Advisory Committee on Emergency Medicine Training
Reply to: Administrator for Emergency Medicine Training
Royal College of Surgeons in Ireland
123 St. Stephens Green, Dublin 2, Ireland
Tel: +353 1 402 2240 Fax: + 353 1 402 2459 Email: EMadministrator@rcsi.ie

Dr. Gareth Quin, Chairperson
Prof. Ronan O'Sullivan, Programme Director
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The Development of Paediatric Emergency Medicine in Ireland

Executive Summary

- There are over 20 hospitals in Ireland where acutely ill or injured children are seen, with children accounting for nearly a quarter of all attendances at regional Emergency Departments (EDs), while over 110,000 children attend the 3 paediatric-only EDs (PEDs) in Dublin on an annual basis.
- There are approximately 60 Consultants in Emergency Medicine (EM) in Ireland, with only 5 in Paediatric Emergency Medicine (PEM) and none specifically appointed to such a role in regional EDs.
- Currently, paediatric emergency care is provided in regional units through a combination of Emergency Medicine and General Paediatric services, often with little integration between specialties.
- There is an urgent need to address Consultant staffing in PEM, through both increases in numbers in the dedicated PEDs in Dublin and in appointments to regional units. The former is particularly important in the context of the imminent development of the *Children's Hospital of Ireland*.
- Increases in Consultant in PEM staffing lead to evidence-based reductions in hospital admission rates, complaints and ED waiting times, with substantial cost savings to health systems.
- Unlike the UK, North America and Australasia, the specialty of PEM is not recognised by the Medical Council in Ireland.
- Recent Consultant appointment processes in PEM have advantaged the applicant who has primarily trained in Emergency Medicine.
- In 2008, the Advisory Committee on Emergency Medicine Training (ACEMT) implemented a mandatory six month rotation in PEM as part of higher specialist training in EM, while a six month rotation in PEM will also feature as part of the forthcoming national basic specialist training programme in EM.
- ACEMT has also decided that recognition of specialty training in PEM would require 2 years additional training in PEM and paediatric critical care. Both components of PEM training outlined below (as part of general EM training and subspecialty training) are supported by clearly defined competencies and a validated curriculum.
- PEM is not a mandatory component of General Paediatrics training, at either basic or higher level.
- ACEMT and the Faculty of Paediatrics, Royal College of Physicians of Ireland have agreed in principle to advance the development of PEM in Ireland in tandem.

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Introduction

The purpose of this paper is to recognise and outline the need for development of Paediatric Emergency Medicine (PEM) in Ireland and to recommend clear guidelines for training for those professional bodies in Ireland with a stakeholder interest in the specialty of PEM.

Background

There are over 20 hospitals in Ireland where acutely ill or injured children are seen. Nearly all of those hospitals will admit children acutely, while others will see children within the Emergency Department (ED) but will not admit e.g. Naas General Hospital, St. Columcille's Hospital, Loughlinstown. Currently, over 110,000 children attend the 3 paediatric-only EDs in Dublin on an annual basis. In most hospitals with EDs that see both adults and children (typically outside Dublin), approximately one quarter of all attendances will be children, and this is consistent with international data.[1,2]

While there are approximately 60 Consultants in Emergency Medicine (EM) in Ireland at present, there are only 5 Consultants in PEM and all are based in the 3 paediatric-only EDs (PEDs) in Dublin. There are a small number of Consultants in EM in other departments who have some subspecialty experience (one with subspecialty training) in PEM but whose current practice either involves a minority component or no paediatric practice. There are no Consultants in PEM who have been appointed to those hospitals outside the PEDs in Dublin with a primary remit to develop PEM in those units.

In a significant number of those hospitals where both adults and children attend, 'surgical' paediatric cases are usually managed by EM, while 'medical' paediatrics is usually managed by General Paediatrics. This would typically mean that paediatric trauma (including major trauma), acute abdominal pain etc, will be seen as the remit of EM, while acute illness will be the remit of Paediatrics. Conversely, serious medical illness requiring resuscitation is often managed by EM, with Paediatrics consulting. Oftentimes, children with 'medical' illness will be reviewed on a General Paediatric ward or day unit after initial registration and triage in the ED. With few exceptions, these 'mixed' hospitals have inappropriate physical infrastructure to manage acutely unwell children e.g. lack of adequate child-friendly and appropriate areas within EDs. Equally, very few of these institutions have appropriate levels of nursing staffing in paediatric emergency care. Having both appropriate infrastructure and nursing provision has been recognised internationally as being integral to the delivery of quality paediatric emergency care.[2,3]

The relatively recent establishment of the central role of Consultants in EM in the provision of clinical emergency care in Ireland, coupled with the attendant responsibility to govern and deliver training in this area, has led to the development of multi-consultant staffing in many EDs and the development of a higher specialist training programme in EM (HSTEM), overseen by the Advisory Committee for

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Emergency Medicine Training (ACEMT). Furthermore, a national basic specialist training programme in EM (BSTEM) will commence in July 2011.

