Royal College of General Practitioners

Royal College of Paediatrics and Child Health

Learning together to improve child health

A joint position paper on inter-professional training by the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health

May 2016

Foreword

General Practitioners and Paediatricians sit at the heart of health care for babies, children and young people. There is strong conviction that some of the traditional boundaries between these professionals must be broken down to provide a high quality health service for the child and their family with the right doctor who has the necessary expertise. Poor health outcomes for children in the UK, the demand for service redesign, and the imperatives for change in training demand multi-professional and interdisciplinary collaboration.

This paper seeks to lay out a vision for Learning Together. This aligns with the policy in both Colleges where recognition of the need to put the child first is shared. The case for change is spelled out and mapped against current experience and training strategies. Opportunities for joint training exist across the spectrum ranging from the recognition and management of the sick child to the young person with chronic or complex problems or the growing number who are challenged by mental health difficulties. This initiative embraces training in medical education, academic training and research. All doctors working with children must be familiar with the issues around safeguarding.

Putting this vision into practice requires collaboration, a willingness to change and imaginative solutions. Many are implemented without need for complexity or disruption of other important, established training pathways. Learning Together is achieved in both health environments, through integration of training posts and with other healthcare professionals. It need not be restricted to the clinical environment and must encourage a whole population approach.

Reviewing current initiatives and some of the exciting pilots going on around the UK, the immediate advantages are clear. Trainees who have been paired, report great advantage and mutual benefit across many clinical and nonclinical areas of competency. Shared planning and educational supervision has fostered closer relationships between doctors who have completed their training and between their multi-professional teams. Learning Together offers great opportunities in Quality Improvement.

If you train together, you will work together. That is a vital part of our Colleges' vision for high quality care for children.



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Exemplars

There are some excellent examples of the strength, potential and practice implications of training together. These are shown in the text.

Our shared vision

The Royal College of General Practitioners (RCGP) and the Royal College of Paediatrics and Child Health (RCPCH) share a common vision that all children and young people should receive high quality care, delivered according to need by trained and competent professionals, in a timely manner and in appropriate settings.

Acute illness, long-term care, disease prevention and health promotion all demand child and family centred standards of care with good medical leadership in the multi-professional team. Paediatricians and General Practitioners are the key medical providers of care for infants, children and young people. One message is clear, we must work together and clearly this demands a focus on shared needs in education and training.

To aid the delivery of this shared vision, the two Royal Colleges have come together to set out some common educational principles and to illustrate good examples of shared learning that will encourage and inform the future development of more integrated approaches to training and assessment between the two disciplines.

RCPCH understands that all paediatricians should have a good understanding of child care in general practice and have opportunities to learn from primary care colleagues. In the future, many paediatricians will work more closely with colleagues in primary care, providing some services hitherto restricted to either the hospital or the primary care setting. Similarly, RCGP is clear that one reason for the extended training period in GP is the need to enhance the expert skills of GPs in caring for children and young people. There is a clear vision that all trainees in general practice, when the training period allows, should have opportunities to learn from paediatric teams.

Innovative, collaborative pilot schemes underpin our vision that shared training can be achieved successfully and should become an essential part of the curriculum for the Child Health specialist and the General Practitioner. This will support improved standards of child health care and foster links and mutual working breaching the primary/secondary care boundary. This should in time extend to embrace common objectives in continuing professional development.

Meeting the challenges in child health

The two Royal Colleges strive to ensure that specialty training remains current, relevant to the needs of patients and promotes the development of a highly skilled, professional, capable and adaptable workforce.

Despite the high quality of current specialty training in the UK, the NHS has been criticised for providing relatively poor health outcomes for the childhood population and for inadequate provision in many aspects of children's and young people's healthcare (ref Wolfe 2011). There is consensus that good integration between services in primary and secondary care will enhance service delivery, inform health service design and improve quality of care to children and their families.

There is also recognition that these service changes provide the opportunity for GPs, paediatricians and other healthcare professionals to learn together in innovative ways. This demands better integration between specialty training programmes and greater multi-professional training opportunities between the key disciplines involved in delivering child health, an issue recently highlighted by the Shape of Training review.

The well-being of the infant and child is the birthplace of adult health. A wealth of evidence now shows that the healthy foetus, newborn and child enjoy better health as an adult. RCPCH sets out to *lead to the way in children's health* and has a number of areas of current focus emphasising the promotion of good health in the service supported by a multi-professional team.

The RCPCH has set out its vision for improving child health (ref vision document) with 5 key objectives:

1. Prevent children and young people from becoming unwell, act early and intervene at the right time
2. Tackle health inequalities
3. Reduce the number of child deaths
4. Make the NHS a better place for children and young people
5. Involve children and young people in decision making on health and wellbeing issues

Meeting the challenges in General Practice training

Although all GP trainees must demonstrate child health competences at relevant points through training, and are assessed on these in the MRCGP examinations, less than 25% of GP trainees undertake a paediatric placement during their three-year training programmes (Facing the Future, RCPCH 2011) and rely on other less targeted opportunities to gain relevant child health experience. A concern about the lack of paediatric training opportunities within GP specialty training was highlighted in the Kennedy Report in 2010:

"Despite the high number of children coming into their surgeries, many GPs have little or no experience of paediatrics as part of their professional training. This means that, technical competence notwithstanding, many GPs lack the confidence to assess and treat children effectively, something that comes from specialist training and experience."
Kennedy, 2010

In response to this and other evidence relating to GP training, the RCGP has put forward proposals to extend GP specialty training from three to four years. This enhanced four-year programme has received support from the governments of all four nations, although implementation remains subject to funding. A key priority within the proposed improvements is to improve GP skills and experience in child health, with the recommendation that specialist-led training in child health is provided to all future GP trainees.

