

# Paediatrician of the future: Delivering really good training

A guide to the RCPCH principles for  
postgraduate paediatric training and how to  
apply them within local training programmes

Version 1.0  
October 2020

This is Version 1.0. As the document is updated, version numbers will be changed and content changes noted in the table below.

Version number	Date issued	Summary of changes

This information is correct and up to date at the time of publication. © RCPCH 2020

# Table of Contents

<b>Foreword</b>	<b>4</b>
<b>Executive summary</b>	<b>5</b>
<b>1. Introduction and background</b>	<b>7</b>
Introduction: Training the future paediatric workforce.....	7
RCPCH philosophy for training.....	9
Workforce context.....	11
<b>2. Training principles</b>	<b>13</b>
Principle 1: Every patient encounter is a learning opportunity.....	14
Principle 2: Complex case management provides rich learning opportunities.....	16
Principle 3: Clinical reasoning skills are explicitly taught within training.....	18
Principle 4: Patients and families are heard.....	20
Principle 5: A biopsychosocial approach is applied at all times.....	21
Principle 6: Leadership skills are developed and nurtured.....	23
Principle 7: Training time and learning opportunities are prioritised within the workplace .....	25
Principle 8: Educational supervision is high quality and provides consistency.....	26
Principle 9: Morale and job satisfaction are improved.....	28
Principle 10: Assessment is used as a learning tool.....	30
Principle 11: Progression and length of training are personalised and flexible.....	31
<b>3. Application in existing settings</b>	<b>33</b>
Learning in the paediatric ward environment.....	33
Learning in the paediatric Emergency Department environment .....	35
Learning in the neonatal environment.....	37
Learning in the child development (community) service.....	38
Learning in the clinic environment.....	41
<b>4. Development and progression</b>	<b>44</b>
Using patients and parents as educators.....	44
Promoting learning in settings other than hospitals.....	46
Having an increased focus on mental health.....	47
Health promotion is an integral aspect of patient management.....	48
Better integrated working with primary care.....	49
A specific focus on the health needs of young people (aged 11-25).....	51
Utilisation of simulation and technology-enhanced learning.....	52
Teaching human factors.....	54
Shared learning with other professions and disciplines.....	55
<b>Appendix 1: RCPCH Progress+ curriculum</b>	<b>58</b>
<b>Acknowledgements</b>	<b>59</b>

# Foreword

The future, it is never as far away as you think it is and whenever we think about the future it is sometimes helpful to think about what has gone before.

So here goes. Shape of Training ... three simple words which have been spoken of on many occasions since Professor Greenaway first produced his report back in 2012. In fact, by the time the RCPCH rolls out its new training programme fully in 2023, 11 years will have passed since the Greenaway report. Many of you would be forgiven for thinking that this moment would never come and yet here we are.

Again, looking back I would like to take this opportunity to remember one of my predecessors, Dr Simon Newell who was VP for Training & Assessment back in 2012 and was first tasked with taking this forward. Many of you will know that Simon was a Consultant Neonatologist in Leeds and his premature passing in 2016 was felt by all in the paediatric community and I would like to dedicate this moment to him.

It doesn't feel that long ago since we launched the new paediatric curriculum, Progress which is held in high regard and was in itself the major prelude to the new Paediatric Training Programme. As I am sure you can appreciate many many hours of work have got us to this point and I would very much like to thank all of those involved in the process from the College staff, my fellow clinician colleagues, our children and young people and to all of those who we consulted with and who have taken the time to not only give us their feedback but who have embraced this exciting opportunity for paediatrics.

The Future Paediatrician document is the culmination of all of this work. It is the basis on which really good training programmes can be constructed to get the very best out of our trainees and the 11 principles will guide you to do just that. COVID-19 has no doubt changed the landscape for all of those who work and train in the medical profession but if nothing else it has reminded us that we are all flexible, versatile, resilient and above all able to adapt at speed to any challenges presented to us and which is why I know that together across the four nations of the UK the future of paediatric training is in safe hands.

**David Evans**  
**Vice President for Training and Assessment**

# Executive Summary

**The paediatrician of the future will face different challenges to those of current consultants; healthcare is changing and the paediatric training programme needs to adapt in order to prepare doctors for this.**

RCPCH Progress, the new paediatric curriculum for excellence (RCPCH, 2018), has provided a starting point for making these changes. The new principles for paediatric training presented within this document, in conjunction with the new training programme structure and guidance being introduced fully by 2023, building on RCPCH Progress to become RCPCH Progress+. High quality paediatric training will prepare doctors to understand and support the holistic needs of children and young people, families and populations. Paediatricians will have an improved understanding of mental and physical health; health promotion and the social determinants of health; and will be skilled in the care for children and young people from birth to the age of 25 years, as appropriate and outlined in the NHS Long Term Plan (2019).

The principles outlined in this document are written for Schools of Paediatrics to describe how they can deliver the very best training. This can begin with the resources already in place but needs to evolve and adapt in order to be most effective, so that training adequately prepares paediatricians for their future roles.

This document is designed as a resource guide, with ideas, illustrations and case-studies drawn from examples of current practice across the UK. Some may be straightforward to implement locally; suggestions are given of how to best work within current constraints and maximise the opportunities for every trainee to access the training they want and need. Some examples may be more aspirational but are designed to be useful prompts for those responsible for designing training, as they consider where and how changes to the training programmes should be targeted in future.

There are four sections within this document:

## Section one:

Provides background on the **RCPCH philosophy** which underpins the approach to programme and curriculum design and outlines the rationale for the development of the RCPCH Training Principles.

## Section two:

Describes the **RCPCH Training Principles** that should underpin all paediatric specialty training, supported by indicators that the principle is being applied, and examples further illustrating each principle in practice:

- Every patient encounter is a learning opportunity
- Complex case management provides rich learning opportunities
- Clinical reasoning skills are explicitly taught within training
- Patients and families are heard
- A biopsychosocial approach is applied at all times
- Leadership skills are developed and nurtured



# 1. Introduction and background

## Training the future paediatric workforce

This document sets out the requirements for a training programme that meets high standards, thereby making explicit the expectations and providing ideas for improvement for Schools of Paediatrics who are designing programmes of training. This document, and the training activities suggested within it, are supported by the [RCPCH Trainee Charter](#) which outlines key elements to improve the paediatric training experience.

Postgraduate training programmes will build upon the learning experience gained from both medical school and at foundation level. There is an expectation that medical schools and the Foundation Training programme will continue to improve exposure to paediatric experiences, providing students with a good grounding in the fundamental skills and knowledge required for the management of children and young people, prior to them entering the paediatric training programme. In order to train clinicians effectively and efficiently, and provide a high-quality service for paediatric patients, it is crucial that all medical school curricula incorporate a comprehensive range of paediatric elements, and provide students with effective paediatric placements. This would benefit not only those clinicians moving into paediatric training but also other disciplines, particularly General Practice and also Emergency Medicine, including many surgical specialties. Further guidance on paediatric experience at undergraduate level is provided within the RCPCH Undergraduate Curriculum.

The revised paediatric training programme is now divided into two levels. The purpose of the first level of paediatric postgraduate specialty training, known as 'core training', is to ensure that all paediatricians are equipped with the skills, knowledge and expertise required to deliver care for infants, children and young people within a range of settings. Trainees will continue to build on this learning throughout the second level of their training, known as 'speciality training', developing further in their paediatric sub-specialty (eg General Paediatrics, Neonates etc) as well as enhancing their generic skills, knowledge and behaviours. They will use their core experience in order to undertake holistic practice which supports and treats the whole child or young person wherever their encounter takes place. The RCPCH Progress+ curriculum (Appendix 1) articulates the standard required by the end of both core and specialty training.

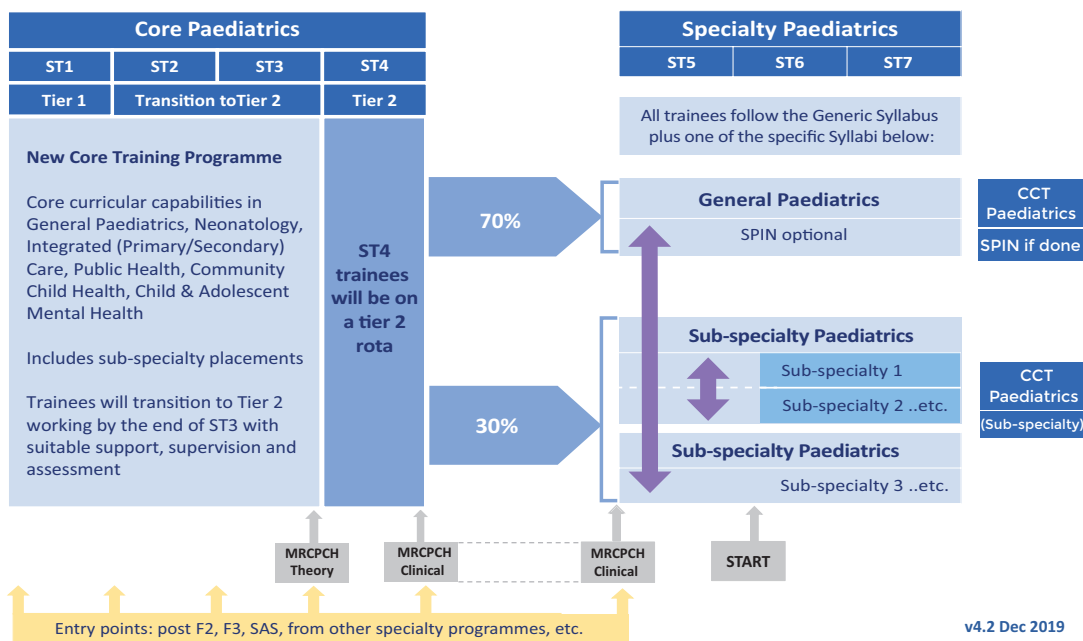
## Keeping children and young people at the centre of everything we do

RCPCH &Us is a children, young people and family network, working with over 2000 young patients, their families and friends across the UK. Through the work of RCPCH &Us we keep children and young people at the centre of everything we do, supporting their voice to inform, influence and shape the work of RCPCH.

We are guided by the United Nations Convention on the Rights of the Child, particularly article 12 which encourages children and young people’s voice in decision making and article 24, providing them with the best health care possible.

In the development of The Shape of Paediatric Training, we have actively sought the voice and views of children, young people and their families. You can find out more about RCPCH &Us at [www.rcpch.ac.uk/and\\_us](http://www.rcpch.ac.uk/and_us)

**Figure 1: Paediatric training pathway**



Within the Paediatric workforce a key challenge is to deliver more inclusive core training. The nature of health care has changed, with an increasing focus on long term and complex conditions, where multi-disciplinary and self-management approaches are more central to care. Training must adapt to meet the changing population needs; the inclusion of child and adolescent mental health and public health capabilities are now seen as vital, along with increased emphasis on leadership behaviours and safety through well-developed clinical reasoning. Paediatricians must deliver integrated health care for children and young people. Integrated care should be seen as a different way of thinking about planning and delivering care: based on people – not buildings or organisations; and based on outcomes – not procedures or activity.

Along with this is the need to address the needs of young people (distinct from children, young people are defined as being between the ages of 11-25 years, as outlined in the NHS Long Term Plan, 2019). This is necessary because of the changing needs of the paediatric population and the recognition of the importance of delivering ‘developmentally appropriate healthcare’. This requires the development of more general paediatricians who can manage the complexity of these patients in all age groups in liaison with specialists across all healthcare boundaries, in particular: interfacing with primary care and mental health; supporting health in the home and school; and focusing on young people as they transition to adult life.



Schools of Paediatrics are required to design training programmes which take account of current and future workforce requirements and give trainees access to a range of settings and experiences, enabling and supporting them to meet the RCPCH Progress+ Learning Outcomes (see Appendix 1). It is assumed that training in the acute environment, as it currently exists, will continue, but in future will provide a broader experience for the trainee, supporting learning opportunities within the full range of settings.

To explore in more detail how this can be achieved, this document describes:

- The RCPCH training principles, which apply to and should underpin all paediatric postgraduate training programmes.
- How those principles can be applied within existing training settings, supported by the Whole Population Approach (see 'RCPCH Philosophy for Training' below).
- Activities that can be used to enhance training, building on what happens now and linking to the vision set out in:
  - [The NHS Long Term Plan for England \(2019\)](#)
  - [The 'Healthier Wales' publication \(2018\)](#)
  - [The Health and Social care delivery plan for Scotland \(2016\)](#)
  - [Northern Ireland Quality 2020](#)
  - [Quality Improvement Framework for Wales](#)

This document seeks to capture and illustrate good practice currently taking place across the UK, and articulate how learning should build on this, and evolve over the next ten years. The RCPCH Progress curriculum was the first step towards implementing this new approach, and it is anticipated that application of the principles outlined within this document will further encourage a positive, flexible and supportive training experience for all paediatric trainees. All case studies are mapped to the RCPCH Progress+ curriculum, indicating the domains they may support, and possible assessment opportunities.

Delivering excellence in training comes with multiple challenges, and RCPCH acknowledges that not all of these can be solved by and through Schools of Paediatrics. Whilst continuing to work with Schools to set high standards and share innovative practice across the UK, the RCPCH also puts responsibility on the Government, HEE and NHS providers to address the wider needs of the paediatric workforce, for example lobbying for better conditions of work.