There is recognition within the Irish EM community, through both the Irish Association for Emergency Medicine (IAEM) and EM's training organisation ACEMT, of the importance of the specialty of PEM. There is consensus in international EM and General Paediatric practice regarding the primary importance of specialists in PEM when considering the provision of appropriate and benchmarked paediatric emergency care.[1-6]

IAEM and ACEMT recognise the urgent need to address consultant staffing in PEM in the following areas:

1. **Consultants in PEM in the existing PEDs in Dublin**
    - Current staffing is as follows:
        - *Our Lady's Children's Hospital, Crumlin (OLCHC)*: 2 Consultants for 32,000 annual attendances
        - *Adelaide, Meath incorporating National Children's Hospital, Tallaght (AMNCH)*: 1 Consultant for 32,000 annual attendances (there is a second position approved and currently filled by two halftime locums; the substantive post was interviewed in early 2010 but no appointment was made)
        - *Children's University Hospital, Temple St (CUH)*: 2 Consultants for 48,000 annual attendances
    - International benchmarks are:
        - *RCH Melbourne*: 12 Consultants for 66,000 attendances
        - *Toronto Sick Kids*: 32 attending physicians (i.e. Consultant equivalents) for 60,000 attendances
        - *CHOP (Philadelphia)*: 50 attending physicians for 78,000 attendances
        - *Alder Hey, Liverpool*: 8 Consultants for 60,000 attendances

While it is unrealistic to consider that Consultant in PEM numbers would approach staffing levels in North America, it is worth noting that the planned *Children's Hospital of Ireland* proposes to care for nearly 70,000 children in the ED at the Eccles St. site, with over 55,000 attending the Ambulatory & Urgent Care Centre at Tallaght. It is thought likely that these figures may change as parents may be disinclined to use a limited hours centre providing different care from an ED, thus decreasing the projected attendances at the AMNCH site but consequently increasing the Eccles St. attendances to a figure in the region of 80,000 attendances per annum. This would make that department the busiest PED worldwide.

A short-to-medium term increase in Consultant staffing in the three PEDs in Dublin to **12 in total** (an **increase of 7 Consultants** from current levels) is recommended. This complement would be expected to deliver care across both the Eccles St. and AMNCH sites going forward, as part of a single

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department with a unified governance structure. This care would not only include emergency and urgent care but would also include the development of observation medicine in a paediatric setting.

Geelhoed *et al*[6] have comprehensively investigated the hypothesis that increased presence of Consultant staff would lead to better outcomes in a PED. A retrospective observational study was conducted in a tertiary PED over a 10-year period, documenting trends in percentage of children admitted, complaints to the department and average waiting times. Consultant numbers increased from 2.6 to 6.2 whole time equivalent staff between 2000 and 2004. Other staffing numbers were essentially unchanged. All parameters examined improved, coincident with increasing Consultant numbers:

- The percentage of children admitted decreased by 27%;
- Complaints fell by 41%;
- The average waiting time fell by 15%;
- The yearly cost of an additional 3.6 Consultants (2005) was $A1.003 million with net saving to the hospital of over $A9.48 million.

2. Consultants in PEM in regional EDs

- There is currently one Consultant in EM with PEM specialty training, working in a regional ED (Dr. Kieran Cunningham at Sligo General Hospital); however Dr. Cunningham was not appointed with the specific remit to develop PEM in that hospital
- Several EDs see enough children currently to justify the immediate appointment of a consultant in PEM. These would include:
  - Cork University Hospital
  - University Hospital, Galway
  - Mid-Western Regional Hospital, Limerick
  - Waterford Regional Hospital
  - Our Lady of Lourdes Hospital, Drogheda
  - Midlands region – currently children are seen in Mullingar and Portlaoise, while the majority of Consultant in EM sessions are delivered in MRH Tullamore. This region would certainly benefit from the appointment of a specialist in PEM to wherever EM services are reconfigured

It would be appropriate for local decision making to guide the on-call arrangements for Consultants in PEM in regional units. If the successful candidate at interview were from an EM training background, then logically that person would be an additional person for the general EM on-call rota. The same principle should apply to someone from a Paediatric background i.e. they should be on the General Paediatric on-call rota.