Critically, meeting this aim does not require all GP trainees to undertake a traditionally structured post in hospital-based paediatric service. Within the variety of placements that exist within GP training programmes, there are <u>many</u> opportunities for child health training to be delivered. In addition to hospital-based paediatric posts, these include placements in

emergency, community and primary care settings as well as integrated training posts. Considerable opportunities exist to create innovative child health learning programmes within a range of workplace settings.

Meeting the challenges in Paediatric training

Children and their families expect high quality care provided locally whenever that is possible combined with available and accessible expertise concentrated in larger centres. The key in training is to ensure that the doctor, the multi-professional team and the service are centred around children's health needs.

Much of current postgraduate specialty training programmes focuses on training paediatricians in a hospital-based system of care. This is essential for the paediatric hospital based specialist and sub specialist but must now be combined with a broader view. Paediatricians gain insight and experience of care in the community during their compulsory Community Paediatric placements and a number will go on to specialise in this field The child's access to the expert hospital based paediatrician does not need to be dependent upon their attendance in hospital. The development of a multi-professional team at the centre of which is integration and connection between hospital and community provides significant opportunities for innovation in training. Many of the children and young people seen in secondary care emergency departments and out-patients could be managed safely within a community or primary care setting (Saxena 2009 and Milne 2010).

Collaborative learning in hospital

GP trainees are highly valued members of the team when part of the paediatric workforce. They bring a different perspective to the acute service, often with excellent consultation skills, a holistic approach to the family and a good understanding of maternal and adolescent health issues. In a paediatric unit in the West Midlands, GP trainees have led teaching sessions which include post-natal depression, adolescent sexual health and epilepsy in young adults.

Bearing in mind current NHS reforms and the shift towards healthcare closer to home, future general paediatricians are likely to spend at least some of their time working in 'out-of-hospital' settings (RCPCH 2011). Training programmes and career pathways will need to be reconfigured accordingly.

Trainees in Paediatrics and Child Health need to learn how to take a whole-population view of the health needs of children and young people, regardless of the setting of care. They should recognise the care pathways that cross the traditional boundaries between primary and secondary health care, and understand the importance of horizontal integration with social care, education and other agencies and sectors. It is vitally important that children receive the right care in the right place with the right expertise. This understanding will improve the delivery of care and support to the individual child and their family. It will also inform the future leaders and managers in our Health Service. Integrated training between General Practice and Paediatrics and Child Health will provide knowledge, understanding,

new perspectives and a platform for new ways to deliver care, design the service and ensure quality.

There are increasing numbers of examples of excellent integrated working between hospitals and GPs, but this should now become universal practice.

Young people, parents and carers challenge us:

- Why should a child have to attend a hospital for routine follow-up?
- How can we have better access for advice to the right doctor with the right expertise?
- Telephone, email hotlines, and video links are not used enough.
- My GP finds it difficult to get expert advice when we need it.
- We went and waited for an appointment to be told that all results were normal.
- When we go into hospital or we come out, the whole team should know about our child's needs and what we are doing to help her.
- I think, whichever doctor I see they should know about me.

Our shared experience

Inter-professional Education occurs when 'two or more professions learn with, from and about each other to improve collaboration and the quality of care' (CAIPE, 2002).

Learning from General Practice skills and experience

The GP's clinical care of children and young people is underpinned by a specific set of strengths: highly developed generalist knowledge and expertise, an in-depth knowledge of the child's family and social background in the context of their community, a holistic and comprehensive approach, an understanding of presenting features of clinical problems at an early stage in their evolution and continuity of care over a long period of time.

GPs work in supportive and collaborative teams within their practice as well as engaging directly with a wide range of allied healthcare professionals and secondary care colleagues. GPs can also facilitate the vital interactions with education, social services and the voluntary sector that underpin the continued health and care of children and young people.

Through their role as generalist clinicians, GPs develop a number of expert professional skills, including the ability to elicit concerns, to manage undifferentiated problems, to deal with diagnostic uncertainty, to identify and prioritise problems with patients and carers, to manage multiple morbidity and to lead and co-ordinate complex care.

Sharing expertise means children do not need to go to hospital

A hospital in the South West and the local General Practitioners have improved service quality for selected children who previously would have been reviewed in a paediatric outpatient appointment. Rather than seeing the child in hospital, a consultant may offer structured written advice. If this is acceptable to the family and their GP, the child is saved a hospital visit. Clinical management is led by the GP and the structured replies are shared with practice colleagues. Other paediatric and GP teams have introduced similar initiatives.

