Community child health training

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Lessons required not just for the trainees

This leading article aims to highlight the main training issues in community child health (CCH) and, in light of work done so far, discuss provision of appropriate numbers of well trained paediatricians to meet the needs of the nation's children.

Community child health is a subspecialty of paediatric medicine that has undergone much change in structure and service provision in recent years, and this is likely to continue in the future.¹⁻³ Given that a large proportion of advertised consultant posts are in community child health, numbers of specialist registrar (SpR) training rotations should reflect this. This appears not to be the case however, although the actual number of specialist registrars seeking or undertaking subspecialty training in community child health is unknown. Similarly, there is little information available as to what training is actually being provided in this subspecialty, both in terms of quality and quantity.

CURRENT UK STUDIES

A postal questionnaire of all known CCH trainees was undertaken in 2000.⁴ One hundred and six higher specialist trainees were identified through paediatric regional advisers and postgraduate deans nationally and by word of mouth through what trainee network there is. Two thirds replied. Subsequently all trainees were invited to two national study days, and a further questionnaire was completed by the 39 who attended.^{4,5}

WORKFORCE ISSUES

Currently there are approximately 2000 consultant paediatricians in the UK, with around one fifth in tertiary specialties. By 2010 it is predicted that there will be a need for 4000 whole time equivalent paediatricians (3400 in England). A significant proportion of these jobs will be in community child health. This subspecialty, however, currently has a high number of flexible trainees (around half). Twenty six per cent of CCH trainees studied wished for a part time consultant post. This would decrease considerably the number of whole time equivalent consultants available to fill posts at the end of their training. Also, with the increasing number of females entering

medical school (up to 70% in some areas) and the increasing acceptance of part time consultant contracts, one would assume the proportion of consultants working part time will only increase. Estimated numbers of whole time equivalent consultants available in the future, therefore, may well be significantly lower than predicted requirements.

Current CCH trainees have strong views about on-call commitments they wish to provide as consultants in the future. Seventy five per cent of CCH trainees felt neonatal on-call would be unwanted or unacceptable.⁴ Fifty two per cent did not wish to take part in acute paediatric services.⁴ This would also have implications for future paediatric workforce planning.

THE HIGHER SPECIALIST CCH TRAINING PROGRAMME

The move from hospital to community based training is often difficult. The trainee often feels disorientated and alone, having moved from a relatively fixed daytime routine of ward rounds and clinics working in close contact with others, to planning their own timetable and working unaccompanied. Only a few departments have introductory packs for trainees including information on local professional services and contact details. Providing these for all would make the transition process of moving into the community base easier and more efficient.

The use of personal learning plans identifying aims and objectives and the means by which these might be achieved ought to be universal, but is not being achieved in practice. The plan should be agreed at the outset between trainee and supervisor. Once set, meeting these goals provides additional training in planning and time management, essential skills for any consultant to acquire.

Only a few regions have formalised training programmes for higher specialist trainees. Published training guidelines⁶⁻⁹ were used to some extent, although a worrying 13% of trainees had not used them at all.⁴ Training guidelines should be provided from the outset and should be part of the introductory pack already mentioned. The Community Child Health College Specialist Advisory Committee (CSAC) has provided an outline of core competencies to be achieved

at SHO, general SpR, and higher SpR level, and further work is now being undertaken to develop guidance on competencies in the special interest areas of neurodisability, social paediatrics, and child public health. There is a dilemma as to whether training should be "modular", providing short but concentrated exposure to any one subspecialty, or whether it should run for the duration of higher specialist training. The ideal would be a mix of the two, though work on how this might be achieved in practice is required. Undertaking a distance learning course or a further degree such as an MSc in community paediatrics or neurodisability would also be beneficial, and suitable courses are being developed.

CONTENT OF TRAINING

Some subspecialties within CCH appear to be more successful than others at giving trainees both adequate quality and quantity of training. Areas such as child protection and neurodisability are felt to be good at providing training, although this is by no means universal. In some areas there was often little or no exposure, for example, visual impairment. In all other subspecialties of CCH, quality and quantity of training was extremely variable.

The balance between service commitment and training needs was also variable among the trainees studied. Over half felt their training was centred towards their own needs. There is an ongoing debate about what proportion of overall training time should be spent undertaking acute hospital paediatric duties. Forty four per cent felt this work was not helpful to their training. Around half felt they should not have to undertake acute work in their senior years of training if they are willing to limit their job opportunities in the future. Others supported merging acute and community care. The benefits of continuity of care for children with complex disability were highlighted in particular.

SUPERVISION OF TRAINING

There appears to be a huge discrepancy between individuals with respect to the provision of supervision, both clinically on a day to day basis, and on a more formal basis from educational supervisors.

Day to day supervision in the community is more difficult than in the hospital setting. The widespread geographical locations of clinics, meetings, etc mean there is less opportunity for the trainee and supervisor to meet. Often patients are reviewed and management decisions made without a senior on the same site. This raises quality of care and medico-legal issues for the responsible consultant, trainee, and indeed patients themselves.

Educational supervisors are currently providing a variable level of support. Time made available to spend with the trainee, knowledge of what objectives the individual should be achieving, and how to achieve them are highlighted as being problematic. Appraisal should depend on regular and confidential discussion between trainee and supervisor at least three monthly, although this is happening infrequently, if at all, in many cases. In-depth knowledge of what is required of trainees is integral to the appraisal process. The supervisor should provide constructive advice on performance, skills, attitudes, and knowledge. Any areas of deficiency of training must be identified in order to suitably plan the trainee's future career. Guidelines for educational supervisors would be invaluable. It is also important to recognise that in order to be an efficient supervisor, designated uninterrupted time is needed.

MONITORING TRAINING

Each year the chair of the deanery specialty committee completes a formal record of progress for each trainee on behalf of the postgraduate dean. This is completed at the record of in-training assessment (RITA) review. This process received the heaviest criticism from the trainees studied. Confusion on the part of the committee as regards what is required of trainees was again the main source of difficulty. Confusion also centred on length and type of training that is creditable towards subspecialty recognition in CCH. Review panels should have the relevant knowledge of: (a) what goals the trainee needs to meet to complete their training; and (b) what the requirements of the Specialist Training

Authority and CSAC are, in order for these bodies to endorse training so that confusion does not arise.

Seventy per cent of trainees currently use portfolios on an informal basis as a focus of personal training. Confusion, however, centres on what they should contain. Formalising their use would help provide clear documentation of what areas of training have been completed or need to be addressed. Work has begun through the Royal College of Paediatrics and Child Health (RCPC) to provide clear guidance on what should be contained in a training portfolio, which should address these issues.

CONCLUSION

With the decreasing length of training, and the increasingly prescriptive requirements trainees need to meet in order to fulfil their training, there needs to be:

- A more efficient training process
- A system in place for the registration of subspecialty trainees
- A review of the number of whole time equivalent trainees required to fulfil consultant posts and the current number being trained
- Clearer guidance on the aims and objectives of training in CCH for both trainees and educational supervisors
- Identification and dissemination of the qualities of training deemed excellent through the structures of the RCPC and British Association of Community Child Health.

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