The recent publication of *The Role of the Consultant Paediatrician with Subspecialty Training in Paediatric Emergency Medicine*[7] by the Royal College of Paediatrics and Child Health (RCPCH) in the

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UK provides valuable assistance in delineating the potential future role of such specialists, as well as highlighting the benefits of collaboration between paediatric and EM stakeholders. That document gives examples of work plans that such a consultant could employ (see below):

Example 1 Paediatric Emergency Medicine with Child Protection

	AM	PM	EVENING
Mon	-	ED	ED
Tues	Child Protection Clinic	SPA	
Wed	SPA	Child Protection Admin	
Thurs	ED	ED	
Fri	Child Protection Clinic	-	
Sat/Sun	1:6 Gen Paeds On Call		

The Role of the Consultant Paediatrician with Subspecialty Training in Paediatric Emergency Medicine- August 2008

Example 3 Paediatric Emergency Medicine with General Paediatrics

	AM	PM	Evenings
Mon	Post take ward round/ ED	Admin	
Tues	Gen Paeds OPD	ED	
Wed		ED	ED
Thurs	SPA	SPA	
Fri	ED	ED	
Sat/Sun	1:5 Gen Paeds On Call		

Reconfiguration of Acute Hospital Services

An important consideration in the development of PEM in Ireland is the ongoing process of acute hospital service reconfiguration. The generic principles of reconfiguration have been supported by IAEM[8], and are supported also in the context of paediatric emergency care. However, little overt consideration has been given, thus far, to care of children and PEM within those areas where reconfiguration has occurred. Indeed, what consideration there appears to have been is concerning in the assumptions that have been made about paediatric emergency care e.g. suitability of local injury clinics, etc.[9] It is appropriate to revisit these issues in those areas where reconfiguration has taken place and is about to take place.

With over 20 hospitals in the state currently providing emergency care to children (to varying degrees of complexity and support), it is imperative that any process which looks at development of PEM in

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Ireland should scrutinise the current delivery of paediatric emergency care and seek to optimise that care. There is a need to create standards for those institutions which care for acutely ill or injured children and ultimately determine whether it is prudent for all hospitals that currently provide such care to continue doing so.

Delivery of additional Consultant in PEM staffing

Ultimately, the challenge of delivering adequate staffing in PEM in Ireland can be distilled into two broad issues, namely:

- Specialty training in PEM
- The PEM component of general EM (and General Paediatric) training

Specialty Training in Paediatric Emergency Medicine

Currently PEM is not a recognised specialty in the Register of Medical Specialists in Ireland. The specialty has been formally recognised in the UK by the General Medical Council in recent years and in North America and Australasia for significantly longer. There exists a precedent in Ireland whereby PEM might be recognised as a specialty i.e. Paediatric Cardiology is a recognised subspecialty of Paediatrics and has a similar number of specialists currently in practice.

The existing route to specialty training and accreditation in PEM and ultimately employment as a Consultant in PEM in Ireland has been through the achievement of a Certificate of Completion of Training (CCT) in Emergency Medicine with one year's additional training, typically including six months dedicated PEM and six months of ward-based paediatrics, of which at least three months would include Paediatric Intensive Care (PIC). This route has been previously ratified as satisfactory by the College of Emergency Medicine when considering the issue of run-through training and *Modernising Medical Careers.*[10]

However, trainees in General Paediatrics have been disadvantaged by these pre-existing arrangements. While it has been possible for a trainee with a CCT in paediatrics to obtain a Consultant post in PEM in Ireland, this was only possible if that trainee qualified to apply for such a post through an 'experiential' route: mandatory requirements would be at least seven years post-registration clinical experience, with at least four years clinical EM experience and two years in paediatric-related specialties. The continuation of this position will pose obvious problems for any paediatric Specialist Registrar (SpR) with aspirations to pursue a career in PEM. The RCPCH (UK) has gone some way to offering clarity and guidance for trainees and there is acceptance that an additional two years of PEM-focused training is sufficient to gain subspecialty accreditation in PEM.[11]

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Those guidelines, along with guidance relating to recognition of an ED for paediatric subspecialty training are succinctly presented in the recently published 'Red Book'[3]:

"Paediatric EM with a CCT in EM

A trainee in EM who seeks to register paediatric EM as a sub-specialty will usually need to undertake at least one year of training in the care of children, over and above that which is required for general EM higher specialist training. The training required to achieve the competencies would usually consist of:

- *six months in paediatric EM: this must be in a department approved by the CEM for sub-specialty training in paediatric EM*
- *six months of ward-based paediatric specialties: at least three months of this should be in ward-based general paediatric medicine, including involvement in the care of emergencies*

Training in the care of unconscious and critically ill children is required. All trainees in EM will have completed twelve months training in anaesthetics and intensive care during the acute care common stem rotation, in years one and two of their specialist training. If this attachment has not included training in the care of children, time must be allowed for this in the course of additional training for paediatric EM as a sub-specialty. Many trainees will need at least three months training in a PICU to attain the necessary competencies.