Learning from Paediatric skills and experience

The consultant General Paediatrician is a general specialist who holds a deep understanding of the science principles underpinning the promotion of child well-being, the management of disease or disability, and the acute or longer term management of complex problems. The majority of paediatricians are general specialists in child health familiar with the challenges faced by the child from foetus to the young person.

The General Paediatrician working in the hospital or in the community should offer a holistic and integrated approach to the management of disease, advice to the child and family, and where necessary longer term follow-up and support. With strong connections back to GPs and other primary care professionals much of this ongoing and input and support can occur within the GP practice. This key aim in training and service delivery is to some extent thwarted by the artificial boundaries in place between professions and sectors with the shared aims of improving child health.

Paediatrics also offers a broad range of training across 17 subspecialties. These range from neuro-disability to neonatology and from specialist community child health to metabolic medicine. These services are typically centralised to provide concentration of expertise and training opportunities. Most are organised around managed clinical networks, offering the opportunity for local delivery of care within a wide variety of settings. The expertise within these networks should be available to children, their families and other members of the multi-professional team, most importantly the child's general practitioner. The General Paediatrician, working in close partnership with the child's general practitioner is extremely well placed to support and facilitate this.

Our shared values and priorities

Both Royal Colleges support the *Principles of Inter-professional Education* proposed by the Centre for the Advancement of Inter-professional Education (CAIPE). In summary, we believe that inter-professional learning between our professions should:

- Focus on the needs of children and young people, their families and communities to improve their quality of care, health outcomes and wellbeing, keeping best practice central throughout all teaching and learning

- Apply equal opportunities within and between the professions and all with whom they learn and work, acknowledging but setting aside differences in power and status between professions

- Respect individuality, difference and diversity within and between the professions and all with whom they learn and work; utilising distinctive contributions to learning and practice

- Sustain the identity and expertise of each profession, presenting each profession positively and distinctively

- Promote parity between professions in the learning environment, agreeing 'ground rules'; and

- Instil inter-professional values and perspectives throughout uni-professional and multi-professional learning.

[Adapted from www.CAIPE.org.uk]

Our shared educational priorities

The two Royal Colleges agree that all healthcare professionals with responsibility for the health of children and young people must be adequately trained to deliver high quality care. The following section highlights some of our shared educational priorities in relation to our two disciplines.

Caring for the acutely ill child

Acutely ill children need prompt access to care delivered by front-line clinicians who have the appropriate skills for assessment, diagnosis, treatment and continuing care. Both Paediatricians and GPs must, therefore, develop the necessary skills to assess and diagnose the acutely sick child, to initiate appropriate investigations, to support self-care when indicated, and to provide age-appropriate treatment and advice to the child and their carers. Training should prepare future leaders for the challenge of ensuring appropriate and rapid access to paediatric specialist services when a child needs this.

Recognising the child or young person with serious illness

The report *Why Children Die* (RCPCH, 2014) found that failure to recognise the severity of illness, by both specialists and generalists, was one of the key avoidable factors in the national audit of child deaths. Specifically, failures were identified in understanding the importance of history, clinical examination, interpretation of physical signs, recognition of complications, clinical supervision and prompt referral and treatment. Opportunities for supervised training in the recognition of serious illness in children and young people are therefore essential for both Paediatricians and GPs.

Both Colleges aim to ensure that their trainees can demonstrate the key competences required to identify and respond appropriately to those children who may have serious conditions, as well as the skills to put in place adequate safety-netting plans for review and to involve more experienced colleagues within appropriate timescales.

Providing seamless care to children with complex and long-term conditions

Increased numbers of chronically disabled children are looked after at home[1]. Integrated care for those with long-term medical needs requires a multi-professional team approach that spans primary and secondary care. This requires a cohort of doctors with a greater degree of inter-professional understanding, who can co-develop patient pathways and whole population approaches that maintain team-based care close to home and provide access to both generalist and specialist care when it is needed.

1 Kennedy I. Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (2010) Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119446.pdf

In addition, strong professional relationships will enable GPs and Paediatricians to actively co-ordinate the challenging period when a young person with long-term illness or disability is transferred into adult services. Paediatricians and General Practitioners are likely to be the key leaders in the multi-professional team, its future way of working and its impact on service design and configuration.

Enhancing health promotion and well-being

Access to community-based antenatal care and healthy lifestyle advice for parents is key to improving longer-term health outcomes in children. GPs and Paediatricians must understand each other's roles and working environments in order to develop more effective family interventions for the prevention and management of potentially avoidable or reversible health conditions, such as obesity or alcohol misuse, which can adversely impact on long-term health and impair life chances.

Improving safeguarding

GPs and Paediatricians require training to enable them to fulfil their safeguarding roles, including recognising patterns of neglect and abuse, supporting at-risk parents and families, sharing information and referring in a timely manner to health or social care colleagues, responding effectively to inter-agency requests and giving relevant contextual information at case conferences.

Supporting the dying child and their family

Increasingly, palliative care services are enabling children and young people with life-limiting illness to be cared for in the community setting. By working together, Paediatricians and GPs can maximise the opportunities to enhance the specialist palliative care provided to younger patients through the course of their illnesses, also enabling them to choose whether to die at home. GPs in particular are well placed to give additional support, care and advice to siblings, parents, carers and other family members during difficult times and to provide ongoing bereavement care.

