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A Framework for Paediatric Emergency Medicine Training and assessment in ST4-6

Introduction
To attain a CCT in Emergency Medicine, trainees must demonstrate a level of competence in managing children who present to an emergency department setting.
It remains the case that the majority of children seen in emergency departments in the UK are seen in all age emergency departments and not stand-alone paediatric facilities and therefore it is important that EM practitioners are confident and competent in the management of children at the time of their CCT- recognising that most, but not all, will maintain these skills throughout their career.

Setting
Children make up somewhere between 20 and 25% of emergency department attendances in generic all age E.Ds.
RCEM recognise the differing and variety of set ups between regions with competing requirements of trainees' time, for example the need to spend one year in a major trauma centre which may be adult only.
The options below therefore are designed to provide different options for paediatric exposure in ST4-6 which HOS and TPD can draw on when considering rotations within their own regions.
It is also recognised that this is not exhaustive and other ways of maintaining paediatric exposure may be devised and may be more appropriate to the particular setting trainees are in.
The endpoint is that all trainees should complete their CCT with up to date, relevant exposure to paediatric patients and are confident and competent in their management as assessed by FRCEM, WBPA and sign off by their educational supervisor and ARCP process.

Options

Option 1
Ensure trainees have at least 20% of their hours rostered to work within the paediatric area of the department and where possible ring fence this as protected whilst working in an all age ED. Trainees should ideally spend no more than 1 year at HST in an "adult only" ED.

Option 2
Where 2 of the 3 years at HST are spent in an adult only ED then consideration should be given to a short paediatric secondment (eg 3/12) in a paediatric centre to ensure continued paediatric exposure. No trainee should spend all 3 years at HST in an adult only department.

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Even when a trainee spends a year in an adult only post and it is accepted that direct exposure to paediatrics is not a key requirement for the year, the trainee should agree some paediatric e learning or other CPD to maintain their skills and knowledge.

Option 3
Where trainees are spending the majority (at least 2/3 years) at HST in all age emergency departments, but where ring fenced time is not always possible -allow / encourage trainees to use some of their educational development time to develop their paediatric skills. This could be done as a day a week for a fixed period during a rotation, or, as a block of time rostered away from their main department in a dedicated PED area.

Progress in the PEM part of the curriculum should be reviewed at the end of ST5 especially if a trainee is moving to an adult only EM for ST6. If it is identified that a trainee has needs which cannot be met in the final rotation, then a local solution should be sought to ensure sign off of PEM competencies before the end of training

For all trainees
Consideration should be given to other opportunities for enhancing paediatric skills and knowledge especially if specific gaps are identified- eg attending paediatric fracture clinics, spending time based on a Paediatric Assessment Unit etc where the outcome is the achievement of a specific competency agreed with the educational supervisor.

Curriculum
Care of children is covered in a number of elements of the new curriculum:
SLO 5 is all about the care of children and has a requirement for formative assessment in challenging or complex cases. This must include paediatric resuscitation cases (see below) as well as feedback on the assessment and management of concerning presentations.

SLOs 2, 4, 6, 7 and 8 can relate to adult or paediatric practice and therefore a proportion of WBPAs logged as evidence against these SLOs would be expected to be related to the assessment and management of children under the age of 16 years

SLO 6 has a specific competency around **paediatric sedation**

SLO 3 is titled adult resuscitation, but the requirements are that all of the domains are evidenced in both adult and paediatric patients- these domains are: airway management and ventilatory support, fluid management and circulatory support, management of all life-threatening conditions including peri-arrest situations, transfer of the resuscitated patient to definitive care, care for ED patients and their relatives and loved ones at the end of life, Lead and support resuscitation teams.

Work-based training and assessments
As with ST3, it is vital that the trainee has clear learning objectives whilst in post. The educational contract outlines the minimum objectives expected. Additional learning experiences can be added to and recorded in the training portfolio and strengthened by some documented reflective learning.

All of the SLO's (except SLO one) have an expectation that they cover paediatrics within the breadth of the SLO. HST's in EM therefore need access to a sufficient cohort of paediatric patients in order to achieve this.

There is no fixed requirement for the numbers of children to be seen, though as a proportion we would expect between 20 and 25 % of cases seen to be children under the age of 16 and this should be reflected proportionally in the number of WBPA and evidence provided. It is suggested that the midpoint review looks at the number of WBPA achieved and cases logged to assess the trainees' access to paediatrics so that this can be addressed before the end of the placement.

These WBPA should be presented and signed off at entrustment level 4 for all of the essential components highlighted above. **Some paediatric evidence should be provided for all SLOs 2-8.**

Additionally we would recommend at least one of the 3 ELSE's per year was based in paediatrics for a minimum of 2 of the 3 years of HST (so a total of 2 out of 9 ESLEs) *or* that a minimum 4 of the 9 ELSE's have a proportion of paediatric cases included in them. Trainees should not come to the end of ST6 with no paediatric cases in their ESLEs.

Trainees should highlight early in their placements if they feel that they require specific support for paediatric components of the curriculum so that this can be addressed with their educational supervisor.

Recommended reading

- Paediatric Medicine, Illustrated Textbook of Paediatrics by Lissauer and Clayden
- Paediatric Orthopaedics, Children's Fractures- A Radiological Guide to
- Safe Practice by Thornton and Gyll
- Paediatric Minor Injuries/ Minor trauma in Children by Davies
- Paediatric Emergency Medicine Secrets, Selbst & Cronan
- Paediatric Emergency Medicine, Cameron, Jelenek et al.
- Self-Assessment Colour Review of Paediatric Emergency Medicine, Brennan, Lassa, Ludwig
- Website: Don't forget the Bubbles
- RCEM Learning

Courses and formal teaching to attend

HOS should review the training offered at regional training days and consider Paediatric medical, Paediatric trauma and Paediatric surgical themed days to ensure curriculum coverage. There is an annual national PEM trainee conference which, while specifically aimed at subspecialty PEM trainees may be of interest and relevance to other HSTs.

Educational contract

It is strongly recommended that each trainee signs an educational contract with their Educational supervisor within two weeks of starting in post including their plan for paediatric exposure in that post. This would help identify any potential issues in delivering the CT's educational needs. Any issues not agreed at that time should be discussed with the TPD.

Sign off

Before sign off at level 4 for paediatric SLO we would expect that both the training faculty feel the trainee is at level 4 for all paediatric relevant SLO's **and** the trainee feels confident to practice independently in these domains. If they don't feel confident, they should have the right to seek further paediatric exposure.