Paediatric EM with a CCT in paediatrics

Trainees in paediatrics seeking registration in paediatric EM as a sub-specialty will need to undertake a two-year training programme. This is undertaken after core higher specialist training. Paediatric trainees wishing to pursue this sub-specialty training will need to apply for a national training grid post in paediatric EM. This ensures equity, as opportunities in paediatric EM are not available to paediatric trainees in every region. Information on this process is available from http://www.rcpch.ac.uk/education/training/hst/subspecialty.html

The training programme for "run-through" trainees in paediatric EM is two years in duration and comprises two years of paediatric EM, including achievement of competencies in paediatric orthopaedics, paediatric surgery, and paediatric intensive care (normally around three months' equivalent time in each, which may be attained on a modular basis).

Recognition of an ED for paediatric EM sub-specialty training

All specialist paediatric EDs receiving injured and acutely ill children are eligible for CEM/PMETB recognition. General EDs that offer high standards of training and good experience in the care of children may be recognised by the CEM, on the basis of the following criteria:

- *numbers of children seen and paediatric case-mix: suitable departments will usually receive at least 16,000 new child patients each year, and in approving a general ED for paediatric EM training, the CEM should seek to ensure that a wide range of paediatric problems, medical as well as traumatic, is seen*
- *adequate facilities for the care of children*
- *specialist paediatric support: there must be paediatric in-patient facilities on the same site as the ED, and a consultant paediatrician must be identified as having special responsibility for the ED*
- *a paediatric EM trainer: a general or paediatric ED offering paediatric EM sub-specialty training must have at least one whole-time equivalent trainer, who is a consultant in paediatric EM*

Recommendations

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1. *EDs seeing more than 16,000 children per annum should employ a consultant with sub-specialty training in paediatric EM.*
2. *Hospital paediatric departments with an on-site ED seeing more than 16,000 children per annum should aim to appoint a paediatrician with sub-specialty training in paediatric EM.*
3. *The appointment of consultants from both backgrounds is an advantage, and is essential for larger EDs."*

A further consideration is the approach adopted by other international training bodies. The general consensus is that a primary 'residency' type training in general EM or paediatrics is then followed by a subspecialty training programme in PEM. This is typically a '4 + 3' process i.e. four years general residency followed by three years of subspecialty training, some of which can be non-clinical or research-orientated.[12,13] The following is a schematic diagram of the structured training programme employed by the Royal Australian College of Physicians and the Australasian College of Emergency Medicine:

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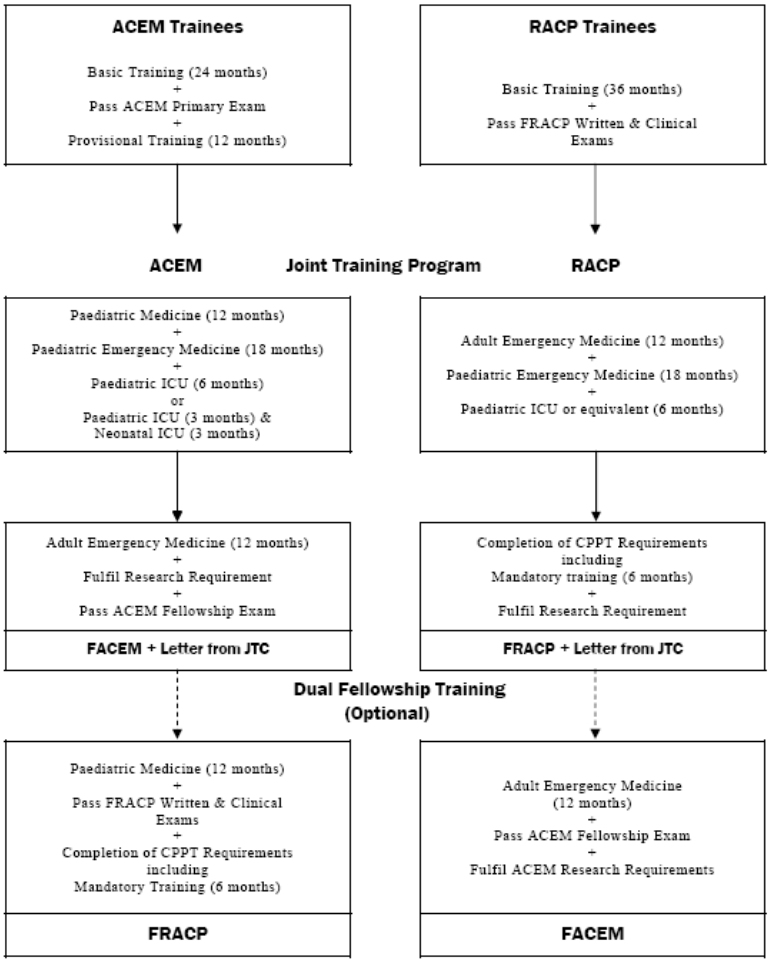
ACEM/RACP Joint Training Program in Paediatric Emergency Medicine