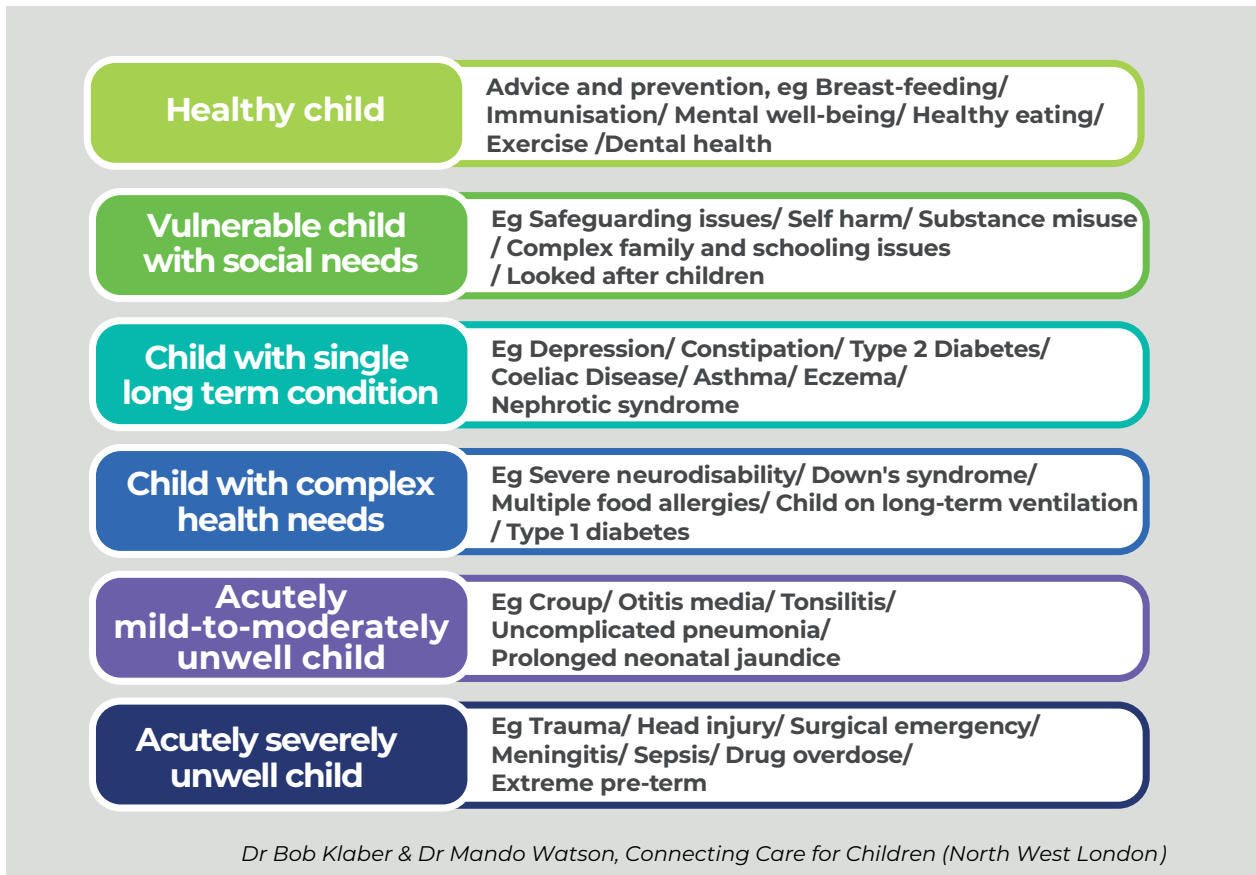
## RCPCH philosophy for training

The philosophy underpinning the training pathway and curriculum for paediatrics is that of putting the child or young person and their wider context at the heart of all clinical practice. The RCPCH Progress curriculum moved away from a disease-based structure and instead advocated a 'Whole Population Approach' that focused on symptoms, and prioritised the needs and complexities of each individual patient and their family.

The Whole Population Approach identifies six broad patient segments, shown below. These should be used to inform the patient pathway. There are a number of themes which would

cut across many or all of the segments, such as safeguarding, mental health, educational issues around school, and transition. Throughout all placements within the paediatric training pathway, trainees should be encouraged to identify opportunities to develop their expertise in management of patient in all segments, and their families, and these common themes.

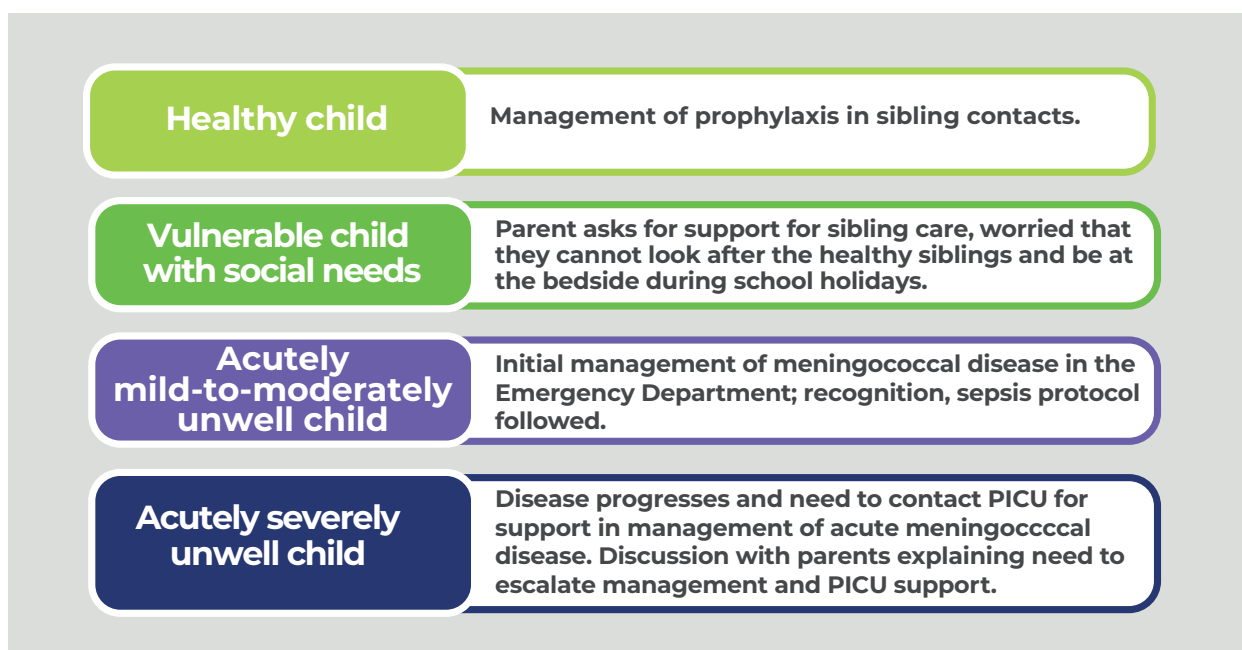
**Figure 2: A Whole Population Approach: Patient Segments in Child Health**



Whilst some placements may give trainees exposure to patients in some segments more than others, there is still the opportunity to interact with some children and young people in most or all segments in every setting. Trainers should support trainees in thinking laterally, considering how each of these segments would apply within any given environment.

The following example illustrates this in the context of Paediatric Intensive Care Medicine. Examples in section 3 demonstrate how this philosophy can be applied in all training settings (ie acute/wards, accident and emergency, neonates, community and clinics). Further case studies throughout the document also incorporate varied examples that illustrate how these segments are important to consider in all settings.

**Figure 3: A Whole Population Approach worked example: PICM Meningococcal disease**



## Workforce context

The Shape of Training report, 'Securing the future of excellent patient care' (General Medical Council, 2013) calls for a flexible and adaptable workforce that is trained to meet the changing population needs. Whilst adapting to these changing patient and service needs, paediatrics is facing significant workforce challenges which impact both on training experience and patient care, including:

### Rota gaps:

To meet the [Facing the Future standards](#), providing safe care for children and young people and keeping up with rising demand, the RCPCH has calculated that we would need an additional 850 whole time equivalent (1104 headcount) consultants and that approximately 150 more doctors must be recruited into ST1 training posts each year for the next five years.

### Workload pressures:

Heavy workloads remain an issue, although there are some welcome signs of improvement in this area. Since 2016 the proportion of trainees who say they worked beyond their rostered hours on a daily basis, has halved (from 18.3% to 9.1%).

### Service provision:

The balance of service provision/training has shifted towards service provision because of unfilled rotas and patients with increasingly complex medical conditions. This needs a long term, sustainable, multidisciplinary solution to enable trainees to train and prepare adequately for life as a consultant.

### **Flexible working patterns and choice:**

37.7% of paediatric trainees are now working less than full time (General Medical Council, The state of medical education and practice in the UK 2018). We need to be a modern, forward thinking and “family-friendly” specialty that allows for flexible working, including Out of Programme (OOP) and Out of Programme Pause (OOPP), where possible.

### **Protected time for trainers:**

Trainers have variable time to provide excellent clinical and educational supervision. The RCPCH supports a [framework for Educational Supervisor accreditation](#). It is important that trainers and supervisors understand the roles they are performing and feel valued in them.

The principles within this document are designed to ensure paediatrics provides consistently high quality training for all junior doctors within the specialty, which will go some way to addressing these issues. Therefore, it is vital that NHS Employers, Deaneries/Local Education and Training Boards (LETBs) and Trusts are committed to supporting Heads of Schools in enacting these principles in full.

## 2. RCPCH Training principles

This section outlines the key underlying RCPCH principles of excellent training:

1. Every patient encounter is a learning opportunity
2. Complex case management provides rich learning opportunities
3. Clinical reasoning skills are explicitly taught within training
4. Patients and families are heard
5. A biopsychosocial approach is applied at all times
6. Leadership skills are developed and nurtured
7. Training time and learning opportunities are prioritised within the workplace
8. Educational supervision is high quality and provides consistency
9. Morale and job satisfaction are improved
10. Assessment is used as a learning tool
11. Progression and length of training are personalised and flexible

For each principle, an explanation is provided of what the RCPCH deems to be an acceptable standard that every training programme should be providing. This is followed by examples indicative of good practice, which are designed to help Schools of Paediatrics judge whether they are meeting the stated principle. Each principle is also supported by a range of practical case studies drawn from real working environments, serving as further prompts for Schools looking for opportunities to embed and promote the principle.

Additional suggestions for implementation and development of the principles are provided within sections 3 and 4.

# Principle 1: Every patient encounter is a learning opportunity

## Schools should develop a faculty that encourages learning from each and every patient and family encounter

*“It is helpful to have lists of opportunities to become involved in which improve access to educational opportunities rather than having dead time. One example has been that we have had a list of children whom locum consultants had asked for follow up for. When registrars have had normal days and the ward is well staffed, they have been able to access this list and do ad hoc phone consultations with parents, deciding if children could be discharged, needed further investigation or management, or needed to be seen face to face. This has increased trainee involvement in outpatient work which is often put on the back burner as inpatient work is seen as the priority.” Trainee ST4*

Every patient and family encounter should be approached as a learning opportunity. Trainees, working hard to deliver a service, are also developing themselves as paediatricians. They should be directed and encouraged to engage with those presentations that will provide the greatest relevance to their training requirements and also need to be reminded that there is something to learn from every patient they see. The trainee should also have the ability to allocate time to debrief and reflect with the trainer on these encounters. The trainee must take ownership of these learning activities but will benefit from guidance by their trainers.

### Examples indicative of good practice:

- Trainees and Supervisors routinely discuss learning outcomes before and after outpatient clinic, and at the end of the ward round, the trainees should ask ‘what did I learn from this case and how could I have done better?’
- When ordering an investigation, the trainee actively considers the risks and benefits for the patient and family and can access advice from senior colleagues.
- When trainees encounter a well child (eg a baby check), they should consider the role of the paediatrician in health promotion opportunities.
- Rota designs give trainees opportunities to follow the patient journey rather than just getting a snapshot of their care.
- Trainees routinely discuss communication techniques with their Supervisor around breaking bad news.
- Trainees regularly use cases to teach medical students, foundation trainees and more junior trainees, both ad hoc (eg on a ward round) or through presenting a case during handover.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
1.1	As a way of amplifying learning around critically unwell children, the consultant makes use of the most acute cases, eg pneumonia or septic arthritis, and directs trainees to related high-quality e-learning resources and evidence-based literature.	CbD Reflection	4. Patient management 11. Research & scholarship
1.2	The trainee assesses babies with prolonged neonatal jaundice and discusses the cases each week with the consultant. Each case is used to explore common issues around breast-feeding, normal infant bowel habits, perinatal maternal mental health and the role of the health visitor in supporting families.	CbD Reflection	4. Patient management 5. Health promotion & illness prevention 11. Research & scholarship
1.3	Trainees consider which imaging reports and investigations are useful to flag for the x-ray meeting as teaching cases and not solely presenting for clinical discussion. These examples can be used to teach the approach to ordering investigations, to consider how to balance risks and benefits of investigations and develop an understanding of the practicalities of the imaging, explaining the investigation to patients and families and knowing how to interpret findings.	CbD Reflection	4. Patient management

## What children and young people say:



We would like you to think about all the hidden health needs for both us as the patient and our family. This includes hidden conditions, the hidden impact on our parents and carers and the services which are hidden from us that could really help.

We had a parent group who created a #HiddenHealth<sup>[1]</sup> toolkit that you can use, that gives a list of questions for doctors to think about when working with patients and families.

\* [www.rcpch.ac.uk/hiddenhealth](http://www.rcpch.ac.uk/hiddenhealth)



#voicematters

## Principle 2: Complex case management provides rich learning opportunities

### Schools should develop faculty that encourages breadth of learning from complex cases

Within paediatrics, trainees can learn from different types of complex cases. Trainers should make these opportunities accessible to trainees and encourage their understanding of the complexities of paediatric assessment and care.

One important example of this is safeguarding, which is an opportunity to learn holistic child health, integrating multiple clinical skills. In safeguarding medicals, clinicians have to take into account the whole picture, thinking about public health, the multidisciplinary team (MDT) and social issues. It is an exemplar of holistic clinical activity; trainees should be encouraged to understand the linkage between different perspectives and how that translates to other aspects of paediatrics.

The skills learnt from managing a medically complex child with severe disability or a severely unwell child in an intensive care setting are different, but equally important.

#### Examples indicative of good practice:

- Trainees take part in a shadowing opportunity to see non-acute safeguarding cases, eg shadowing a social worker, nurse, midwife or health visitor who is undertaking safeguarding work.
- Medically complex cases are now more prevalent on wards and need to be supported in and out of hospital. Trainees are given responsibility for ward round reviews, discharge planning meetings and following these patients up outside of the hospital setting.
- Trainees work with CAMHS on cases such as eating disorders, drug overdose in the context of family psychosocial dysfunction, and challenging behaviour.
- Trainees are given the opportunity in the child development centre to participate in a comprehensive review of patients with severe neurodisability.
- Trainees are confident in using research to inform evidence-based practice, referring to guidelines, standards or other literature.
- Trainees are encouraged to share their learning from complex cases with their colleagues.

#### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
2.1	The trainee sees children and families in the acute setting, and considers the whole social background. For example, a child with a pneumonia is seen acutely, and is noted to have severe dental caries. On further questioning, the mother tells the trainee she has three other children and is struggling to cope. The trainee links in with the health visitor, the GP and the social worker to provide appropriate support.	CbD MiniCex Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention 9. Safeguarding



	Case study	Evidence	RCPCH Progress+ domain
2.2	Palliative care represents an opportunity for rich learning. A child with a life limiting condition is seen on the paediatric ward with an intercurrent illness. The trainee takes the opportunity to review what support is being offered to the family (carers in the home, local nursing services, respite, social care support, voluntary agencies/charities) and considers what other support may be available to them. The trainee also reviews the advance care plan and arranges a meeting between the consultant and parents (and child if old enough) to update this.	CbD MiniCex Reflection	4. Patient management 6. Leadership & team working 10. Education & training
2.3	A weekly MDT meeting is held where two - three of the most challenging cases are discussed. Presented by trainees, cases are selected if they provide diagnostic, managerial or safeguarding challenges, or simply have a really good learning point. The session is very well attended with consultants from different specialities, any trainees who are free, and multiple other members of the MDT. This allows for brainstorming of ideas and sharing of learning which is great for trainees and for patients!	MSF CbD MiniCex	4. Patient management

## What children and young people say:



It is really important to us that doctors see the whole person in front of them, not just a medical thing that needs fixing. Please remember to talk to us about how we are feeling and coping (mental health) and share with us apps that help us to track our medicines and emotions like the ones in the NHS Apps Library<sup>[1]</sup>. Also think about who else can help us locally from charities or support groups for our conditions or supporting things like poverty.

\* [www.nhs.uk/apps-library/](http://www.nhs.uk/apps-library/)



#voicematters

## Principle 3: Clinical reasoning skills are explicitly taught within training

### School faculty should encourage trainees to develop their clinical reasoning skills by applying the methods of clinical reasoning to create a differential diagnosis

Clinical reasoning is a process by which clinicians collect cues, process the information, come to an understanding of a clinical problem, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process. Simply put, it is an intellectual process leading to a ‘working diagnosis’ and a clinical management plan.

Clinicians should encourage trainees to develop a range of clinical reasoning techniques, such as pattern recognition and formulation and challenge of differential diagnoses.

#### Examples indicative of good practice:

- Trainees are encouraged to consider a differential diagnosis for each patient they assess and to present evidence that helps refute or confirm these.
- Trainees are given the opportunity to assess a wide range of common conditions to improve their pattern recognition abilities.
- Trainees get exposure to clinical cases that demonstrate pathognomic signs and symptoms.
- Trainees always keep an open mind and consider a wide range of differential diagnoses, but equally have the confidence and competence to make a diagnosis.

#### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
3.1	The trainee presents a case on the ward round. The consultant pauses after the history and asks the team to suggest a differential diagnosis and discuss the key elements of the examination to support or refute these first ideas. The consultant then points out the clinical reasoning that underpins the discussion before asking the trainee to continue with the presentation.	CbD MiniCex Reflection	2. Communication 4. Patient management 10. Education & training
3.2	On the ward there are a number of patients with asthma; some are very similar and some are slightly different. At the end of the ward round, the consultant has a reflecting learning conversation with the team to explore these patterns and signpost how people can build up their own internal library of patterns on the basis of their experience and existing knowledge.	CbD MiniCex Reflection	2. Communication 4. Patient management 10. Education & training
3.3	The consultant signposts when a particular finding almost guarantees a certain diagnosis. For example, the combination of short stature, webbed neck and increased carrying angle in a female suggests Turner syndrome and cases when it does not.	CbD MiniCex Reflection	2. Communication 4. Patient management 10. Education & training

## What children and young people say:



It is good when you use your skills to help us understand what is going on, eg a young person with cerebral palsy and limited speech likes it when they are talked to directly and when the consultant emails before with questions and information. A child with epilepsy liked it when they got a copy of the brain scan which was drawn all over by the doctor to explain what happens. A young person said about how the doctor used easier words and did a drawing to explain what was going on.



#voicematters

## Principle 4: Patients and families are heard

### Schools should develop faculty that encourage and promote person-centred care

Patients and their families should form the centre of learning for trainees. Too often, patients and families are seen as passive recipients of care; instead they should be seen as a resource to support their self-management, to support each other and to be experts in their own care. All trainees should attempt to explore the wider context and meaning of health and illness for families, as part of a holistic approach.

#### Examples indicative of good practice:

- Trainees have the opportunity to follow patient journeys over a prolonged period, and in different settings, reflecting on the impact of their interventions.
- Trainees learn techniques to help them draw out and amplify the patient voice.
- Trainees use patient feedback on outcomes relevant to them as part of a quality improvement project.
- Trainees understand involvement of children and young people at individual, service and strategic levels.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
4.1	The consultant prompts the trainee to discuss the non-medical aspects of a case with the family and how the illness affects them. For example, rather than focussing on their medical condition, what does their illness mean to them and their family? How many medicines do they have to take a day? What do they need to take on holiday? Can they go for sleepovers? What effect do healthcare appointments have on their parents' working lives and careers? What about their siblings? The trainee is encouraged to talk about the experience of healthcare for families - how many different people do they see? How many different appointments in different places? This is done in a non-clinical setting or in a patient's home.	CbD Reflection	2. Communication 5. Health promotion & illness prevention 6. Leadership & team working 7. Patient safety
4.2	Trainees complete an emotional mapping exercise charting a family's experience of healthcare/patient journey, and use this to try and make improvements to services.	CbD Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention 11. Research & scholarship
4.3	A "What matters to us" exercise is undertaken by a trainee when trying to work out how adolescent services for diabetes should develop locally. Young people who use the current service are encouraged to share their views at their visits. This information is then used by a group of young people working with staff to support the redesign of services.	Reflection	8. Quality improvement

**What children and young people say:**



Ask us! We have lots of ideas and if asked in the right way, we can help you to understand more about what is happening for us but also ways to help make your service the best it can be. We have made resources about being [LGBT+ in health services](#)<sup>[1]</sup> about [transition](#)<sup>[\*\*]</sup> or on getting ideas on [service design](#)<sup>[\*\*\*]</sup>. The RCPCH &Us team can advise too - email them at [and\\_us@rcpch.ac.uk](mailto:and_us@rcpch.ac.uk) and maybe you can come and meet us!

\* [www.rcpch.ac.uk/rainbow-health-supporter](http://www.rcpch.ac.uk/rainbow-health-supporter)

\*\* [www.rcpch.ac.uk/resources/young-peoples-experiences-health-transition](http://www.rcpch.ac.uk/resources/young-peoples-experiences-health-transition)

\*\*\* [www.rcpch.ac.uk/resources/recipes-engagement-children-young-people-lead-rcpch-us](http://www.rcpch.ac.uk/resources/recipes-engagement-children-young-people-lead-rcpch-us)



**#voicematters**

## Principle 5: A biopsychosocial approach is applied at all times

### Schools should develop faculty that understands and can teach a bio-psychosocial approach

*“My TPD’s were incredibly accommodating in helping me to achieve my unusual training requirements. The really positive thing is that after I had done the placements, work was done to create permanent placements for paediatric trainees in CAMHs, and so other trainees have also benefitted from this, as have the children who have experienced a more integrated approach.”* New Consultant

Medicine traditionally relies on categorical diagnoses, which are supposed to map to specific pathology, and explain the symptoms of a child who has been placed in that category. However, clinical experience teaches us that this is an imperfect model - children in socially vulnerable situations, experiencing negative emotions or with family dynamic issues are all prone to suffer more symptoms, whether or not a pathology has been identified. Also, many diagnoses are essentially clusters of symptoms without identifiable pathology, meaning that these ‘psychosocial’ factors can add greatly to the efficacy of paediatric practice by altering the context in which symptoms are experienced.

#### Examples indicative of good practice:

- Trainees are encouraged to consider the psychosocial situations of all patients and families.
- Trainees attend and contribute to psychosocial/MDT meetings where these are held.
- Trainees have opportunities to spend time with the CAMHs teams and to attend some of their sessions.
- The School delivers teaching on psychosocial aspects of illness as part of their curriculum delivery.

#### Case Studies:

	Case study	Evidence	RCPCH Progress+ domain
5.1	A 14 year old young man is seen in clinic for review of asthma management after two recent admissions. The trainee undertakes HEADDSS assessment which enables the young man to discuss his smoking and cannabis use and their impact on his asthma. Taking regular inhalers has been challenging as he is living between three homes, his mother’s, father’s and girlfriend’s. The trainee and patient develop a management plan together.	CbD Reflection	4. Patient management 5. Health promotion & illness prevention

	Case study	Evidence	RCPCH Progress+ domain
5.2	<p>The trainee sees a patient who has a persistent headache without obvious cause. They take a history and construct from it a formulation of the predisposing, precipitating and perpetuating factors underlying their symptoms, as well as any protective factors within the patient and family which could be exploited to aid recovery.</p> <p>The consultant and trainee work together exploring these psychosocial issues with the patient and then to negotiating an understanding of the patient's difficulties with her family and the rest of the professional network, incorporating biological and psychosocial aspects of her history and presentation.</p>	CbD Reflection	4. Patient management 5. Health promotion & illness prevention
5.3	<p>The trainee attends a working group set up between CAMHS and paediatrics to look at improving the care and experience of young people attending ED following self-harm. They lead on engaging young people and gathering data on their experience and suggestions for improvement.</p> <p>The trainee learns the complexity of the relationship between CAMHS and paediatrics, and the barriers that need to be overcome to achieve joint working.</p>	CbD Reflection	5. Health promotion & illness prevention 6. Leadership & team working

## What children and young people say:



Having healthcare workers that understand our emotional health and wellbeing is important to us. We know that children and young people with long term conditions struggle more with their mental health, and that we can find it difficult to talk to you about it when you are busy, and we have things like our medicines to talk about. We have made resources that help us to share what we are feeling like the [emoji cards](#)<sup>[\*]</sup> or the [feelings posters](#)<sup>[\*\*]</sup>.

\* [www.rcpch.ac.uk/resources/emoji-card-game](http://www.rcpch.ac.uk/resources/emoji-card-game)

\*\* [www.rcpch.ac.uk/being-men](http://www.rcpch.ac.uk/being-men)



#voicematters

## Principle 6: Leadership skills are developed and nurtured

**Schools should develop a faculty that supports and enables leadership development for all trainees, appropriate to their training level**

*“Doing clinical work alongside service improvement and development has been something I have really enjoyed during this time period. For me, each aspect has informed the other – the service improvement work improving my knowledge and broadening my experience, and my clinical work informing my ability to input into service development”.*

Trainee ST4

Trainees of today are the consultants of the future and need to be better prepared to adapt into this role. The paediatric curriculum encourages the development of leadership skills from the very first day of training, and all trainees should have the opportunities to practice and improve these skills at every training stage.

Trainees should also develop skills required to support quality improvement. Quality improvement needs to be seen from the perspective of improving clinical outcomes but also improving those things not directly related to clinical management, eg service delivery, delivery processes, efficiency in the workplace.

### Examples indicative of good practice:

- The consultant regularly takes time to speak with trainees, sharing clinical and non-clinical insights from their day’s work.
- Ward rounds and day time work are used to give trainees opportunities to practice leadership skills under direct supervision.
- The School hosts regional training events focused on aspects of leadership and management.
- All trainees are encouraged to participate in quality improvement projects during each post.

### Case Studies:

	Case study	Evidence	RCPC Progress+ domain
6.1	ST3 trainees “act up” to registrar level, in a supported way during day time hours, or on the weekends. This may involve trainees leading a ward round, where the consultant and trainee agree explicit objectives (eg involvement of nurses, timeliness, prioritisation) at the beginning of the round, and at the end of the round spends some time to debrief around these objectives. Another option involves the consultant and registrar to swap roles during a ward round, giving the trainee an opportunity to lead the ward round under direct supervision; time is spent afterwards to discuss the experience.	Leader HAT ACAT Reflection	6. Leadership & team working

	Case study	Evidence	RCPCH Progress+ domain
6.2	Consultants regularly share details of their leadership responsibilities with trainees and encourage them to take a leadership role in each post, eg running junior doctor teaching programme, being a junior doctor forum rep, or trainee representative on the medicines committee. Departments also keep a list of quality improvement projects that they are led by trainees.	Leader Reflection	6. Leadership & team working
6.3	A child is seen in clinic with developmental delay. The registrar carries out a full history and examination and arranges for them to be seen by other members of the MDT (physio, OT, SLT, portage). Following a period of assessment by all allied health professionals, the registrar arranges and chairs a family support planning meeting (a meeting for the parents with all involved professionals) to share their findings and make a plan about how best to support the child and their family. The written plan is shared with all involved following the meeting.	Leader Reflective event	4. Patient management 6. Leadership & team working

## What children and young people say:



We need health workers to take the lead and make sure everyone is linked up and working together. It can be really hard work for us when there are lots of different people involved and different computer systems or different locations to remember everything. Sometimes we need you to speak up for us to other teams or help to get the right support in schools. Your leadership skills help us feel confident it what is happening and that we are all doing this together.



#voicematters

## Principle 7: Training time and learning opportunities are prioritised within the workplace

**Schools should ensure that trainees are placed in posts that provide a programme of core training which balances service provision with the opportunities for learning**

The new model for paediatric training will provide opportunities for high quality training provision, undertaking activities which promote high educational value and impact. Trainees



should be encouraged to identify and utilise learning opportunities that naturally occur within their day to day roles. If all principles are properly applied to trainees' work, it is likely that most 'service work' becomes educational, as long as there is a mechanism for feedback. Emphasis will be placed upon working more effectively with other professionals; this could mean the delegation of tasks to best meet the skills required.

### Examples indicative of good practice:

- The use of a multi-professional workforce is promoted within paediatric departments to ensure non-training tasks can be delegated away from paediatric trainees.
- Rota designs that offer training/education weeks or engagement with wider training opportunities.
- Placement of trainees in the same trust for at least one year.
- Consultants proactively encourage trainees to identify opportunities for completing Supervised Learning events (SLEs) within clinics, ward rounds etc.
- Rota designs give trainees opportunities to follow the patient journey rather than just getting a snapshot of their care.
- Trainees are actively encouraged to develop their own skills in teaching and developing others.

### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
7.1	A local GP training scheme wants to give more trainees experience of paediatrics. GP training posts are re-assigned from surgery to paediatrics and the expansion of the rota enables each trainee to have two or three weeks of 'education' time per rotation. This provides dedicated time for trainees to attend clinics and to carry out quality improvement projects with primary care colleagues.	CbD Reflection	4. Patient management 5. Health promotion & illness prevention 8. Quality improvement
7.2	Whilst consultants are present, certain ward rounds each week are designated as being trainee-led, with direct supervision and immediate feedback of clinical practice from attending consultant. Supervised Learning Events (SLEs) are completed in real time, allowing training whilst providing service.	HAT Mini-Cex Reflection	6. Leadership & team working
7.3	Non-training tasks are delegated to other health care professionals. For example, once a week, a senior midwife completes baby checks so that juniors can attend teaching. During this time a consultant would carry the crash-bleep such that training is truly protected. Other examples include paediatric phlebotomists taking routine bloods, and physician assistants seeing routine admissions and complete discharge summaries.	N/A	N/A

## What children and young people say:

We want you to know what it is like to be a child or young person today. It would be good if you learn from us about our (fun) lives, the TV programmes we watch, how to make slime, the way social media is used (for good and bad), the pressures some of us have with our families/identity/school work, what we like and how to include this knowledge into your work. Have a look at our [top tips for doctors<sup>\[1\]</sup>](#) for more ideas.

\*[www.rcpch.ac.uk/beingme](http://www.rcpch.ac.uk/beingme)

#voicematters

## Principle 8: Educational supervision is high quality and provides consistency

**Schools should ensure that trainees are supported by well-trained faculty, including expert Educational Supervisors, and a learning culture is encouraged in the workplace supported by trainers from all disciplines and professions**

Wherever possible, trainees should have the same Educational Supervisor throughout core training, and a consistent Educational Supervisor through higher level (specialty) training, providing longer term support and understanding of their developmental needs. Educational Supervisors and trainers from paediatrics and other professional backgrounds will maximise learning opportunities for the trainee and create a thriving learning environment.

The supervisor role is one that enables the trainee to flourish, providing a balance between the development of autonomy within their role. This allows trainees to be accountable for their actions within the clinical environment while still being supported and nurtured.

### Examples indicative of good practice:

- Schools and training units take care when pairing trainees with their supervisors.
- The School hosts a faculty development programme to foster high-quality facilitation and feedback (eg case study 23.2).
- Schools work towards supporting educators as outlined by the HEE quality framework 2017/18 (<https://www.hee.nhs.uk/our-work/quality>).
- Feedback is part of everyday activity. Trainees and Clinical Supervisors are encouraged to give feedback and reflect on daily activities and to seek 360o feedback from others on a regular basis.

- Trainees coming back into the work place from time out (OOP, maternity, research) are supported by their School to reintegrate them into the workplace, for example by inviting them to attend a Return to Practice course; and encouraging them to engage with return to work programmes (eg SuppoRTT).
- Trainees participate in nurse-education sessions, fostering two-way learning indicative of a learning culture in the workplace.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
8.1	The School of Paediatrics runs an end-of-post survey to explore the trainee experience in depth. Faculty meetings review the findings and senior trainers in the School visit Local Faculty Group meetings to support cross-fertilisation of good practice and an action plan for areas of challenge.	N/A	N/A
8.2	Trainers and Supervisors attend educational supervision update sessions run by the School of Paediatrics which include skills of feedback; trainee well-being and morale; the ARCP process; knowledge of the curriculum and recent changes in the training programme.	N/A	N/A
8.3	The School of Paediatrics reviews trainer reports during their ARCP meetings and gives trainers written feedback on their trainer's report, concentrating on areas of excellence and making suggestions for improvement.	N/A	N/A

**What children and young people say:**



We help every year at the PAFTAs<sup>[1]</sup> by having a judging panel where young people help decide on the best trainee of the year and the best Education Supervisor. We can see that the best ones have good support, look after each other, have the fun stuff too (coffee together, cheese & cake parties) and get to do good work with children and young people, plus have an open door so doctors can have a chat with other doctors whenever they need it.

\*<https://www.rcpch.ac.uk/news-events/news/pafta-winners-2019-are>



#voicematters

## Principle 9: Morale and job satisfaction are improved

### Schools should support recruitment and retention to minimise gaps in the rota and implement systems that support morale, resilience and pastoral care

Schools should play an active role in improving recruitment into paediatrics, and take a systematic approach to understanding and addressing issues negatively impacting on retention and morale. Trainee well-being and resilience sessions should be set up and promoted in deaneries and trusts. Return to work trainees should be aware of how to access extra help and support when returning after a period of absence.

#### Examples indicative of good practice:

- Schools and Deaneries take an active part in encouraging Trusts to implement the recommendations of the 'Improving doctor's working lives' working group.
- Schools and Deaneries actively promote diversity and value all trainees career choices
- Senior nurses support the triage of paediatricians' bleeps.
- Trusts consider the introduction of a taxi service to transport staff home late at night.
- A dedicated pastoral lead is available for each training location.
- Peer-led coaching and mentoring is promoted within the School.
- Tailored resilience and stress management training is available within the School.
- Mindfulness awareness sessions for trainees are available within the School.
- Critical incident debriefs are held in training units.
- Excellence reporting with positive feedback being a core part of all working teams.

#### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
9.1	<p>Trainees returning after a period of absence (eg maternity leave or OOP) receive a whole-day of training with:</p> <ol style="list-style-type: none"> <li>high fidelity paediatric simulation scenarios</li> <li>hot topics talk: signposting to key updates in paediatrics</li> <li>workshops addressing issues associated with flexible training, academic training and completing work-place based assessments, eportfolio and the RCPCH curriculum</li> <li>resilience workshop supported by a clinical psychologist discussing self-care, mindfulness and ways to try and balance work and life</li> <li>an opportunity to network with other trainees returning and the course faculty with signposting to mentoring support, HEE SupportTT guidance is followed(<a href="https://heeoee.hee.nhs.uk/psw/supportt-supported-return-training/supportt-plan">https://heeoee.hee.nhs.uk/psw/supportt-supported-return-training/supportt-plan</a>)</li> </ol>	N/A	N/A

	Case study	Evidence	RCPCH Progress+ domain
9.2	The School runs regular sessions for educational and clinical supervisors to highlight and raise awareness of trainee and trainer well-being and morale. This allows the development of a climate of support and understanding of the pressures and stresses faced by all within the system. It also supports the development of key ideas on how to mitigate against these pressures for the benefit of patient care. Excellence reporting and incident reporting is approached with a positive outlook as ways to learn from excellence and improve care of staff and patients.	N/A	N/A
9.3	Networking sessions are included within regional teaching events. This gives trainees the chance to meet informally, to get to know each other and develop peer to peer support.	N/A	N/A

**What children and young people say:**

.....

We need someone to look after the staff too! We want you to know that we know it is hard, and we know you work long hours but you are our lifesavers and that's why we want you to be looked after as well. For the NHS 70th birthday we asked children and young people what they thought of the NHS<sup>[1]</sup> and the staff and they said it's the best invention of the 20th Century and THANK YOUUUUUUUU!

\* <https://youtu.be/EYAwRhK-e1M>

.....

#voicematters

## Principle 10: Assessment is used as a learning tool

**Schools should ensure Supervisors review trainees’ portfolio, looking for evidence of reflection on the principles outlined in this document**

Assessment is an essential element to support the charting of learner progression. It is important that the value of both formative and summative assessment is appreciated. Feedback is integral to everything trainees do, and by giving high quality feedback on assessments and ePortfolio evidence trainers can help trainees enhance their learning from each assessment.

Trainees’ portfolios should include activities and reflections on clinical reasoning, the biopsychosocial model, learning from patients, leadership development and an understanding of human factors in clinical care. There should be ample evidence of holistic care, including

mental health, public health and primary care aspects of child health and evidence of learning from patients in settings outside of hospitals. Opportunities to learn in this way are given in later sections of this document.

**Examples indicative of good practice:**

- Consultants have Supervised Learning Event (SLE) clinics where they supervise trainees seeing patients in a clinic setting, providing feedback directly.
- Consultants have timetabled CbD mornings once a month where trainees can book a session to talk about a case.
- Regular reflective practice sessions are included in weekly teaching timetables.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
10.1	Schools have regular educational supervision updates for trainers which include discussions about the quality and timeliness of assessments, opportunistic feedback and ways of ‘stretching’ thinking to be more holistic, using existing assessment tools. TPDs could travel to local units on a regular basis to deliver these and to engage with local teams.	N/A	N/A
10.2	Senior trainees who undertake assessments have ongoing training in assessment as part of their regional training sessions so that they can support core trainees.	Reflection	10. Education & training
10.3	Both trainers and trainees are vigilant and proactive in identifying opportunities for assessment in the clinical setting on an ongoing basis – HAT at handover; ACAT during resuscitation; LEADER when doing a ward round or managing a MDT meeting; DOPS when completing a procedure; DOCS on clinic letters or medical reports, eg safeguarding LAC/EHCPs. Feedback should be to drive and promote excellence and not just meet expectations.	N/A	10. Education & training

**What children and young people say:**



We think it is important that you have children, young people and families involved in assessments. We have been trying out new ways to do this for the MRCPCH exams and RCPCH Start assessments, thinking about using emoji’s, having questions written by children and young people and us giving feedback in assessments. We also have shared our ideas on all parts of the curriculum which will help you when you have assessments to know what is important to us, read our [Progress booklet](#)<sup>[1]</sup>.

\* [www.rcpch.ac.uk/resources/rcpch-progress-what-domains-mean-children-young-people](http://www.rcpch.ac.uk/resources/rcpch-progress-what-domains-mean-children-young-people)



#voicematters

## Principle 11: Progression and length of training are personalised and flexible

**Schools should ensure trainees and trainers understand how and when to accelerate and encourage a training environment where trainees can progress through training at pace**

Progression through the training programme will be measured by achievement of the curriculum Learning Outcomes at ARCP and defined way points. It is expected that core training will be achieved within 3-4 years, at which point the trainee progresses to specialty training (eg General Paediatrics, Community Child Health, or Neonatal Medicine), alongside the generic capabilities. Some trainees may be able to achieve the Learning Outcomes at a quicker rate and therefore, may have the potential to accelerate their training and subsequent CCT. Others, including Less than Full Time and those taking opportunity of OOP/OOPP, where this is available, will take longer. The priority will be on flexibility, individuality and personalised programmes.

### Examples indicative of good practice:

- Trainees and Educational Supervisors engage with the curriculum, with trainees encouraged and supported to progress to higher level Learning Outcomes early, where appropriate. Schools ensure the ARCP process allows for accelerated progress and planning of early progression to specialty training and CCT.
- Training opportunities outside traditional hospital paediatrics posts are valued, encouraged and support evidence of progress against the curriculum requirements, eg learning about diabetes management by taking part in a diabetes summer camp.
- Trainees are encouraged to personalise the curriculum to match their own priorities, strengths and interests.
- ARCP panels mention in their report the possibility for trainees to fast-track their training, when the appropriate skills are achieved and significant progress being made.

### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
11.1	The trainee spends time abroad working in a Paediatrics department in resource limited country, eg with Global links programme or other. There their role involves service delivery and redesign and MDT training in addition to clinical practice. This is mapped against the generic curriculum capabilities.	Reflection	1. Professional values and behaviours 6. Leadership and team working
11.2	Trainees spend time working in a non-Paediatric post, eg a GP post or CAMHS. Relevant clinical Learning Outcomes can be achieved during these posts in addition to generic Learning Outcomes and may contribute to accelerated progress through the programme.	Reflection	1. Professional values and behaviours

	Case study	Evidence	RCPCH Progress+ domain
11.3	<p>The School ensures they provide posts during core training that give trainees opportunities to gain additional curriculum competencies. These will likely involve an agreement that a proportion of their time can be used in a non-clinical setting to gain these competencies. These posts will usually be most suitable for well performing trainees as the expectation will be that the non-clinical component will not lead to an increase in training time. Non-clinical components may be in teaching (for example run the School VLE), in management as part of a leadership pathway for trainees potentially leading to a chief registrar post later in training or in academic training as an Academic Clinical Fellow (ACF).</p>	N/A	N/A

## What children and young people say:



We think it is important that you get the chance to do participation work in your training too, and that you get to know about the [United Nations Convention on the Rights of the Child<sup>\[\\*\]</sup>](#) and how to work with families and patients in quality improvement and do fun projects with us. Why don't you come to find out more about [RCPCH &Us<sup>\[\\*\\*\]</sup>](#) and what we do? You could think about helping with our projects so we can help you with having different experiences.

\* [www.rcpch.ac.uk/rightsmatter](http://www.rcpch.ac.uk/rightsmatter)

\*\* [www.rcpch.ac.uk/and\\_us](http://www.rcpch.ac.uk/and_us)



#voicematters



## 3. Application in existing settings

Throughout core training, trainees should have the opportunity to gain experience in a variety of settings and environments, including wards, emergency units, NICUs, clinics and the community. This is crucial in helping them develop their skills and knowledge and prepare for and make decisions about their next career steps.

Whilst core training will include clinical work in each of these settings, and this will be necessary for a trainee to meet the core curriculum Learning Outcomes, a trainee does not necessarily need to be ‘placed’ in all of these clinical areas for a set period of time. The amount of time spent in any of these settings will be determined by trainee’s learning needs and career aspirations and allows Schools to take a more flexible and creative approach, meeting service needs and the requirements of Shape of Paediatric Training. For example, instead of a trainee spending one fixed block of time, eg three months or six months working in the community, they may do shorter placements over a longer period of time, such as day release, job shares. This has multiple benefits, including providing breadth of experience, giving the opportunity to follow patients and families over a prolonged period to monitor development and impact, and helping trainees understand how services are inter-dependent and can be better joined up to improve the patient’s experience.

This section provides examples of how to get the most from training in each of the paediatric settings, and demonstrating how the Whole Population Approach can be applied within every setting to maximise learning and development opportunities. The Whole Population Segmentation Model should be used to broaden the understanding and learning beyond the hospital setting.

### Learning in the paediatric ward environment

#### Schools should encourage hospitals to use ward-based experience as a source of rich learning

The paediatric ward provides a rich environment for learning. Trainees will be exposed to common and unusual clinical conditions. They will also learn generalist skills, such as leadership/followership, MDT working and communication. The case study examples below show how the trainee and the trainer can agree suitable opportunities for learning in this environment and how these could be evidenced.