The recent evolution of palliative care as a subspecialty within paediatrics and child health has promoted this understanding of integrated care. In parallel, there has developed a body of understanding, knowledge and expertise which should be available to children and their families and also to the healthcare professionals striving to provide comfort and support in these difficult circumstances.

Improving young people's mental health and resilience

The UK has the highest rate of recorded self-harm in Europe; in most cases self-harm is a coping mechanism for emotional distress, but it is also a risk factor for suicide. Sensitive assessment and close liaison between GPs and Paediatricians in respect to young people who have self-harmed, or are at risk of suicide, will enable the provision of more effective strategies to mitigate risk.

Shared training in the recognition of common mental health problems in younger people and the promotion of mental well-being will enable GPs and Paediatricians to provide opportunistic and targeted mental health promotion to their patients. Working together, and alongside local mental health colleagues, GPs and Paediatricians can use their collective expertise to develop strategies to enhance mental resilience in their local population.

Developing youth-friendly services

Tomorrow's GPs and Paediatricians must have the skills and capability to contribute to the design of health services that children and young people can access easily for issues regarding their mental, emotional, physical and sexual health. This requires these doctors to learn and apply the practical measures that can improve accessibility to children and young people and to involve them in their healthcare. For example, ensuring that appointment booking systems within practices meet the needs of school age children and take into account the particular needs of disabled children and young people.

Improving research and quality in child health

In addition to improving clinical outcomes, inter-professional training should also encompass research skills, critical appraisal, working with data and supporting child health research activity. Scientific understanding and research must cross any current barriers between hospital, community and primary care settings whenever there is a need for further research to inform child health practice. There is also an opportunity for joint learning in quality improvement in relation to the care of children and young people, through the development of shared quality improvement projects that span traditional healthcare boundaries. Many of these projects will take innovative approaches to the use of data, and will focus on a whole-population view of improving care.

Research inspired by GP training in paediatric emergency department

Duncan, a GP trainee, spending time in ED noticed small number of frequent attenders. In one year 8% of attenders accounted for 23% of all paediatric ED attendances. Review of the same children in their primary care practice found that 70% were also seeing their GP frequently. Children largely fell into 2 cohorts: recurrent viral infections (65% of attendances); chronic illness (26% of children). This insight has suggested new ways of exploring the very important issue. [Hockey DJ, Fluxman J, Watson M, et al. Arch Dis Child Published Online First: October 7, 2013]

Transitional care into adult services

Improved expectations and better life expectancy in children with long-term and sometimes very complex healthcare needs presents a challenge to general practice, paediatrics and adult services. The GP and the paediatrician are crucial in this situation. Future training must encourage understanding of these problems. Services for the young person and young adult are improving. The transition for the adolescent in moving between services should not be allowed to disrupt care, cause upset, or generate additional stresses or difficulties for the family.

Meeting the training needs of tomorrow's doctors

Delivering doctors with generalist expertise in child health

The majority of children and young people in the UK receive their everyday physical and mental health care from doctors with generalist clinical skills, most commonly in the urgent care or primary care environments. The relatively low prevalence of serious illness in the general population means that that some specific aspects of child health training may be more cost-effectively delivered in secondary care specialist environments. For example, a specialist paediatric placement can provide trainee doctors with exposure to large numbers of sick children in a safe, supervised environment within a relatively short period of time.

Although the majority of hospital-based paediatric placements result in exposure to a range of acute paediatric problems, including children with serious illness, this experience alone is not sufficient to train doctors in managing the wide range of health issues encountered in the community or primary care context. The prevalence, nature and presentation of conditions encountered in the primary and secondary care populations vary significantly – as do the investigations and therapeutic options available to the doctor. As a result, the diagnostic and decision-making frameworks the doctor must adopt to operate effectively and safely in these two environments are significantly different.

Studies of GP training in the hospital sector point to its strengths but also highlight gaps in the experience it provides to aspiring generalists. In the West Midlands, 98% of GP trainees who had completed a 4-6 month paediatric specialty placement reported that they had confidence in managing a child presenting with diarrhoea and vomiting, 64% reported confidence in managing a child with failure to thrive, and 56% felt confident in managing a child with recurrent abdominal pain. However only 19% felt able to manage a child presenting with behavioural problems – as very few had encountered children presenting with these common problems in their secondary care training posts[2].

Hence it is important that tomorrow's generalist doctors have adequate opportunities for interdisciplinary training across the primary and secondary care environments and that they gain appropriately supervised exposure to the full range of young patients.

Our shared principles for high quality training

Both Royal Colleges believe that to be most effective, inter-professional learning should be seeded throughout undergraduate and postgraduate training. It should encourage the learners' active participation in planning, delivering, applying and evaluating their learning, based on adult learning principles. Doctors training in the two professions should be given opportunities to learn with, from and about each other; training activities should, therefore, be designed to facilitate interaction and promote the free exchange of ideas. Learners should be encouraged to compare roles and responsibilities and to share their developing expertise and experience, while working towards shared educational objectives.