Based on current UK training body regulations and international programmes in PEM subspecialty training, ACEMT extended, in 2008, the minimum period of additional training required to gain subspecialty accreditation in PEM from 12 to 24 months. This additional training assumed 6 months higher training in PEM already completed to reach an acceptable standard for general EM. Going forward, with the development of BSTEM, trainees will have completed a further additional 6 months of PEM (therefore 12 months in total during general EM training). This can have the effect of shortening the length of PEM specialty training to **18 months** for EM trainees

Therefore, at the end of training, a subspecialist in PEM (from an EM background) would have completed a minimum of **30 months** in PEM in *total* (including PIC).

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Ideally (for EM trainees), the majority of this training would occur as part of a recognised fellowship programme after CCT. Currently, EM trainees must spend a minimum of 4 years on HSTEM. While the programme is technically 5 years in duration, many trainees will receive retrospective recognition for prior experience gained. With the introduction of BSTEM, and a more seamless transition through training, it would be envisaged that retrospection will become unnecessary in most cases. Revised structures of EM training, currently undergoing discussion with HSE MET and ACEMT, will likely have a 4 year HSTEM in the near future.

There are embryonic plans to create a PEM fellowship programme in Ireland, in advance of the development of the *Children's Hospital of Ireland*. This 2 year programme could be structured as follows:

- PEM (OLCHC) 6 months
- Paediatric ICU (OLCHC) 6 months
- General EM or General Paediatrics (AMNCH) 6 months
- PEM (CUH, Temple St) 6 months

As the programme develops, it would be expected that it would attract international applicants. Equally, Irish trainees pursuing PEM subspecialty training will continue to apply to UK and international programmes. Appropriate training in PEM undertaken during a higher training programme e.g. during out of programme experience (OOPE), should be considered as contributory towards total requirements for specialty recognition.

For those trainees from a Paediatric background, a reasonable approach would be to have a requirement for 2 years PEM specialty training in addition to 3 years core Paediatric training – this is currently the model employed by Faculty of Paediatrics for other paediatric subspecialties and has been applied to existing trainees who are pursuing PEM specialty training. However, this requirement should ideally be associated with 6 months of PEM completed as part of either basic or core higher training in Paediatrics.

Thus, a jointly agreed process of subspecialty training in PEM might appear as follows:

