Archives of Disease in Childhood, 1986, **61**, 917–920

Personal practice

General professional training in community child health

L POLNAY AND E J MORE

University of Nottingham and Nottingham Health Authority

SUMMARY A scheme providing general professional training for doctors in community child health is described. The scheme covers three years and gives broad clinical experience in general hospital paediatrics, community paediatrics, psychiatry, and general practice. The aims of the scheme and service needs and future structure for our trainees are discussed.

Over 4000 doctors work within the community child health services in Great Britain.[1] In spite of numerous reports and working parties,[2–8] health authorities have generally been slow to implement any training proposals for doctors in community child health comparable with those provided for other groups of doctors. Yet the clinical content is broad, including primary and specialist services,[9] statutory obligations with respect to education and social services,[10] and the complex task of liaison within and across professional boundaries. The Nottingham scheme is designed to provide a three year general professional training in community child health. The scheme operates within the recommendations of the Forfar report[8] and covers a three year period. The first trainee was appointed in February 1984.

Aims of the scheme

These are as follows:

(1) To provide a basic training in paediatrics.

(2) To show the need for knowledge about the local community to understand better the problems with which its inhabitants present.

(3) To provide knowledge about the service networks that exist both within and outside medicine in the community. This knowledge needs to be quite extensive, involving health, education, social services, and voluntary organisations. The outcome of service integration and interprofessional working can only be achieved through such knowledge.

(4) To provide a long term perspective. Although we are concerned about short term outcomes where acute problems arise, the concept of 'fit for the future' embodied in the Court report[4] should underlie the work of the community paediatrician.

(5) To emphasise the importance of health education and preventive medicine and to develop personal skills in this area.

(6) To encourage initiative and innovation in community child health practice.

(7) To develop insight into the difficulties of child rearing and to establish rapport and empathy with parents and children.

Outline of the scheme

The scheme contains the following personnel.

(1) Senior house officer in paediatrics at the University Hospital, Nottingham, appointed for six months, which is split into two month sections in paediatric accident and emergency, paediatric medicine, and paediatric surgery or orthopaedics.

(2) Senior house officer attachment in Inner City Community Paediatric Team, appointed for one year.

(3) Senior house officer in adult psychiatry, appointed for six months.

(4) Trainee in general practice (arranged through the Nottingham Vocational Training Scheme), appointed for one year.

The scheme uses existing training posts, other than the new one year attachment in community child health, which is funded from the child health budget. This takes place within the Community Paediatric Team, which provides services to part of the inner city area of Nottingham with a population

aged 0–15 years of approximately 21 000. The whole team is linked to the University Department of Child Health. The team leader is a senior lecturer holding honorary consultant status. The organisation of the Community Paediatric Team is described elsewhere.[11] As well as the senior lecturer there are two lecturers, who have teaching and research commitments in the University in addition to their clinical responsibility in the community, two part time registrars (funded by the Regional Retraining Scheme), and the two senior house officer appointments.

The year in the community consists of three elements: supervised clinical experience in the community, attendance on the Nottingham University Day Release Course in Child Health, and a series of attachments to a wide range of other child or family centred resources. Table 1 shows the timetables of each of the two senior house officers, with rather more responsibility being given in the second six months.

The clinical experience consists of child health and school health services After a short introductory period of observation the work of the senior house officers is initially in parallel with the senior lecturer. The good clinic premises available enable two doctors to work in parallel so that the trainee has access to the senior lecturer for help with clinical problems. There is a weekly tutorial session at the end of one afternoon at which individual cases and general management issues are discussed. The trainees are encouraged to sit the Diploma in Child Health examination, and guidance on background study is given.

The Nottingham Postgraduate Course in Child Health has been running since 1976. It covers three terms of 10 weeks each. Term A covers the child and his illness, term B the child and his handicap, and term C the child and his behaviour. An average of 12 doctors from districts in the Trent region attend the course, coming from community child health, general practice, and hospital paediatrics. Information units and case histories augmented by slides are provided for each of the sessions and are read in advance. The course day consists of a discussion of the course units, which is usually led by a consultant, and often followed by practical demonstrations and visits—for example, to special schools. There is a multiple choice question paper at the end of each term and a research project is carried out by each course member over the year. These projects (a number of which have been published) are presented at an open meeting on the last day of each term. Each term is self contained so that the doctors can begin at the start of terms A, B, or C. In addition to the year course, there are also short skills modules on hearing/otorhinolaryngology, ophthalmology, and immunisation. Future skill related modules are planned in other areas—for example, developmental surveillance.

The attachments to other medical and non-medical services are largely completed in the first six months. These are summarised in Table 2. They have served to provide knowledge about other disciplines and promote understanding and cooperation between agencies.

The attachment to the adult psychiatric service is to a consultant with both hospital and community responsibilities. It is our belief that psychiatry is an essential component of the training of every paediatrician. Problems presenting in children are often related to difficulties in their parents and do not arise de novo. A senior house officer post in child psychiatry is not available to our trainees as previous psychiatric experience is regarded as necessary for the appointment.

After the year as a trainee in general practice the doctor will have experience of children within the three medical settings in which they are seen: hospital, general practice, and community paediatrics. This should provide balanced knowledge and appreciation of the service as a whole.