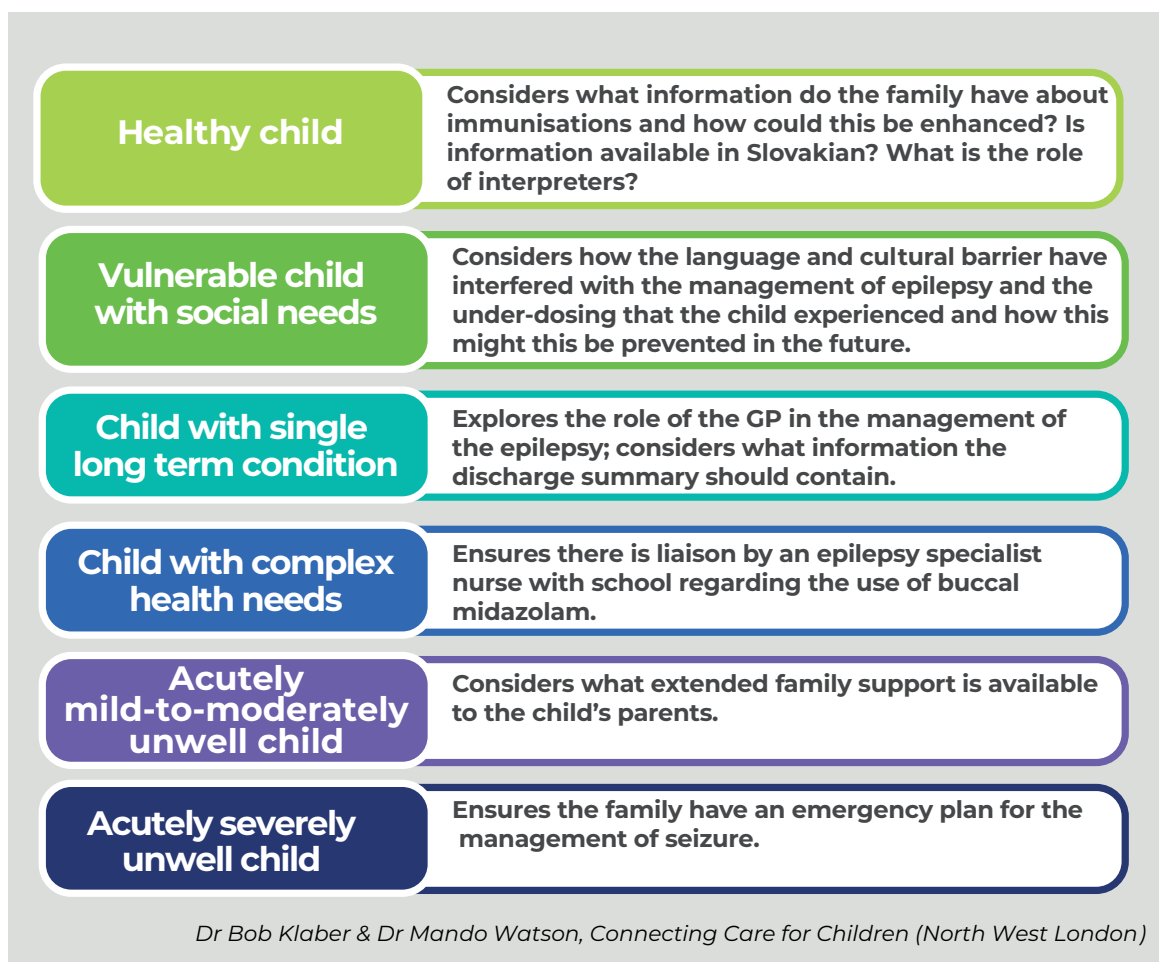
#### Case studies:

	Case study	Evidence	RCPE Progress+ domain
12.1	When communication between a family and a staff member was strained and developing into conflict on the open ward, the clinician took this as a learning opportunity. They modelled good conflict resolution techniques, supporting a calm conversation that resolved the conflict between the parent and staff and then ran a debrief for the ward team, asking for reflections and reinforcing key learning points at the end of the discussion.	CbD Reflection	1. Professional values and behaviours 2. Communication

	Case study	Evidence	RCPCH Progress+ domain
12.2	The trainee completes a discharge summary and discusses with their Clinical Supervisor how best to enhance written communication across primary and secondary care boundaries.	CbD Doc Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention
12.3	The trainee updates a local guideline for the management of convulsive status epilepticus and ensures consistency in all settings (A&E, special school, community nursing).	CbD Reflection	8. Quality improvement

**Figure 4: Application of the Whole Population Approach in the ward setting:**

A five year old Slovakian child with epilepsy is admitted to the children’s ward in status epilepticus triggered by a viral infection. There is a significant language barrier and face-to-face interpreters are not available. Telephone interpretation is used and it becomes apparent that the anti-epileptic medication is not being used correctly and there is evidence of under-dosing with sodium valproate and lamotrigine. Further, the child is unimmunised and has no GP.



**What children and young people say:**

.....

We think that where ever you are, there are always chances to practice the best ways to communicate with us. Our top tips are: make it easy for me to tell you what I need or what I think, we want to feel that we understand you and what you are saying so that we don't have to ask family afterwards. We think communication is about building up trust, it's nice when the doctor knows I like cadets and asks me at the start, it makes me feel comfortable.

.....

#voicematters

## Learning in the Paediatric Emergency Department environment

**Schools should encourage hospitals to use A&E-based experience as a source of rich learning and include other emergency settings, such as 111 and urgent care centres**

Trainees can learn a great deal working in the Paediatric Emergency Department. They will be exposed to undifferentiated patients, and trainees in core paediatrics should be given the opportunity to ‘start from scratch’ to work up a clinical diagnosis and management plan with them. The Emergency Department also provides trainees with the opportunity to hone their safety netting and communication skills; to manage paediatric emergencies; and, as they gain experience, have opportunities to lead a department, decide management plans and coordinate flow.

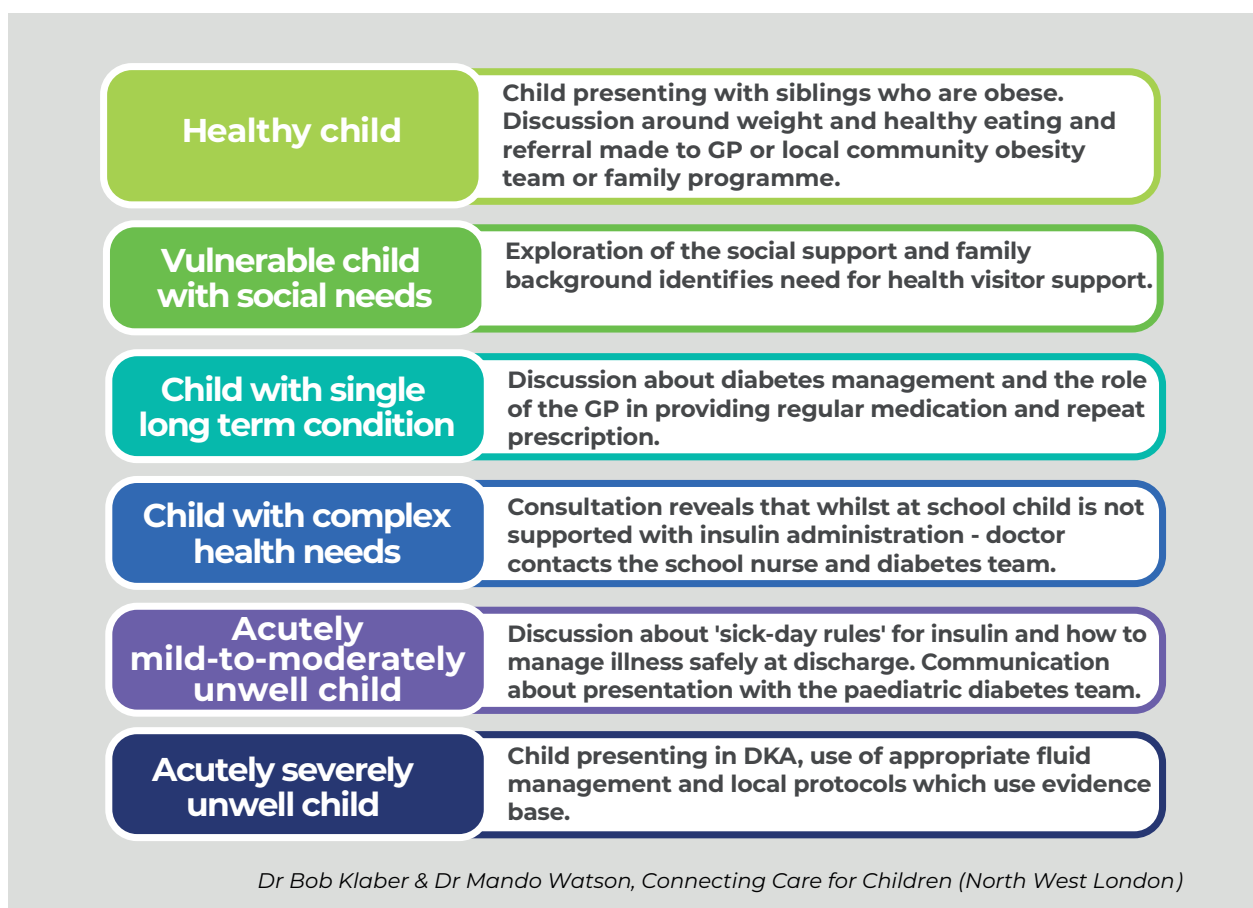
**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
13.1	Trainees have medical students attached to them. The trainee must allocate the medical student suitable patients to see, review the patients and provide relevant teaching.	Reflection	10.Education & training
13.2	The trainee undertakes a HEADDSS assessment on all young people aged 12-18 that they see in A&E. They collate a resource for use by A&E professionals to signpost young people to local services for sexual health, substance misuse issues, mental health etc.	CbD Leader Reflection	2. Communication 5. Health promotion & illness prevention 9. Safeguarding 10.Education & training

	Case study	Evidence	RCPCH Progress+ domain
13.3	Senior clinicians are present and approachable in acute paediatric settings: a senior clinician is present in the A&E, or acute admissions department in a supporting role. Trainees at all levels see patients and go to the senior clinician for advice and review. Senior clinicians help identify key learning experiences appropriate to trainee needs (for example, procedures or clinical cases that the trainee has identified they would like more exposure to). This encourages trainees to seek advice appropriately and so expands learning opportunities.	Leader ACAT	2. Communication 5. Health promotion & illness prevention 9. Safeguarding

**Figure 5: Application of the Whole Population Approach in the emergency setting:**

A 12 year old child presents to A&E with vomiting and diarrhoea. He has a background of diabetes requiring insulin and is noted to be obese, as are his younger siblings who are three months, eighteen months and three years old. He does not have any short acting insulin with him and parents say they have not had time to collect his prescription.



## What children and young people say:

When we go into A&E it can be a scary place. If it's our first seizure, we don't know what is happening or if it could happen again. If we have asthma, we are worried that people don't understand how quickly it can get worse. If we have a sickle cell crisis we need help to manage our pain quickly. It helps us when there are people who are good at explaining things, who are patient and try to keep us calm when we are scared.

#voicematters

## Learning in the neonatal environment

**Schools should encourage hospitals to use NICU-based experience as a source of rich learning and include related settings such as antenatal clinics and community midwifery**

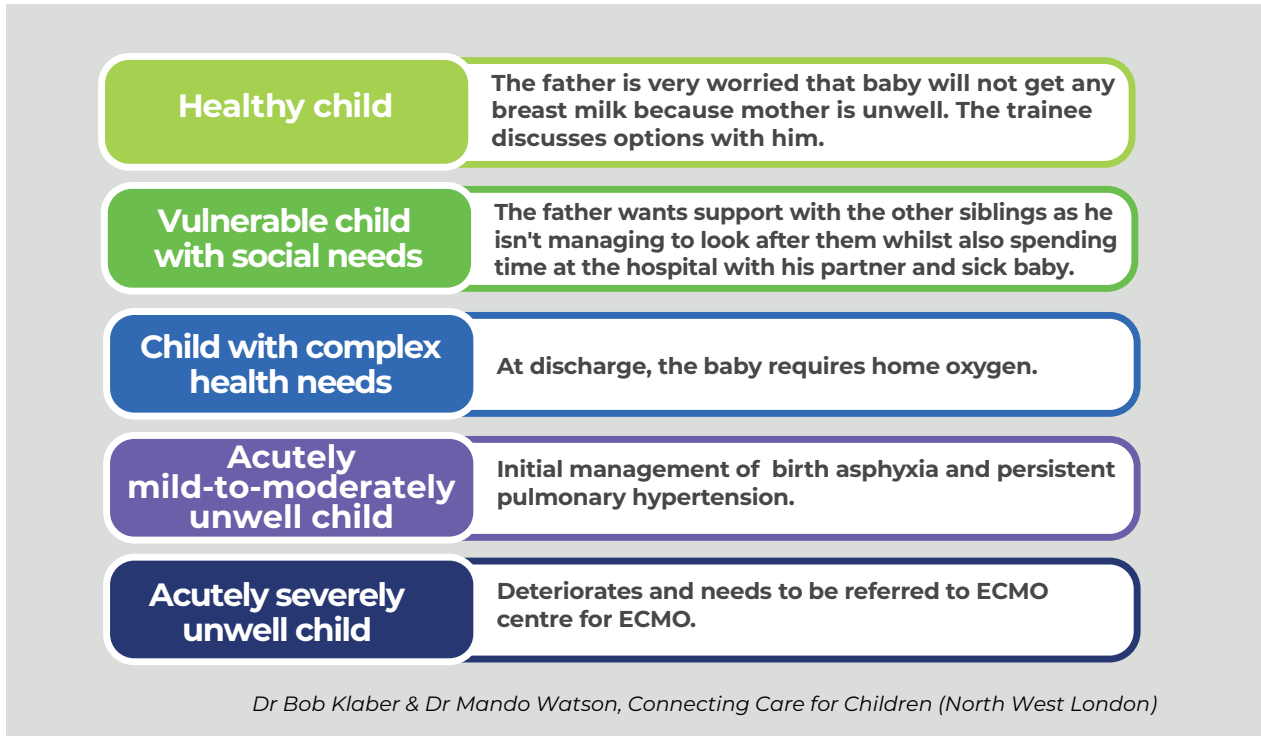
The neonatal setting provides trainees with ample opportunity to manage the critically sick patient, to learn and practice important practical procedures and to work as part of a multi-disciplinary, multi-professional team. Trainees can appreciate the impact of maternal health on the neonate, the challenges of parenthood and the effects of social determinants. The neonatal setting also provides ample opportunity to learn about healthy infants, health promotion and the impact of life course medicine.

### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
14.1	Trainees are given the opportunity to attend the baby clinic. They 'adopt' a case predicted to have significant congenital abnormalities, attend antenatal appointments with the family and visit the family after the baby is born.	CbD Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention
14.2	After completing baby checks for that day, the trainee joins the community midwives who are doing home visits. They see the families in their home setting and learn about the role of midwives in promoting breast-feeding and identifying mothers at risk of perinatal mental health difficulties.	CbD Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention
14.3	Trainees are invited to present a 10-minute micro-teach on how local data on breast-feeding compares to national data using the indicators related to breast-feeding brought together on PHE's Fingertips tool.	Reflection	10. Education & training

**Figure 6: Application of the Whole Population Approach in the neonatal setting:**

A child with meconium at birth comes out with poor Apgar Score and needs intubation. The baby's mother is unwell and taken to adult ICU. The baby is transferred to the neonatal unit for further management.



**What children and young people say:**



We can be embarrassed when people talk about breast-feeding, but we think it is important and would like it if doctors explain it to us as siblings as well as our parents. Some young mums in our groups talked about how important it is to know about local support groups that are around to help with things like housing, food, budgeting and making friends and getting advice so see if you can visit some or find out about them so you can tell people about them.



**#voicematters**

**Learning in the child development (community) service**

Schools should encourage community placements to deliver rich experience in the child development service, schools, multi-agency working and collaboration with primary care, mental health and public health

The new training programme for paediatrics means trainees will be placed in community posts in year 2, 3, or 4, where currently they are placed in year 4 or 5. This community placement is critical to teach paediatricians generic skills that will be essential, whatever future role they take. These skills should also be taught in other core placements.

It will be important to ensure that trainees are sufficiently exposed to CAMHS, non-acute safeguarding, neurodevelopmental cases, including child development, children’s centres and specialist schools. Trainees should also have the opportunity to work with health visitors, school nurses and therapists, and with public health professionals and general practice. The Whole Population Segmentation Model fits naturally with this setting.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
15.1	The trainee sees a patient with developmental and behavioural difficulties in the community paediatric clinic and uses it as an opportunity to contact CAMHS, join a CAMHS clinic and learn about the different CAMHS services available locally.	CbD Reflection	2. Communication 4. Patient management
15.2	<p>The trainee sees a child in the clinic with significant behavioural difficulties referred for suspected ADHD. They take a history from the parents and examine the child.</p> <p>They signpost the family to a parenting course, obtain detailed information from the school and obtain Conner’s questionnaires from both the family and school. They interpret this as indicating difficulties with attention in both settings. They go to observe the child in school and discuss with his class teacher and SENCO. The teacher says he is struggling with literacy as well as attention and plan to consult with their support services within education for further advice.</p> <p>The trainee reviews the child a few months after the completion of the parenting programme to assess the impact of the parenting course and to review the results of the information collated. At this point consideration is given as to whether a diagnosis of ADHD is appropriate and also if any further medical intervention is required.</p> <p>The situation improves at home and at school with specific support for literacy and improved parental understanding.</p> <p>The trainee was given the opportunity to follow the case, even though the trainee had moved onto a new post.</p>	CbD Reflection	2. Communication 4. Patient management

	Case study	Evidence	RCPCH Progress+ domain
15.3	The trainee reviews a child with complex disability at the child's (special) school. Before the consultation the trainee meets the MDT and learns about the challenges they have in supporting this child. They find managing the fits particularly difficult. The trainee takes the initiative and arranges a further visit to the school, this time with the epilepsy nurse specialist, to run a short teaching session for school staff on epilepsy.	CbD Reflection	2. Communication 5. Health promotion & illness prevention 6. Leadership & team working

**Figure 7: Application of the Whole Population Approach in the community setting:**

A four year old child with Trisomy 21 is reviewed in community clinic having moved from another part of the country. They had an AVSD which was repaired in infancy. They live with their parents and two other siblings in rented accommodation and are due to start at school in the next academic year.

**Healthy child**  
A child has an underlying chromosomal condition but things are currently going well. The trainee ensures that the child is in receipt of all screening and health services that children with Down syndrome should receive - vision, hearing, immunisation, dentist, neck stability, annual bloods, considering access to support and other groups, and whether there are any barriers to accessing these. They draw up a checklist to be used in clinic to ensure all key areas are always covered at annual health reviews.

**Vulnerable child with social needs**  
The trainee supports the child with entry into nursery, attending a 'team around the child' meeting to ensure all their needs will be met prior to starting, and that the correct level of support will be in place. They arrange for the child to have Portage. The trainee considers barriers to participation for the child and family such as mobility and housing needs and supports the family to ensure that the correct benefit payments are in place.

**Child with single long-term condition**  
The child has a cardiac complication from their Down syndrome necessitating frequent hospital stays and surgical interventions. The trainee attends cardiology clinic with the child and attends the cardiology MDT, meets the Clinical Nurse Specialist and learns about his role in the long-term management of complex congenital heart disease.

**Child with complex health needs**  
The child has an Down syndrome associated complex congenital heart disease and requires home oxygen. The trainee shadows the respiratory nursing team to do a home visit and does a teaching session at the child's nursery to describe their needs to staff.

**Acutely mild-to-moderately unwell child**  
The child has an inter current illness - the trainee manages this and also develops a leaflet for parents and the special school/community nursing team advising what to do when their child is unwell.

**Acutely severely unwell child**  
The child requires high dependency care - the trainee reflects on this with senior support and discusses the treatments and prognosis with the family.

*Dr Bob Klaber & Dr Mando Watson, Connecting Care for Children (North West London)*



**What children and young people say:**

.....

Sometimes we wriggle and can't sit still. Sometimes it's too noisy or bright for us to concentrate on what you are saying. It can be hard for us and our parents / carers to come to see you, so it helps if there are things we can touch or play with and use to help us to talk or understand what you are saying. It helps if you know lots about getting help from other teams – look at [our list](#) <sup>[1]</sup> of things to think about.

\* [www.rcpch.ac.uk/hiddenhealth](http://www.rcpch.ac.uk/hiddenhealth)

.....

**#voicematters**

## Learning in the clinic environment

**Schools should encourage clinic experience to provide meaningful learning, with high quality supervision and opportunities for continuity of care**

*“Myself and my consultant, along with local GPs and the general paediatric consultant body, developed a series of GP referral pathways for our most common referral reasons. In being involved in discussions with my consultant about referrals and auditing our referrals from primary care, I gained a lot of insight into why children are referred to paediatrics, and into how triaging decisions are made by consultants who are reviewing referrals. In creating referral criteria and pathways for common referral reasons, I did a lot of reading including reading relevant NICE guidelines, review articles, and guidelines from other hospitals, which also helped my own knowledge enormously, and gave me good frameworks for doing my own consultations. Alongside this I sought input from primary care referrers into this new way of working to ensure that we create pathways which best serve local children and their families.”*

Trainee, ST4

Trainees should have had adequate exposure to clinic management in order to develop communication skills, understand the diagnostic process and the management of long-term conditions. This cannot just be reflected in the number of clinics but also the quality of the learning environment in the clinic. Trainees also need to learn how to carry out consultations remotely, using video-technology. The Whole Population Segmentation Model should be used to broaden the understanding and learning beyond the immediate problem.

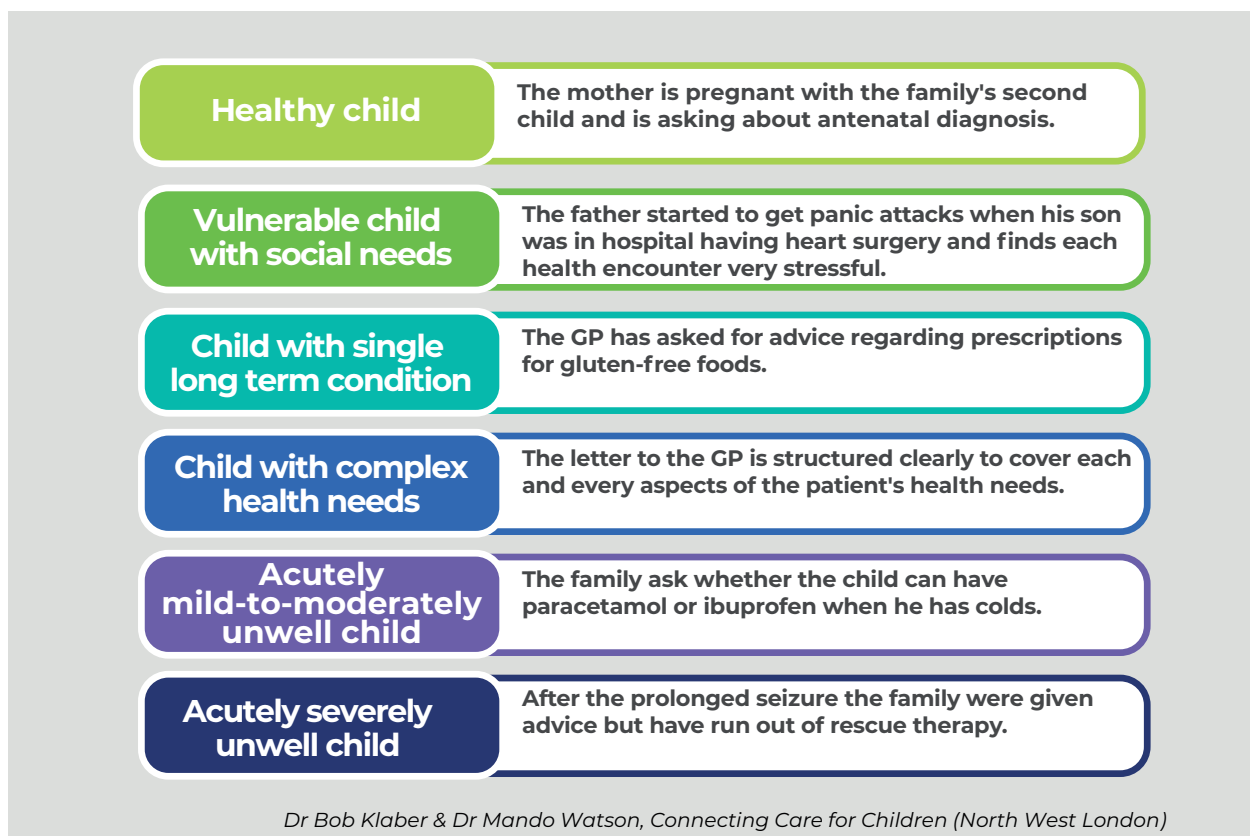
### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
16.1	A consultant clinic is scheduled with three rooms and three trainees. Patients are allocated double time. The consultant does not have a separate list but takes a 'helicopter' role, providing clinical support to patients and teaching to trainees.	CbD Reflection MiniCex	2. Communication 4. Patient management 5. Health promotion & illness prevention

	Case study	Evidence	RCPCH Progress+ domain
16..2	A trainee arranges for a patient to return to follow up, the booking is made on a day when the trainee can be present in clinic. The patient and trainee benefit from continuity of care and learning.	CbD Reflection	2. Communication 4. Patient management 7. Patient safety
16.3	A trainee is taught about the practices and principles of 'agenda setting' in the clinic environment, for the doctor, patient and parents. This will be different for each but all needs should be considered and given time. For example, if a family comes for ADPKD screening for their son; the doctor wants to rule out/in the condition, the child is disinterested and not engaged yet in this process, and the parents are still mourning the loss of a baby with antenatal Autosomal Dominant Polycystic Kidney Disease (ADPKD) which caused lung hypoplasia and who died.	CbD Reflection	2. Communication 4. Patient management

**Figure 8: Application of the Whole Population Approach in the clinic setting:**

A six year old child who had a prolonged seizure last year attends clinic for follow up. He has had multiple generalised tonic clonic seizures but these are few and far between. The family have agreed to wait and watch and not start anti-epileptic drugs yet. There is a background of tetralogy of Fallot. On testing for poor growth, the child was diagnosed with coeliac disease and is on a gluten free diet which has helped the growth somewhat. The GP letter alludes to the family's anxiety regarding the child's complex health needs.



## What children and young people say:



We have a project about epilepsy and what help we need to have support for our mental health, groups that we can go to, help with practical tips for living with epilepsy and support with our worries and anxieties about things like school or injuries. We need clinics to think about the support they offer and the team involved from the receptionist to doctor to school to CAMHS worker. Have a look at [what we have said<sup>\[1\]</sup>](#) and see if it helps you in your work.

\* [www.rcpch.ac.uk/resources/epilepsy12-us-voices-rcpch-us-network](http://www.rcpch.ac.uk/resources/epilepsy12-us-voices-rcpch-us-network)



**#voicematters**

## 4. Development and progression

This section provides further examples of approaches that Schools of Paediatrics can take in order to stretch beyond simply providing a satisfactory training experience to one that is excellent. This builds on the principles in section 2 and using real life examples from Schools across the UK, illustrates how training programmes can maximise opportunities for learning and best prepare trainees for their future roles in an evolving paediatric service.

In the medium to longer term it is expected that training programmes will incorporate these approaches, building on existing good practice or introducing new ideas, and the descriptions of expected performance against each of the training principles will be updated to reflect these higher expectations.

The approaches recommended within this section are:

- Using patients and parents as educators.
- Promoting learning in settings outside of the hospital.
- Having an increased focus on mental health.
- Health promotion as an integral aspect of patient management.
- Better integrated working with primary care.
- A specific focus on the health needs of young people (aged 11-25).
- Utilisation of simulation, digital and technology-enhanced learning.
- Teaching human factors.
- Shared learning with other disciplines and professionals.

Additional examples of how to develop training programmes to incorporate these approaches are provided on the RCPCH website. If you would like to contribute a case study from your region, please contact [qualityandstandards@rcpch.ac.uk](mailto:qualityandstandards@rcpch.ac.uk).