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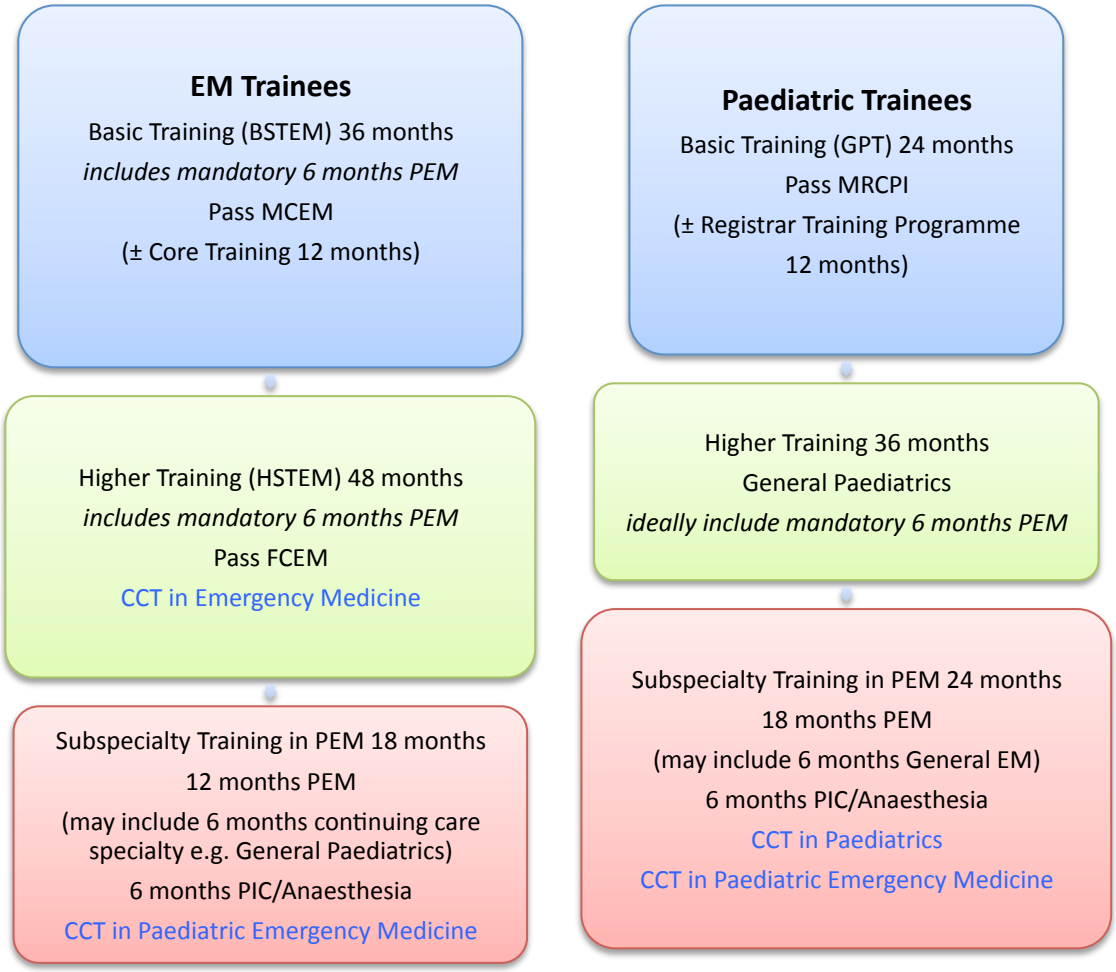
Advisory Committee on Emergency Medicine Training/Faculty of Paediatrics
Joint Training Programme in **Paediatric Emergency Medicine**



The training programme outlined above should be resourced to recruit and train a minimum of **3-4 trainees** per annum. The majority of these trainees would be sourced from Ireland (and the UK) but it would be envisaged that some international trainees would be recruited – this could be part of an 'exchange' programme whereby the Irish trainee could take a training post for 6-12 months in an internationally recognised PEM programme, with the international trainee reciprocating.

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Curriculum

The joint curriculum and assessment framework for subspecialty training in PEM, devised conjointly by RCPCH and CEM in 2005, and revised in 2010, will be the curriculum for subspecialty training in PEM governed by ACEMT (and by extension the Faculty of Paediatrics of the Royal College of Physicians of Ireland).

Assessment

The joint programme outlined above would be administered by ACEMT, with formal representation from Faculty of Paediatrics. A similar model works effectively already, with RCPI and RCSI representation on ACEMT for many years.

Assessment of trainees' progress through subspecialty training in PEM should be based on similar assessment through general EM training:

- Workplace based assessment (WPBA)
- Trainer-trainee meetings at departmental level
- Record of In Training Assessment (RITA)-type assessment
- Final recommendation by ACEMT/Faculty of Paediatrics of completion of subspecialty training

Any overseas experience undertaken by a subspecialist trainee would require that training to be recognised by the parent college in the particular country for PEM subspecialty training before ACEMT/Faculty of Paediatrics would recognise equivalency e.g. an Irish trainee undertaking fellowship training in Australia would require that training to be recognised by ACEM and/or RACP. The joint training programme in PEM would thus sign off on a trainee's eligibility to be registered as a subspecialist in PEM.

Medical Council Registration

A fundamental goal of the development of PEM in Ireland will be the inclusion of Paediatric Emergency Medicine in the Specialist Division of the Register of Medical Specialists. Some informal discussion has occurred to advance this crucial issue but a formal process needs to be embarked upon. As in other countries, it is proposed that PEM would be included on the register as a subspecialty of both Paediatrics and Emergency Medicine. There exists precedent of a kind, insofar as Paediatric Cardiology is a recognised subspecialty of Paediatrics.