Table 1 *Senior house officer—general timetable*

	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
Morning:					
First six months	Primary schools observation/clinical practice	School clinic/ nursery classes	Postgraduate course and visits	Secondary schools	Visits
Second six months	Primary schools clinical practice	School clinic special school	Postgraduate course and project work	Secondary schools	Home visits
Afternoon:					
First six months	Clinical discussion/ primary schools	Child health clinic	Postgraduate course and visits	Child health clinic/ home visits	Visits
Second six months	Clinical discussion/ primary schools	Child health clinic	Postgraduate course and visits	Child health clinic/ home visits	Child health clinic

Table 2 *Summary of attachments to non-medical and medical services in the year's training, most of which are completed in the first six months*

Health
Dermatology
Ears, nose, and throat
Orthopaedics
Paediatric surgery
Ophthalmology
Chest clinic
Children's hearing assessment centre
Genetic counselling clinic
Child development centre
Growth clinic
Community nursing
Community health council
Child health unit administration
Health education department
Education
Classroom experience in primary and secondary schools
Special schools with community paediatrician:
Moderate learning difficulties
Severe learning difficulties
Physical handicap
Deaf
Partially hearing unit
Education welfare service
Schools psychological service
Social work
National Society for the Prevention of Cruelty to Children special unit
Area social services team
Residential children's home
Observation and assessment centre

Discussion

Several outcomes are possible after completion of the scheme. Most doctors will be expected to work within community child health. The need for doctors in community child health will continue, though more specialist skills are likely to be required of them as general practitioners and community nurses take on some of the primary care functions. Some doctors will enter general practice, which has become increasingly interested in child health surveillance and prevention.[12] We acknowledge, however, that, although our candidates in theory have satisfied the requirements for postgraduate training in general practice, further experience in adult specialties would be necessary. Other doctors may wish to undertake further training in paediatrics, community medicine, or other specialties.

The scheme as outlined operates on a full time basis. We are also attempting to provide an equivalent training for other doctors on a part time basis. We see this as an area for further expansion for the training programme.

The programme puts great emphasis on training as well as the service content. We feel this is essential if high standards are to be attained in clinical practice. They are necessary if the development of community paediatrics is to continue. Many children are admitted to hospital for largely non-medical reasons;[13] others are admitted for essentially preventable disorders or because of late diagnosis. We see community paediatrics as needing to address itself to these problems. Other developments might be a more community based service for handicapped children, paediatric home care services, and close working relations with general practitioners. Community paediatrics may also provide a more cost effective alternative to hospital outpatient care. (Tresidder J. Unpublished report.)

We recommend that each district should have training posts in community child health just as they do in other specialties. Appointments to career grade posts should be from those doctors who have completed this appointment or an equivalent training. The doctors in career grades (clinical medical officers, senior clinical medical officers, or consultant paediatricians in community child health) will provide the continuity of care of service while doctors in training posts will be appointed for fixed terms. One doctor in each district needs to carry responsibilities for training. Lastly, and essentially, adequate funds must be available to support initial training and further postgraduate medical education to maintain clinical standards.

We thank Professor David Hull, Dr Margaret Oates, Dr Norman Miles, Dr P Lane and Dr J Bilkhu, and all the doctors involved in the child health services in Nottingham. Typing was by Miss Lorraine Elliott.

References

1. Department of Health and Social Security. *Survey of community health service medical staff, England, Wales and Scotland.* London: DHSS, 1983.
2. Standing Medical Advisory Committee, Child Welfare Centres. *The Sheldon report.* London: HMSO, 1967.
3. Working Party on Child Health Services. *Towards an integrated child health service. (The Brotherston report.)* London: HMSO, 1973.
4. Committee on Child Health Services. *Fit for the future. (The Court report.)* London HMSO, 1976.
5. British Medical Association. Report of the working party on community health doctors. (The Preston report.) *Br Med J* 1979;**i**:503–4.
6. Report of a Working Party on Community Doctors. The Clarke report. *Br Med J* 1980;**281**:955–6.
7. Report of a Working Party on Career Structure and Training of Community Health Doctors. The Anderson report. *Br Med J* 1982;**284**:359–62.
8. Report of a Joint Working Party on the Training of Clinical Medical Officers in Child Health. The Forfar report. *Br Med J* 1982;**284**:637–40.
9. Davies LM, Bretman MD. What do community health doctors do? Survey of their work in the child health service in Nottinghamshire. *Br Med J* 1985;**290**:1604–6.
10. More E. Protection of children. In: Polnay L, Hull D. *Community paediatrics.* London: Churchill Livingstone, 1985: 336–47.

[11] Polnay L. The community paediatric team—an approach to child health services in a deprived inner city area. In: McFarlane JA, ed. *Progress of child health.* Vol 1. London: Churchill Livingstone. 1984:187–99.

[12] Royal College of General Practitioners. Reports from General Practice No 22. *Healthier children-thinking prevention.* London: Royal College of General Practitioners, 1982.

[13] Wynne J, Hull D. Why are children admitted to hospital? *Br Med J* 1977;**ii**:1140–2.

Correspondence to Dr L Polnay, Memorial House, General Hospital, Standard Hill, Nottingham NG1 6HA, England.