teams support tertiary, secondary and community services.

The local services may be fortunate enough to have paediatricians or other clinicians with an interest in paediatric palliative medicine. They can provide local support to families and work with specialised PPM teams to provide palliative care. SPIN (special interest) accredited training is now available for doctors to formalise their interest through a one-year training programme with the RCPCH.

Whilst some palliative care comes into every doctors' work, a specialist palliative medicine consultant requires in-depth expertise. The number of children with life-limiting conditions is increasing as are the clinical needs of these children. Palliative Medicine is a specialty of increasing complexity including the use of controlled drugs, high doses of medications, providing safe care often outside of a hospital setting and advanced communication skills. This also includes working with families to make complex ethical decisions balancing the benefit and burden of all interventions with the ongoing lived experience of the child.

Demand for a capable workforce to support the health care of the growing numbers of children with life-threatening and life-limiting conditions has become an urgent need. Despite consistent evidence of increasing patient need, over the past fifteen years there have been minimal training opportunities to develop the numbers of consultants required to support clinical services in the UK. There is a need for both consultants in paediatric palliative medicine (GRID trained) and clinicians with a paediatric palliative care interest (SPIN trained) to be available to all children with life-limiting conditions within their geographical location.

It is reassuring to all in the field that palliative care is being recognised as an important and much needed service. However, this urgent need to create and fill consultant posts should not be at the expense of high-quality care. Children and their families deserve to be cared for by competent well- trained clinicians.

We understand that Health Education England (HEE) will not be expanding the overall number of GRID training posts and new PPM posts will only be possible if other subspecialities relinquish their training posts. HEE has not kept pace with the emerging clinical and service needs of children with life-limiting conditions and the critical need for formal training in the field.

The RCPCH CSAC and APPM primarily support the expansion of training places so that more doctors can safely be trained, and the workforce can expand. Ring-fenced money for palliative medicine training would lead to the creation of additional specialist PPM GRID and PPM SPIN training posts resulting in rapid expansion of consultants. Specialised PPM centres are already well placed and eager to deliver that training and there are doctors keen to receive this training. The more doctors who are trained, the more training sites can be set up and the specialty could develop at an ever-increasing rate.

The CSAC and APPM recognise that building the PPM workforce will take time to meet the full requirement. In the interim there needs to be clarity around the provision of medical support to children with life-limiting conditions. This includes a call for a robust process to balance the risk of no clinical support to a local service and lack of trained and experienced staff.

There must be transparency regarding the recruitment and appointment of consultants to provide paediatric palliative care, where appointments are desperately needed and there is a risk that they may be filled with staff inadequately trained for the role they are employed to do. We understand that this expertise is desperately needed but inadequately trained and inexperienced consultants potentially place the patient, their family, the doctor themselves and the service at significant risk.

The CSAC and APPM do recognise and value the work being done by some excellent doctors who have gained experience in different ways recognising their gaps in knowledge and actively seeking out educational and training opportunities. We do not want to lose them. We need a way of supervising, supporting, training and regulating which would also require funding. There needs to be a rigorous, validated process whereby doctors can receive work-based training or time released for training during their working week to support and develop their practice. This process ideally could then be formally recognised to support equivalency in training either at GRID or SPIN level.

The workforce crisis in paediatric palliative medicine is at a critical stage, putting children and their families at risk of significant harm. We call on the government and those responsible for the provision of health and social care for babies, children and young people to address this issue with the utmost urgency. This country needs more consultants in PPM and must address the ongoing paralysis in funding for training doctors in the field of paediatric palliative medicine. The RCPCH CSAC and APPM implore that training and supervision is funded and that HEE (and their counterparts in the devolved nations) create additional training places when funding is secured. This will allow the specialty to expand safely and urgently to prevent the unnecessary suffering of children and the continued pressure and burnout of staff working in the field.

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