There is sometimes confusion surrounding the terms ***Subspecialisation*** and ***Dual Accreditation***. It is proposed that the joint PEM training programme outlined above will primarily provide **subspecialisation** e.g. a paediatric trainee who completes PEM subspecialty training will be eligible to be included in the Register of Medical Specialists under both *Paediatrics* and *Paediatric Emergency Medicine*, but not *Emergency Medicine*. For the latter to occur, the trainee would need to complete

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training of equivalence to HSTEM and pass the exit examination of HSTEM in Ireland, the Fellowship of the College of Emergency Medicine (FCEM). Equally, if an EM trainee with PEM subspecialty training wishes to be included in the division of *Paediatrics*, the trainee would need to complete additional training of equivalence to core General Paediatric training, while at the same time passing the Membership of the Royal College of Physicians in Ireland (MRCPI) Medicine of Childhood examination. It is these latter processes that define **dual accreditation**. It is assumed that very few specialists would choose this option based on experience from international PEM training programmes.

Assuming success is achieved in gaining Medical Council recognition of PEM as a subspecialty of both EM and Paediatrics, then the Consultant Applications Advisory Committee of the HSE should be advised that any future posts in PEM be advertised as the post of '**Consultant in Paediatric Emergency Medicine**', with the requirement that '**applicants must be eligible to be registered in the Specialist Division of the Medical Council Register in *Paediatric Emergency Medicine***'. This would remove the disadvantaged position that currently exists with respect to paediatric trainees and improve competition and the standard of applicants to these posts.

Links with General Paediatrics

There is a clear need for a mutually agreed and defined pathway to subspecialty accreditation in PEM which enables trainees with CCT in either EM or General Paediatrics to pursue a career in PEM. In 2008, ACEMT recommended opening dialogue with the Faculty of Paediatrics of the Royal College of Physicians of Ireland. Anecdotally there were an increasing number of SpRs in General Paediatrics who had expressed an interest in PEM but who were disadvantaged for the reasons outlined previously. It is particularly important that both training bodies work together to improve the profile and training opportunities in PEM. To that end, representatives from ACEMT met with the Board of the Faculty of Paediatrics and presented the case for a conjoined approach to PEM. This was unanimously supported.

Both training bodies should jointly endeavour to gain Medical Council recognition for the subspecialty of PEM. This in turn could potentially facilitate an agreed pathway to dual accreditation in both specialties as exists very successfully in international systems.

Paediatrics in General Emergency Medicine Training

Higher Training (HSTEM)

Historically the paediatric component of higher training in general EM in the UK and Ireland (under the auspices of the then Faculty of Accident and Emergency Medicine) formally required the trainee

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to complete a 'secondment' in general or ward-based paediatrics. The duration of this secondment was designated as three months and this was the regulation previously accepted by ACEMT as the minimum requirement for higher training. However, some trainees had completed a six-month rotation in PEM at SHO level *before* they commenced higher training in EM. This had been traditionally completed as a 'standalone' post rather than as part of a formal basic training scheme in EM. It should be noted that the St. James's Hospital basic EM training scheme has included six months PEM in its mandatory rotations since July 2008 and the Midlands EM scheme followed suit in 2009.

The College of Emergency Medicine and the Royal College of Paediatrics and Child Health have both published guidance for trainees relating to *Modernising Medical Careers* and run-through training in EM and General Paediatrics in the UK with specific reference to PEM.[10,11] Furthermore, both colleges have jointly produced an agreed framework for competences for subspecialty training in PEM. The core difference between these guidelines and previous versions is the acceptance that three months ward-based paediatrics would not deliver all the PEM competencies required as a component of general EM training. The following is an extract from the College of Emergency Medicine *Framework for Paediatric Emergency Medicine Training and Assessment in CT3*[10]:

*"**Setting***
The CEM has agreed that PEM can be delivered in a variety of different settings, each with its own strengths and weaknesses. This will necessarily vary across different regions.

Option 1
This is the preferred option and requires the CT3 PEM trainee spend their 6 months working in a PED. The CEM has defined what constitutes a PED and must have more than 16,000 new Paediatric attendances a year and a supervising Consultant in PEM with a recognised sub specialty interest.
CT3 doctors would be expected to form part of the junior workforce and as such will see unselected Paediatric medical and surgical cases. Ideally some time should be spent outside of the PED, to better understand clinical outcomes of some conditions. Attendances on post take ward rounds, at outpatients (for common medical and orthopaedics conditions), at case conferences for '?NAI' and reviewing admissions to PICU should be encouraged.
It is anticipated that the Consultant in PEM would be the CT3's Educational Supervisor (although not needed to complete all of the WPBAs, as some of this can be completed by Senior Specialist Trainees in Paediatric EM and medicine). The outline of this WPBA is available on the CEM web site.