2 Walker V, Wall DW, Goodyear HM. Paediatric training for GP VTS trainees: are we meeting the requirement? Education in Primary Care (2009) 20(1): 28-33

Educational and clinical supervisors from the two professions should work together to plan, deliver, and assess shared workplace-based learning activities, structured around agreed curriculum objectives. This will ensure that learning is focused on the trainee's needs and relevant to their longer-term career pathway. Supervisors should use formative forms of assessment to guide and enhance learning in practice, with recognised tools such as supervised learning events (SLEs). It is therefore important that consistent assessment criteria are developed for shared learning activities and that these shared experiences give the learners from both disciplines the same credit towards their professional qualifications as more traditional uni-professional training activities.

Ideally, each trainee professional should gain experience of working in the other's environment, in order to gain the greater common understanding required to be able to better connect care in the future. A flexible approach to delivery should be adopted, focused on outcomes, so that training can be tailored locally to needs of the local population and configured to the particular circumstances of the service, practice or locality.

To ensure relevance to patient need and to facilitate the consideration of safety aspects, patients, parents and carers should also be involved in the planning, delivery and evaluation of inter-professional education.

Trainers in general practice and in paediatrics and child health should be familiar with the training needs of doctors on both career pathways. These trainers should be able to contribute to training, assessment and professional development of both sets of trainees as well as those training in other child health professions.

Delivering specialty training curricula

General Practice

GPs provide a high standard of care to the children and young people they serve. The RCGP curriculum requires that every GP specialty trainee must demonstrate his or her competence in child health before entry into independent practice. Relevant competences are described in the curriculum and assessed in all three components of the MRCGP assessments, through externally moderated exams and a continuous process of workplace-based assessment.

It is recognised, however, that the current three-year training programme places significant limitations on the amount and variety of child health experience available to GP trainees. Although all GP trainees gain supervised child health experience in primary care, only a minority undertake a placement in a specialist paediatric service. Many trainees gain relevant experience in non-paediatric hospital placements (such as A&E), although a significant proportion of trainees' experience in child health is limited to the opportunities available to them within their primary care training practice. The development of GP Child Health hubs, where paediatricians are running outreach services alongside GP and other primary care colleagues within GP practices, will strengthen the child health learning opportunities for GP trainees in their primary care training practice.

The RCGP has proposed that in future, within an extended and enhanced training pathway, opportunities for specialist-led child health training should be provided to all GP trainees. This requirement could be achieved through a range of delivery mechanisms, tailored to local circumstances – examples include trainees undertaking curriculum-focused placements in hospital-based or community-based paediatric services, children's A&E and unscheduled care services, integrated training posts, and shared training programmes based in general practices or other community child health services.

Shared training opportunities with paediatricians located in general practice settings could be particularly valuable for GP trainees in the latter stages of training who wish to consolidate their existing skills, those with limited previous paediatric experience (e.g. those who had no Paediatrics or A&E placement in their Foundation or GP ST1-2 rotation), and those who have a specific training need relating to child health that has been identified in partnership with their educational supervisor.

This integrated policy should form the foundation for shared opportunities in career development, training and CPD for GPs who have completed their training. Although many GPs will remain as generalists, some will develop extended roles in both the commissioning, development and delivery of child health services, through the acquisition of credentials and other additional training.

Training is only the beginning

Regular Consultant and General Practitioner meetings are a formidable place for mutual learning. A Paediatrician reports how she has used reflective practice to define the CPD achievements from time spent with colleagues in General Practice. Seeing children in this setting has informed her clinical practice, service development, and has also resulted in a joint research initiative.

Paediatrics and Child Health

The current programme of training in Paediatrics and Child Health has 3 levels. All who complete training are skilled in the care of infants, children and young people and have achieved generic capabilities in in areas including communication, management, leadership and evidence-based practice. In level 3, a majority complete training in general paediatrics, often with an area of special interest. Those who choose to work in a paediatric subspecialty, enter training in a National Grid through competitive entry across the UK.

Exposure to training in General Practice is variable. Some have experience in this area during Foundation training, in some programs there was an opportunity for brief periods in GP and recent pilot programs of joint training initiatives for trainees in the two Royal Colleges have been successful. All paediatricians should understand the principles and practice of integrated health care between community-based and hospital-based teams. Clearly essential when helping and supporting the child with complex or chronic disease, this is equally necessary when the child has an acute problem.

Such integration is crucial in health promotion and dealing with the modern epidemic in areas such as obesity and mental health. This is also a key area in quality-control, service design and future developments. Clearly paediatricians and general practitioners are central to any health care planning for children.

Some paediatricians, largely amongst those working in general paediatrics or community child health, will deliver care in the community setting. This has been successfully introduced in a number of models of care and the need to blur the current boundaries is a subject of current emphasis. These paediatricians have specific training needs and these are well addressed by joint training initiatives.

Are you ready to be a consultant? START assessment

In RCPCH all trainees complete a near final year, formative assessment of readiness to become a consultant. This includes assessment of clinical decision making, team leadership, service management, use of research, complex care planning and so on. Each trainee receives feedback on strengths and learning needs. A new scenario will ask about setting up an email advice line for General Practitioners, hoping to explore current provision, new ideas and the key issue of the stakeholders who should be involved.