### Using patients and parents as educators

**Schools should develop activities that encourage learning from patients and families**

*“I organised a sporting event for young people with diabetes. This allowed me to develop managerial/leadership skills liaising with contacts in and outside the NHS and co-design with parents. Giving me a unique insight in the complexity of a child with a significant long term condition and the impact on the family unit of the whole. In the future this will help me as a clinician think more holistically when approaching patient care and to have a greater impact at every clinical encounter.”* Foundation Trainee

Children, young people and families have deep ‘lived experience’ of their health-related conditions. They provide important learning opportunities; a talk given by a patient is often as memorable to the trainee as personally managing the case in the clinical setting, and the patient perspective can give powerful insights into successful communication and effective patient care. Common examples of how Schools already support this approach include:

- Asking a parent or young person to speak on a study day.
- Having a 'what matters to me' poster on the ward for families to use.
- Trainees go on group outings for children with type 1 diabetes.
- Trainees 'adopting a patient' with a new diagnosis to better understand the true nature of lived experience, ie they follow the patient after discharge, going to the school, home and GP appointment.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
17.1	Communication skills training is delivered as part of the ST1 induction programme. This includes a patient journey where a child with a complex medical condition and their parent is invited to narrate their experience of healthcare. Trainees are then given a chance to ask questions focusing on the impact of the condition on the child and the non-clinical aspects of the case.	CbD Reflection	2. Communication 4. Patient management 5. Health promotion & illness prevention
17.2	A programme for learning integrated care includes a patient experience and involvement theme. Participants are shown how to: <ol style="list-style-type: none"> <li>i. Actively promote patient involvement.</li> <li>ii. Be aware of the different ways patient experience and outcomes can be measured (eg PREMs and PROMs)</li> <li>iii. Access some of the patient/user groups that enable the patient voice to be heard</li> <li>iv. Describe the process of authentic dialogue with patients, sometimes known as co-production, and be familiar with examples</li> <li>v. Work with patients, families and user groups to improve services. Trainees design quality-improvement projects that are informed by authentic insights into the patient's perspective</li> </ol>	CbD	6. Leadership & team working

## What children and young people say:



Yes! We want to work with you to help teach about our conditions and experiences and to improve services. What works best for us is if we have support to get ready to explain our experiences and help after in case it brings up old feelings. We also like it when we can meet other patients and families and work together on helping to educate others through projects. We created a [guide on how to involve us](#) that you can look at for more tips<sup>[1]</sup>.

\* [www.rcpch.ac.uk/resources/involving-children-young-people-specialised-commissioning](http://www.rcpch.ac.uk/resources/involving-children-young-people-specialised-commissioning)



#voicematters

# Promoting learning in settings other than hospitals

## Schools should develop opportunities for trainees to learn in non-hospital settings

All training posts should create opportunities for trainees to experience clinical care out of the hospital, giving them a broader understanding of patients' needs. This should not simply be restricted to when they are in community posts; for example whilst in A&E, a trainee could spend a session with the local ambulance service, urgent care centre, or teaching basic life support in a local school.

Patients with long term conditions may spend one hour per year seeing a specialist in clinic; they spend 8765 hours a year out of hospital. Families experience healthcare in a wide range of settings; trainees who are aware of these are better skilled to signpost these resources to families.

Ideally all trainees should do a home visit at least once per year, for example administering antibiotics with community nurses; visiting a complex neonatal patient after discharge; or providing rapid response after a child death. Trainees should also be encouraged to attend community settings for young people with complex health needs, such as specialist clinics, schools, colleges and further education environments, and to develop an understanding of occupational health for young people who are approaching employment/apprenticeships.

### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
18.1	Trainees spend a session in a sexual health drop-in clinic. They improve their skills in talking with young people about sexual health and learn how to respond to common sexual health concerns, eg STIs, contraception.	CbD Reflection	2. Communication 5. Health promotion & illness prevention 6. Leadership & team working
18.2	The trainee sees a 17 year old young person with 4-limb Cerebral Palsy and learning difficulties in the school clinic. The physio and social worker also attend, and they collectively discuss transition to the adult services.	CbD	2. Communication 5. Health promotion & illness prevention 6. Leadership & team working

## What children and young people say:



Did you know that there are groups of children and young people that already meet in your local area that you can visit to find out what they think and talk about your work in paediatrics? Have a look for your local children in care council, parent carer forum, youth cabinet or council, young carers group, youth watch/hospital youth forum... there are loads of ways you can get to meet us and learn with us outside of clinics. Come and see us!



#voicematters

## Having an increased focus on mental health

### Schools should develop activities that encourage learning in mental health

*“The training in CAMHs that I had gave me excellent skills and contacts with the CAMHS teams. I was able to share my skills with other trainees in East of England by organising training days on mental health as part of our registrar training program”* New Consultant

When doctors leave medical school they are usually prepared and trained to view the person as a whole, and see all symptoms in their biopsychosocial context. The challenge for specialty training is to maintain this breadth of vision in the face of acute clinical pressures that encourage us to see children and families as cases to process, rather than people with a story.

However, a biopsychosocial approach (see Principle 5) is essential to properly understand a large proportion of paediatric presentations in all settings and to put in place lasting, meaningful intervention.

Trainers have a key role in empowering and encouraging trainees continued interest in their patients as people, rather than as vessels for pathology.

#### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
19.1	A teenager is admitted to the children’s ward with an overdose of paracetamol. This is their third overdose in six months. They have a history of child sexual abuse (CSA) and self-harm. On the ward they are withdrawn and find it difficult to open up to professionals and continue to have suicidal ideation. A meeting is planned with CAMHS and social care; the trainee attends and then discusses the case with their Supervisor.	CbD	1. Professional values and behaviours 2. Communication 7. Patient safety 9. Safeguarding

	Case study	Evidence	RCPCH Progress+ domain
19.2	The trainee attends a school visit with a mental health practitioner to assess how a young person with autism and anxiety is managing at school.	CbD Reflection	2. Communication 6. Leadership & team working 9. Safeguarding

**What children and young people say:**

.....

We need all health care workers, whatever they are seeing us about, to feel confident to talk to us about our feelings and how we are coping with our conditions or life as a child/young person. It doesn't always need to be a specialist worker, but if everyone did mental health first aid training and made time to ask "are you ok" it would be a big help, some ideas are in our [Doctor Pocket Book](#)<sup>[1]</sup>. If we do need a specialist, help us to see them quickly.

\* [www.rcpch.ac.uk/resources/doctors-pocketbook-talking-young-patients-about-mental-health](http://www.rcpch.ac.uk/resources/doctors-pocketbook-talking-young-patients-about-mental-health)

.....

#voicematters

## Health promotion is an integral aspect of patient management

### Schools should develop activities that encourage learning in public health

The World Health Organisation (WHO) defines health promotion as 'the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.' This means health promotion occurs at an individual level, local level or national level through health policy.

As indicated, even at an individual level, understanding the impact of social circumstances, deprivation, family strengths and difficulties, economic circumstances and all the other influences of life can have profound impact on the way we deliver care for our patients. It stretches beyond obesity, mental health, smoking and exercise because understanding these factors for each patient and family allows us to tailor our healthcare to what will be accepted by the family and more likely to be successful. In this way health promotion is an integral part of paediatrics.

Health promotion during adolescence is particularly effective, providing the "triple dividend" of improving the health of young people now, the adults they will become and the health of their future children.

Trainees should be encouraged to look at local public health data, eg Fingertips data and work out what is happening in their local landscape. Supervisors should support trainees in



identifying health promotion opportunities throughout their day-to-day practice; for example, safe sleeping advice could become a key discussion point at a perinatal meetings where an SUDI case is presented.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
20.1	A child in clinic discuss walking to school rather than getting the bus, and it transpires that he passes multiple food outlets on the way. The trainee encourages the young person to plan an alternative walking route.	CbD	2. Communication 4. Patient management 9. Safeguarding
20.2	Several young people from the same school have been seen with alcohol intoxication. The trainee works with local young people, youth workers and school staff to develop an alcohol awareness programme within the school	Reflection	2. Communication 5. Health promotion & illness prevention

## What children and young people say:



We were asked “what do we think is important to keep us healthy, happy and well”. 77% of the 1791<sup>[1]</sup> who answered said we need help to stay healthy, more awareness raising on conditions and to have services that are welcoming to children and young people. We think more should be done to explain in ways we can understand about making healthy choices and how to do this if you don’t have lots of money or live where there are no shops or facilities.

\* [www.rcpch.ac.uk/resources/rights-matter-what-un-convention-rights-child-means-us#what-do-children-and-young-people-want-and-what-are-we-doing-next](http://www.rcpch.ac.uk/resources/rights-matter-what-un-convention-rights-child-means-us#what-do-children-and-young-people-want-and-what-are-we-doing-next)



#voicematters

## Better integrated working with primary care

**Schools should develop activities that support learning around integrated child health**

*“To understand more about the role of school nurses I spent a day in school and assisted in a nursery led session ‘What is a doctor? What is a nurse?’ This day was invaluable and helped me better appreciate the role of another health professional. In the future this will allow me to manage patients more holistically and consider social prescribing as part of all my management plans.”* Foundation Trainee

*“I organised joint training days with GP and paediatric trainees to help us to share experiences and knowledge and promote integrated delivery of care.”* New Consultant

In the NHS the GP provides a pivotal role; in child health, both health visitor and school nurse play a key role as well. By working closely with primary care, the paediatrician will support joined-up care and more preventative approaches, through earlier recognition and treatment of health issues. Interdisciplinary working provides clinicians and other health professionals with the opportunity to learn clinical knowledge and skills from one another, and identify how to work in a more joined-up way to provide holistic care centred around the patient's needs. Common examples of how Schools already support this approach include:

- Expecting trainees to make regular telephone or personal contact with local GPs to discuss patients, rather than solely relying on letters or emails.
- Trainees leading on developing integrated services for common or local problems, by identifying something that isn't working well in their area and working together with a GP trainee to find a solution.
- Trainees participating in the review of the child after a complex discharge. Trainees should aim to see a family after a long inpatient stay, jointly with primary care, for a routine review either in a primary care or home setting. This helps understanding of the limitations and resources within primary care.

### Case studies:

	Case study	Evidence	RCPCH Progress+ domain
21.1	The trainees involved with discharge planning for a patient with complex needs who has recently been an in-patient. The young person is approaching 17 and will soon be leaving paediatric care. The GP will take over holistic care. The trainee attends an extended consultation at the GP practice; the family experience joined up care between the hospital specialists and the (trusted, family) GP.	CbD MiniCex Reflection	2. Communication 4. Patient management 6. Leadership & team working
21.2	A GP and Paediatric trainee notice that in their area there were lots of OPD referrals and ED attendances for feeding problems in the newborn period. The pair collected data to show this, and then set up a joint feeding clinic within primary care to see patient groups and support families.	MiniCex	5. Health promotion & illness prevention 8. Quality improvement
21.3	Trainees take on the GP email advice service. They draft responses to each query and the consultant reviews each response before it is sent. The consultant role models the importance of taking the GP perspective into account.	CBD	2. Communication

## What children and young people say:



It can be very frustrating when we see lots of different people and have to remember who said what so that we can tell the next one. We would love it if there is one system to share all our information, but if there isn't, then we need you to help tell our GP what is happening and what to do if we get more ill, so that we feel confident that they can help us too.



#voicematters

## A specific focus on the health needs of young people (aged 11-25)

### Schools should develop activities that encourage learning around young people's health

The morbidity, including complex morbidities, among young people presenting to paediatrics is increasing. Young people's health needs have not always been appropriately met within traditional paediatric settings, although traditional paediatric services currently stop at age 16 or 18. There is increasing recognition of the health needs of adolescence and young adults 16-25 (AYA) requiring paediatricians to work with adult physicians and GPs to meet those needs.

Trainees need the skills and confidence to engage with young people including:

- Seeing young people alone.
- Explaining confidentiality.
- Taking a psychosocial history (HEADDSS).
- An understanding of common clinical presentations, eg management of long term health conditions in adolescence; sexual health; mental health; eating disorders; persistent physical symptoms (MUPS) and CFS/ME.
- Following a young person who has recently transferred to adult care.
- Shadowing a clinician that straddles both adult and paediatric care, eg surgeon, GP, Gynaecologist, ENT.
- Thinking about the impact of childhood illness on adult health and lifestyle.

Trainees also need to apply the principles of Developmentally Appropriate Healthcare (DAH), including transition for those young people with long term health conditions or disabilities, such as learning disabilities.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
22.1	A 15 year old girl presents to A&E with vomiting. During HEADDSS assessment she talks about having had sex but her parents don't know. The trainee asks more about the relationship including age difference, use of substances, coercion and considers CSE screening questions. The young woman consents to a pregnancy test which is positive and the trainee shares the result with the patient. They discuss how and if she will tell her parents, and whether the trainee can help with this. The trainee considers a safeguarding referral and signposts to early pregnancy unit and teenage sexual health clinic.	Safeguarding CbD Reflection	5. Health promotion & illness prevention 9. Safeguarding
22.2	The trainee sees a young person with Chronic Fatigue Syndrome (CFS) in the paediatric assessment unit with escalation of pain, and then follows up by attending MDT and shadowing the occupational therapist on a school visit to discuss how the school timetable can be modified to facilitate attendance.	CbD Reflection	5. Health promotion & illness prevention 6. Leadership & team working

**What children and young people say:**



We have been thinking about how important youth friendly<sup>[1]</sup> and youth aware (especially about identity and youth issues) services<sup>\*\*</sup> are for us to feel supported, safe and like we can come to you if we need to. We need you to read between the lines as sometimes it is hard to tell you what is going on, and to have the skills to treat us differently to meet my needs but as an equal, respecting my rights.

\* [www.rcpch.ac.uk/resources/what-do-young-people-want-nhs-long-term-plan](http://www.rcpch.ac.uk/resources/what-do-young-people-want-nhs-long-term-plan)

\*\* [www.rcpch.ac.uk/resources/state-child-health-us-2019](http://www.rcpch.ac.uk/resources/state-child-health-us-2019)



#voicematters

## Utilisation of simulation, digital and technology-enhanced learning

Schools should actively support the use of technology-enhanced learning, and simulation faculty development.

*"I contributed to the Connecting Care for Child Twitter feed. This allowed me to link and engage in patient and health focused conversations outside of the clinical setting on a national scale. This was unique experience and of great value to my training as*

*increasingly children and young people turn to social media for support through their health journey. Health promotion will become an integral part of any clinician's future career."* Foundation Trainee

Schools should develop comprehensive simulation faculty development programmes. Experience indicates that Clinical Supervisors who work as simulation faculty will facilitate feedback and learning in the workplace, well-beyond formal simulation activities.

For each aspect of the curriculum, classroom techniques should be chosen that best fit learning requirements. Simulation can be used well beyond physical emergency resuscitation scenarios. Trainees should experience simulation that draws on local simulation expertise, organised through the Schools of Paediatrics. There are increasing opportunities for technology-enhanced learning, for example online teaching, digital apps and part-task trainers.

Common examples of how Schools already support this approach include:

- Learning to undertake a clinic consultation through role-play with video and actors.
- Managing a psychotic patient in the emergency department through simulation.
- Using simulation to teach high-quality handover skills.
- Using a mindfulness app to support personal wellbeing.
- Using WhatsApp groups for trainees to encourage peer to peer learning and support.
- Trainees and trainers share learning microteaching via multidisciplinary WhatsApp groups and Twitter.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
23.1	<p>Life support training has already been enhanced by in-situ and real time training using high fidelity manikins. Paediatric Simulation can also be used to train professionals in MDT working. This can be done using everyday scenarios, eg workload management; interpersonal relationships within teams; polite and constructive challenge to team members; negotiating to enhance the delivery of safe and efficient care and managing safeguarding concerns. These are just a few examples.</p> <p>This can be done using scenario-based role play using defined realistic "scripts" with or without actors. The observer in the team is responsible for noticing the overall team skills displayed with learning being gained by the participants through a process of reflection and skilled facilitation. This will help develop skills of feedback within teams as well. Teams that train together work more effectively together.</p>	CbD	4. Patient management

	Case study	Evidence	RCPCH Progress+ domain
23.2	<p>Trainees have the opportunity to learn to be Simulation Trainers through a modular training programme that teaches all aspects of becoming a Simulation Trainer, covering technical aspects, leadership, safety and educational principles. Trainees become expert at facilitation and feedback, using this in all settings, not just in the sim lab; they learn the value of team in-situ teaching, often with low-fidelity scenarios; they use team in-situ teaching to identify latent errors and strengths, and use these to improve safe practice; the programme encourages leadership development.</p>	ACAT	<p>4. Patient management 10. Education &amp; training</p>

**What children and young people say:**

.....

It would be great if doctors can think about how to use technology with us so that we can have review appointments using video call and not miss so much school coming in or have a way we can send you questions between appointments. We don't always want our health contact by social media though, so please ask us! You can also get young people involved in simulations, one group talked to us about doing reverse simulations with the young people as doctors and the doctors as young people!

.....

#voicematters

## Teaching human factors

### Schools should develop faculty that understand and can teach human factors

The WHO defines human factors as ‘the study of all the factors that make it easier to do the work in the right way’ and ‘the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work’ (WHO, 2016).

There is increasing evidence that human factors play a key role in patient care, safety and risk. Understanding the biases in thinking is helpful. Patient safety and high quality care can be materially changed by these insights.

Schools of Paediatrics can address this through teaching decision making skills, situational awareness, crisis resource management, situational awareness, cognitive bias, and high quality frameworks for handovers. A practical example of their application could include all staff using the SBAR (Situation, Background, Assessment, Review) communication tool. Another example would be to ensure all trainees receive training early in their paediatric career on how incidents

are investigated and their potential role in these investigations, and then asking them to review recent serious incidents and analyse common themes.

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
24.1	A trainee undertakes a pathway analysis, for example of septic arthritis, reviewing how long it took from presentation to joint washout and explores the factors that contributed to delay. They identify issues with decision making in the paediatric A&E department, and some logistical issues with getting children to theatre quickly, causing undue delays.	CbD	6. Leadership & team working 8. Quality improvement
24.2	A trainee links up with the child death review team and follows a case from presentation through to completion of the child death review process. They learn about the analysis of the factors that led to the death and modifiable factors or errors that contributed to the death.	CbD	1. Professional values & behaviours 6. Leadership & team working

**What parents and carers say:**

.....

225 parents of children and young people with complex health needs shared their biggest concerns in relation to patient safety which were: communicating with other carers and healthcare professionals about their child’s medication, remembering which medication to give and when, their child’s response to receiving the medication and how to administer the medicine and how much to give. Remember if we are providing up to 18 hours of care a day, we need to know we can talk to you about the support we need too.

.....

#voicematters

## Shared learning with other professions and disciplines

Schools should develop opportunities for trainees to learn from other professionals and disciplines. This can be through formal training activities and an interprofessional learning culture in the workplace.

*“I did 9 months of clinical genetics - aside from the clinical experience of how another specialty works in its approach to a range of useful things - clinics, sensitive conversations, MDT working – would recommend!” Trainee*

Learning with and from other health professionals will be a vital component of cultural change and valuing of roles to enhance the quality of care given to the children, young people and their family. This integrated learning with others occurs across a range of health and social care contexts.

It is crucial that meeting the needs of children and young people is managed from a multi-disciplinary perspective. The Paediatric trainee will therefore need to be skilled in working as part of this multi-disciplinary backdrop.

Inter-professional and inter-disciplinary work provides rich learning opportunities. Working across a range of teams within both primary and secondary care (including social care), the trainee will apply skills that promote the well-being of the child, valuing the contribution of others, working constructively within a team and developing their own personal leadership skills. Common examples of how Schools already support this approach include:

- Community nursing teams, specialist nurses, Physician Associates, Advanced Clinical Practitioners, health visiting and social work teams.
- Every trainee having an opportunity to learn through working with a local GP.
- Joint regional learning.
- Team huddles.
- Inviting Advanced Clinical Practitioners and Physician's Associates to attend their teaching sessions for paediatric trainees to enhance training for both groups of learners.
- 

**Case studies:**

	Case study	Evidence	RCPCH Progress+ domain
25.1	Safeguarding peer review meetings are held once a month in a multidisciplinary training setting, involving the liaison health visitor, named nurse, named midwife and named doctor for safeguarding. Trainees present cases that have raised challenging issues with recognition and response, multi-agency working and staff support.	Reflection	9. Safeguarding
25.2	A joint training day is held with paediatric trainees and GP trainees, followed by a social event. A resilience trainer from the Navy spent the day working with trainees to foster relationships between professionals, explore stressors in our work environments and consider strategies for managing working in high pressure environments.  The training was successful in helping professionals from primary and secondary care understand each other's perspectives and differing pressures. The day was joint funded by the education budget for paediatric trainees and GP trainees. Attendees fed back that the day would help improve professional relationships in order to facilitate integrated care.	Leader	2. Communication 6. Leadership & team working
25.3	In the Emergency Department, formal teaching takes place for the whole team: nurses and doctors from different professionals. This works well because it is supported by senior members of the nursing and medical team.	Leader	6 Leadership & team working 10. Education & training



## What children and young people say:



It helps us when doctors and different teams coordinate our care well, talking and sharing and learning what works from each other. It helps when you have joint appointments with us too, so we all know the same information and remember to work with our schools. Sometimes our schools and doctors are amazing, and sometimes we move or change places and it can be difficult when the don't know or understand about our condition.



**#voicematters**

# Appendix 1: RCPCH Progress+ curriculum

The table below shows the proposed RCPCH Progress+ curriculum Learning Outcomes, these are subject to GMC approval. All paediatric trainees must demonstrate that they have met these Learning Outcomes by the end of their training level.

The generic core and generic specialty syllabus provide more detail on each Learning Outcome, including the Key Capabilities (mandatory aspects of the outcome which must be explicitly evidenced), and Illustrations (examples and prompts of other evidence which may help a trainee show they have met the standard described by the Learning Outcome).

Domain	Core training	Specialty training
<b>1. Professional values and behaviours</b>	In addition to the professional values and behaviours required of all doctors (Good Medical Practice), a paediatric trainee must adhere to legal frameworks relating to babies, children, young people and families/carers, including relevant safeguarding legislation related to the four nations.	Acts as a role model by taking a self-regulatory approach in ensuring professional values and behaviours, demonstrating the qualities required by a paediatrician undertaking independent practice.
<b>2. Professional skills and knowledge: Communication</b>	Develops effective professional relationships with babies, children, young people and their families/carers as well as colleagues, enabling active participation in planning and implementation of care plans - this will include demonstrating listening skills, cultural awareness and sensitivity; communicating effectively in the written form, by means of clear, legible and accurate written and digital records.	Applies communication skills in a range of contexts, for example, in multi-disciplinary teams (MDT), with children, young people, families/carers, external agencies and other professionals, across a range of media, including legal and child protection reports.
<b>3. Professional skills and knowledge: Procedures</b>	Undertakes key paediatric clinical procedures both elective and emergency, including responding to and leading emergency situations and performing advanced life support, recognising when and how to escalate and adapting clinical assessments to meet the needs of babies, children, young people and families/carers.	Capable in the full range of clinical skills relevant within <GENERAL PAEDIATRIC/SUB-SPECIALITY>, including appropriately co-ordinating the skills of other health professionals, when required.
<b>4. Professional skills and knowledge: Patient management</b>	Conducts a clinical assessment of babies, children and young people, formulating an appropriate differential diagnosis; plans appropriate investigations and initiates a treatment plan in accordance with national and local guidelines, tailoring the management plan to meet the needs of the individual.	Considers the full range of differential diagnosis, treatment and management options available, including new and innovative therapies, relevant within <GENERAL PAEDIATRIC/SUB-SPECIALITY>; anticipating the need for transition from paediatric services and planning accordingly.

Domain	Core training	Specialty training
<b>5. Health promotion and illness prevention</b>	Promotes healthy behaviour in conversations with children, young people and their families/carers, from early years through to adulthood; taking into account the potential impact of cultural, social, religious and economic factors on the physical and mental health of children and families.	Works with the wider healthcare community, promoting wellbeing, physical and mental health to improve the health of babies, children and young people.
<b>6. Leadership and team working</b>	Develops personal leadership skills and demonstrates their own leadership qualities, adjusting their approach, where necessary; utilising these skills to work constructively within multi-disciplinary teams (MDT), valuing the contributions of others.	Leads in multi-disciplinary team (MDT) promoting an open culture of learning and accountability by challenging and inspiring colleagues, supporting the development of leadership qualities and critical decision-making skills.
<b>7. Patient safety, including safe prescribing</b>	Recognises the importance of patient safety, including safe prescribing and exposure to risk/hazard.	Takes responsibility for investigating, reporting, resolving and evaluating risk/hazard incidents, within different paediatric healthcare settings, including communication with affected children or young people and their families/carers.
<b>8. Quality improvement</b>	Applies quality improvement (QI) methodology to clinical practice, thereby learning and reflecting to foster positive change.	Independently applies knowledge of quality improvement (QI) processes by initiating, planning and undertaking projects and audits to improve clinical effectiveness, patient safety and patient experience.
<b>9. Safeguarding</b>	Understands the professional responsibility of safeguarding babies, children and young people; accurately documents and raises concerns in a proficient manner to appropriate staff and agencies.	Independently leads the process of safeguarding for babies, children and young people, including assessment, investigations and reporting.
<b>10. Education and training</b>	Plans and delivers teaching and learning activities, to a wide range of audiences and provides appropriate feedback to others.	Demonstrates the required knowledge, skills and attitudes to provide appropriate teaching, learning opportunities, supervision, assessment and mentorship in the paediatric healthcare setting.
<b>11. Research and scholarship</b>	Adopts an evidence-based approach to baby, child, young people and family's/carers health practices, including critically appraising published research.	Demonstrates the independent development and revision of guidelines and policies, ensuring these are centred on current clinical research and evidence-based healthcare, to improve babies, children and young people's health and paediatrics service delivery.

# Acknowledgements

*Paediatrician of the Future: Defining really good training* was authored by the RCPCH Shape of Training Implementation sub-group.

Dr Mando Watson (Consultant General Paediatrician)  
Yvonne Savage (RCPCH Quality & Standards Co-ordinator)  
Jenni Thompson (RCPCH Quality & Standards Manager)

We would like to acknowledge the valuable contribution of the following members who assisted in authoring and reviewing this document throughout its development. Some of the participants were trainees when they contributed to the document, but have now moved into consultant posts:

Dr Katie Birley	Paediatric Trainee
Dr Nancy Bostock	Paediatric Trainee
Dr David Evans	Neonatal Consultant and RCPCH Vice President for Training and Assessment
Dr Emma Bradley	Training Programme Director (Severn), RCPCH CCH CSAC representative and Consultant Community Paediatrician
Dr Cathryn Chadwick	Head of School (East Midlands) and Consultant Neonatologist
Dr Max Davie	RCPCH Health Improvement Officer and Consultant Community Paediatrician
Dr Emma Dyer	Paediatric Trainee
Dr Hannah Jacobs	Chair of the RCPCH Trainees Committee and Paediatric Registrar
Dr Chloe Macaulay	Consultant General Paediatrician
Dr Katie Mayers	Paediatric trainee
Dr Rachael Mitchell	Consultant in Paediatric Emergency Medicine
Dr Katherine Neely	Paediatric Trainee
Dr Nelly Ninis	Consultant General Paediatrician
Dr Emma Parish	Paediatric Trainee
Dr Phil Parslow	Consultant General Paediatrician
Dr Christine Pierce	RCPCH Curriculum Lead and Consultant Paediatric Intensive Care Paediatrician
Dr Jane Runnacles	Consultant Paediatrician
Dr Karin Schwarz	Head of School (Yorkshire & Humber) and Consultant Neonatologist
Emma Sparrow	RCPCH & Us
Dr Arpana Soni	Paediatric Trainee
Dr Sanjay Suri	Training Programme Director (Yorkshire) and Consultant General Paediatrician
Dr Gillian Turner	Consultant Community Paediatrician
Dr Judith Van der Voort	Head of School (Wales) and Consultant Paediatric Nephrologist
Dr Sara Warraich	Paediatric Trainee
Dr Alice White	Foundation Trainee
Dr Elizabeth Wortley	Paediatric Trainee



**Paediatrician of the future:  
Delivering really good training**

A guide to the RCPCH principles for  
postgraduate paediatric training and how to  
apply them within local training programmes

Version 1.0  
October 2020