Putting our vision into practice

This section describes some exemplars and models of good practice we have identified in inter-disciplinary training relating to child health:

Learning together in general practice and paediatric environments

Trainees in general practice and paediatrics will gain from training in each other's environment. The **Learning Together** pilot model involves the creation of a series of 'Child Health Training Clinics' within GP practices that provide relevant shared training experiences. These clinics are jointly run by the GP registrar (GPST3-4 level), placed within the training practice, and a senior General Paediatric trainee (ST6-8), visiting from the local secondary care provider. In this model, the two doctors work in the same room seeing patients together (i.e. a 'shared surgery). The clinics can be based around a series of patient appointments but may also include 'virtual MDTs' (i.e. discussion about the patient without them physically being in the clinic) and other educational activities.

The following notes explain some of the key arrangements that underpin the model:

1. The GP trainee (GPST3-4) provides continuity throughout the year, and offers the practical knowledge in how to access the GP record, GP prescriptions and how to request investigations and involve other team members and community-based services.

2. Data from the pilot scheme suggests that a fixed pair of Paediatric trainee and GP trainee get most out of doing 4-6 clinics together. The model is, however flexible to different local constraints and training needs and due to the nature of acute hospital rotas, a number of different Paediatric trainees may rotate into the clinic over a 12 month period. Although not ideal in terms of continuity, it offers larger numbers of paediatricians the opportunity to experience this type of clinic, and will also offer the GP trainee different angles and perspectives on paediatrics and child health from the different Paediatric trainees they work with. Getting this balance between continuity and diversity is key and this needs to be negotiated on a local basis.

3. The focus of the clinics is around a sharing of ideas and learning in both directions. The GP trainee leads the consultation for some patients (e.g. where there is an established relationship with the patient or where the focus is on something that the GP trainee has a particular area of developing expertise - e.g. consultation skills; sharing the management plan; uncovering ideas/concerns/expectations; problem prioritisation, etc.). In other consultations, the child health related experience of the Paediatric trainee allows them to be the natural lead. This balance helps to foster a culture of peer-learning.

4. Although the primary outcome is educational, these clinics do reduce referrals into the local secondary care provider and hence potentially have a positive financial impact for Clinical Commissioning Groups looking to reduce OPD referrals. A full economic analysis has been done looking at various outcomes and is available elsewhere.

5. After clinics, the trainee pair is encouraged to discuss patients seen with the GP trainer supervising clinics, and where possible, the wider members of the practice team - including other GP trainees, nursing staff and, other members of the Child health team, in an MDT-style meeting. This allows sharing of clinical information and clinical continuity, but also allows for cascading of the learning that occurred between the trainee pair as a result of the consultation. It also allows for discussion for other patients (the “virtual MDT”) and topics that have arisen, adding to the educational value of clinics.

6. Some of clinics could take on a specific focus, aligned to work that the practice particularly needs to do (e.g. targeting a specific patient group, such as children with asthma or constipation). This type of activity would be of great value to the children, and would provide learning on a number of different levels (e.g. clinical management of the condition, public health aspects, health promotion, case management, working with primary care nurses, etc.). It may also have an impact on hospital attendances and admissions for long-term conditions.

7. There is an opportunity for the trainees (in both professions) to support other child health related CPD learning for other members of the practice (other GPs, practice nurses, health visitors) as well as developing their experience in taking a more preventative, ‘public health’ perspective on their child health work. There might also

be the possibility for joint home or school/college visits and other project or quality improvement work.

8. Supervision and senior support for these clinics would come jointly from the GP trainer (who has responsibility for the GP training) and the Consultant Paediatrician (who has responsibility for the Paediatric training).

9. Governance arrangements need to be formalised – model agreements (e.g. SLA & Honorary Contracts) have already been developed for existing pilots which can be adapted.

10. The relationship between the GP trainee and the Paediatric trainees opens up opportunities for the GP trainee to access hospital-based learning opportunities that they otherwise may not have.

The evaluation of the first large scale pilot Leaning Together programme supported by UCLP demonstrated the value of GP and Paediatric trainees working and learning together. In addition to gaining experience and building competences in consultation and clinical skills *and* clinical knowledge these clinics gave the trainees the opportunity to develop new insights and perspectives into the challenges and opportunities of seeing children and young people within a primary care setting. A notes review from of patients with four common conditions (fever, asthma, eczema and constipation) seen in primary care by GP trainees before during and after participating in LT clinics showed a statistically significant improvement in guideline adherence during and after clinics suggesting that this learning actually has a positive impact on clinical care. The pilot has now been extended to South London and the learning themes are being explored in more detail. This will be reported later this year.

A further pilot being developed in London is the Programme for Integrated Child Health (PICH – see www.pich.org.uk). Initially begun as a programme for Paediatric trainees 2014-15 to develop skills in integrated child health, it has extended to GP trainees 2015-16. This programme is run alongside clinical training for Paediatric registrars and GP ST2-3 trainees. Trainees are paired across specialty and work together addressing various themes with the aim of developing skills and competences in integrated child heath. As part of the programme they attend monthly seminars on these themes, have a PICH mentor and have to develop several projects aligned to the themes with the ultimate goal of working in an integrated way across primary and secondary care.

Learning together in paediatric services

Naturally we can begin with recognition of the sick child. Appreciation early in the course of disease of potentially life-threatening illness is a considerable challenge across the age spectrum of paediatric care. Appropriate management of emergencies and direction of children to high dependency or intensive care can be life-saving. Clinical experience, supported by focused learning and familiarity with systems designed to aid detection of the sick child allow acquisition of skills and some confidence in this area. Much can be learned of a child's condition through observation and short-term review. These are essential skills for GPs working with children in primary care.

Collins emphasised the importance and training potential of community-based paediatrics. This is a massive opportunity. Clearly it ranges from the long term needs of the child with complex problems to safeguarding team, neuro disability and to health promotion. Child mental health, social care and education should also be embraced within training in respect of care delivery, service design, and specific skills (e.g. Safeguarding Conference; Statementing; Adolescent care; Transitional care into adult services).

Child well-being and good health promotion demand familiarity with normality across childhood. The practitioner should understand the range of child growth and development. Learning related to disease prevention and maintaining good health would gain from training in a variety of settings.

Paediatrics also offers opportunities to gain experience in multi-professional team working, ethics and the law, and the care of the child and family when the child is dying.

We also need to remember that we are training the future leaders, managers and educators and key role that trainees play in quality improvement. Better understanding of what the different sectors can offer a child and the family can only help improve service design. This is a key element of what we must do to improve child mortality.

Learning through integrated training posts

Integrated training posts (ITPs) are now widespread in GP training programmes and could potentially be expanded to include trainees in other disciplines. Based on evidence from the GMC annual national trainee survey, they are extremely popular with trainees as a way of providing GP contextualised learning opportunities across a range of specialty areas. GP Directors and Deans are likely to use this model to deliver a large proportion of approved training posts should four-year GP training be implemented.

Joined up clinical supervision

One group have found that a regular open meeting provides quality control and has become a lively place for imaginative innovation. The meeting is open to paediatric and general practice supervisors and to trainees. New ideas are explored, trainees are helped to achieve their objectives, and it is a forum for related discussions - interested outside groups including commissioners and public health have attended on occasion.

The contractual basis of these posts is a standard 10 session GPC/COGPED GP Specialty Trainee contract based in general practice. This might consist of seven clinical and three educational sessions per week and must be compliant with the European Working Time Regulations (EWTR). The clinical and educational sessions in the post are divided between the 'base' general practice and another clinical service, based on mutually agreed arrangements and the learning plan of the trainee.

There is a wide range of such posts in place at the moment – examples of specialties and services offering placements include:

- Child health/paediatrics
- Community and Adolescent Mental Health Service (CAMHS)

- Community mental health
- Dermatology
- Diabetology and metabolic medicine
- Gynaecology
- Homeless medical services
- Learning disability services
- Medical education
- Substance misuse services
- Sexual and reproductive health
- University/student health; and
- Urgent care and assessment.

The trainee's work plan varies between posts. A typical post might consist of:

- Base practice – 3 or 4 clinical sessions and two educational sessions (e.g. tutorials and day release courses)
- Specialist service – 3 or 4 clinical sessions (activity depends on nature of service) + one educational session (e.g. unit-based teaching)
- If the post involves out-of-hours shifts, the timetable is adjusted according to EWTR principles. A large proportion of acutely ill children present out of hours so that shifts out of hours are essential to gain experience of assessing the acutely ill child.
- Some integrated posts include study towards an additional qualification, but in general the focus is on integrated care and cross working between general practice and the specialist service.

Workplace based assessments are undertaken in both settings (proportionately). The clinical supervisor in the specialist service is required to meet GMC defined standards for a clinical supervisor and the training environment must meet the deanery's learning environment standards. The posts are registered within the GP specialty programme with the GMC.

In relation to future GP training, a range of other options to increase capacity in primary care have been proposed; for example, an innovative **hub and spoke** model of training, whereby a trainee is based in a training practice (the 'hub') but gains experience for periods of time within multidisciplinary teams in other suitable practice-based or community-based services (the 'spokes'), as their growing experience and independence allows. This would provide great opportunities for multidisciplinary learning and would help to address capacity issues. However, such a model of training would require a change in current training practices and robust arrangements would need to be put in place to ensure that the trainee has access to adequate clinical supervision and that the working environment is well-resourced and appropriate for specialty training.

Learning with other healthcare professionals

Training programmes offer many opportunities to learn with a wide range of healthcare workers who care for children and young people, including doctors in many specialties. Much of the care provided to children in the NHS is provided by nurses, health visitors, social workers, pharmacists, physiotherapists and many others. Learning arises directly from clinical contact with these professionals – such as with midwives delivering antenatal and postnatal care, health visitors visiting children at home, or with specialist nurses managing

young patients with chronic diseases. Many hold skills which should at least be understood by the doctor and not infrequently acquired in the context of multi-professional learning. Gaining an understanding of the way the interfaces work between all these professionals is a key educational outcome for inter-disciplinary learning, as is understanding the roles, responsibilities and decision-making processes of non-clinical administrative and management staff.

Team working is just as important in primary and secondary care, although the team structures and relationships may be different in the two environments. Trainees need the opportunity to understand not only the specific role they play within a clinical department but also how they relate with the other staff – both as a member and a leader of a multi-professional team. Multi-professional working also provides opportunities for learning around different approaches to research. Doctors, and their training programmes, have not traditionally had opportunities to gain experience and competencies in qualitative research, ethnography and co-production. Finally, there are opportunities for trainees to join other healthcare professionals in organised joint educational activities, learning together through in-house or locality based programmes.

Learning through a whole population approach

This model aims to improve experiences and outcomes for children and their families by taking a whole population approach, drawing paediatric expertise and community support into primary care, where children's and families' needs are known and can be managed well.

Based on a GP Child Health Hub model built on clusters, or networks of practices, it connects professionals from primary, secondary and tertiary care to encourage:

- Shared learning and development
- Co-creation and co-production approaches to service design
- A whole person approach to caring for families
- Patient, parent and professional confidence in the provision of child health services in primary care settings
- A whole-population approach to the care of the hub's children and young people; notably through providing the opportunity to develop real, locally led, preventative approaches

The model supports the training and education of primary care professionals, including GPs, practice nurses, health visitors, mental health workers, social workers and paediatricians, by enabling them to work and learn together within a GP Hub. Practice Champions, who are children, young people, parents, carers, grandparents and others, can be recruited, trained and supported to support other parents and families through the early years (the year pre- and post-birth) and, through the development of youth champions, peer-support can be offered for young people with long term conditions.

The shared experience of training and learning can only encourage better communication and working relationships between the trained members of the health care teams across the boundaries. It will create better healthcare deliverers and better leaders and should

generate improvement in health care outcomes. "The carers who trained together, will carry on working together"

Learning in non-clinical environments

The increasing emphasis on care in the community means that much direct care is now provided in patients' homes, which provide a range of different learning opportunities. Within child health, GP practices, community mental health clinics, GP Child Health Hub MDT meetings, baby clinics, children's centres, youth clubs, health visitor home visits are just some of the activities and settings where trainees have gained learning experiences during integrated child health training posts. With thought and planning there is every chance that these sorts of opportunities could be extended much more widely.

Clearly no trainee is going to experience all these environments. It is important however that there is appreciation of the breadth of the multi-professional team and insight into the massive variety of places where health and health promotion are important.

Opportunities to engage with children and young people outside the healthcare facility should be encouraged. Trainees should take the opportunity to follow a child through their care pathway.

Learning through quality improvement

Over the past 20 years there has been increased awareness of the need to improve quality across health care in the UK, driven by a need to improve safety, effectively translate evidence into practice, achieve cost-efficiencies, reduce health inequalities and meet the changing expectations of patients.

Case based discussion and Quality Improvement

Ian, a paediatric trainee, saw a child in outpatients with toe walking and referred to physiotherapy. In work place based assessment, he decided with his supervisor to explore the patient pathway with his trainee buddy in general practice. The pathway was very "bumpy" and a QI project followed leading to clear routes for referral for expert physiotherapy assessment.

Tomorrow's GPs and Paediatricians share a common need to demonstrate an academic and evidence based approach to their work. The benefits of quality-improvement activity in relation to child health are potentially huge and include greater patient safety, improved health outcomes, increased holistic care, safer and more cost-effective prescribing and referrals, and an evidence-based approach to practice, plus a move to a more integrated, multi-professional workforce.

Evidence from the Health Foundation has shown that active learning strategies which combine quality improvement education with practical work are more effective for the development of quality improvement skills than didactic or passive training methods (Health Foundation 2012). Further evidence has shown that the most effective educational

approaches to support quality improvement are likely to involve opportunities for the learner to gain knowledge in quality improvement methodology, to engage in practical experience of quality improvement within a supportive learning environment, and to receive targeted feedback and mentoring as required.

Quality improvement initiatives from the Royal Colleges, Health Education England and the Academy have demonstrated:

- Quality Improvement based on general principles embedded in local services can be effective and save money.
- There are important and apparently simple principles and methodologies which can greatly enhance QI ideas, methods and implementation.
- Ideas for QI come from a variety of members of the healthcare team. The best ideas come from the trainees.

RCGP has proposed the introduction of a Quality Improvement Programme as part of an enhanced GP training programme. This will consist of three aligned components:

1. A package of education, support and mentoring on clinical leadership, change management and service improvement.
2. The completion of trainee-led QI project work, founded on local service need.
3. Assessments providing meaningful information for the learner through quality feedback, as part of a broader, low-burden, integrated assessment package.

This closely reflects the current programme in both Royal Colleges. There is a drive to involve all trainees expecting them to take responsibility for planning and undertaking a practical quality measurement and improvement project, with mentoring and educational support provided by a range of complementary activities including participation in peer learning groups and structured supervised learning events (SLEs). It is expected that trainees will have the flexibility to choose and design their own personal project within community-based practice, in wider healthcare communities and in secondary care. Elements of the programme are being piloted.

Quality Improvement very readily provides opportunities for personal innovation and creativity in trainees in GP or paediatrics. We would encourage joint QI initiatives and must be partnered by trainees from both Colleges. It is an opportunity for trainees to work with professionals in a range of other disciplines, to make a significant difference to the care of local populations of children and young people.

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