Option 2
CT3 may be able to split their time between a dedicated PEM and a general EM. However, the general ED must have more than 16,000 new Paediatric attendances a year (in a dedicated area) and have a Consultant in EM with an interest in PEM (but not necessarily with sub specialty training),who would be the Educational Supervisor for the training during this 3 months.
The trainee attached to this type of Paediatric area would be expected to spend most of their working time there. It is suggested that the best daytime shift would be between the hours of 0900 and midnight, as this covers most of the Paediatric attendances. However late shifts, until the Paediatric area is closed would also be acceptable. Dedicated Paediatric areas in large departments usually close over night and it is accepted that CT3s may spend their night shifts seeing adults, but continue to be called for major Paediatric medical and trauma emergencies out of hours. This might need an adjustment in rostering.

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There may be periods of time, out of hours and at the weekend when the trainee is required to work in the main ED due to staffing needs. However no less than 80% of the CT3 time should be spent seeing Paediatric cases and every attempt, either by rearranging rotas or employing non-career grade staff grades, should be made to accommodate CT3 PEM trainees.

Option 3

Unfortunately currently there are only 20 recognised PEDs in the UK. Due to their small number and geographical location some trainees will simply not have the chance to work in an accredited PED. However the throughput of suitably trained Consultants in PEM will continue to improve and it will only be a matter of time before all trainees will have the opportunity to spend some time in CST time in a PED.
It is recognised that there is a great amount of expertise in the general Consultant in EM workforce in seeing and assessing Paediatric cases, after all PEM does make up for 25% of the average annual attendance in an ED.
Trainees can spend all of their 6 months PEM training in a general ED with a PEM focus. This must fit the criteria above i.e. see more than 16,000 new Paediatric cases a year and have a designated Consultant in EM with an interest in PEM who is able to act as an Educational Supervisor.
It is essential that the CT3 spends at least 80% of their time seeing PEM, although it is recognised that some out of hours work and weekend work will have to be spent with adult service delivery. However, every opportunity should be made to allow the CT3 PEM trainee to work in the Paediatric area, by rota adjustment and deployment of SAS doctors.

Option 4

In this option the CT3 trainee could spend 3 months in a general ED, as in option 3 and 3 months (or less) attached to a general medical Paediatric ward/Paediatric Assessment Unit. During this time the CT3 trainee would be part of the acute Paediatric receiving team, seeing acute admissions and GP referrals, either in the ED or on the assessment unit. The Educational Supervisor for this period would be the Consultant Paediatrician and sign off at the end (STR) would be by the Consultant in EM with a PEM interest.

It would be acceptable for some of the options above to be 'mixed and matched' e.g. 3 months in PED and 3 moths Ward based. It is crucial that the CT3 trainee has a designated Clinical Supervisor for what ever model is agreed and is also clear who the trainee's Educational Supervisor is for final sign off. The CEM would not encourage any CT3 trainee to spend all of their 6 months of PEM training purely on a general Paediatric ward. We are firmly of the opinion that the competencies required and reflected in the PEM curriculum are best demonstrated in the (P)EM environment and this has been reflected in the topics for the PEM WPBAs."

Based on these guidelines, ACEMT recommended in 2008 that PEM would become a mandatory component of higher specialist training in EM (HSTEM) and that the PEM component of HSTEM would be delivered over a six-month rotation in a dedicated PED, either in Ireland or potentially abroad in an ED recognised for paediatric subspecialty training. The alternative of fulfilling requirements in a mixed regional ED with large numbers of children is increasingly viable at present because many of the regional units see enough children; however none currently seeing the requisite number have a PEM subspecialist on staff, and current work practices dictate that the majority of 'medical' paediatrics is triaged to general paediatrics. It should, however, be acknowledged that these units currently provide excellent exposure to paediatric trauma, as well as providing training in procedural sedation in children. ACEMT recommended that the competencies to be acquired by the general EM trainee at the end of his/her six month PEM rotation would be those adopted by the College of Emergency Medicine for ST3 trainees.

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Basic Training (BSTEM)

The new national Basic Specialist Training Programme in Emergency Medicine, developed by ACEMT in conjunction with METR and RCSI and commencing in July 2011, will include a mandatory six month rotation in PEM for all trainees. This underlines the commitment of ACEMT to deliver an appropriate general training programme in EM, with PEM recognised as an integral part of this programme.

Emergency Medicine in General Paediatrics Training

There is no mandatory requirement to complete a PEM rotation as part of (either basic or) higher training in General Paediatrics. This is at odds with international norms, where most training systems would include a mandatory PEM component of both basic and higher training in paediatrics. Certain paediatric trainees have sought, and been granted, a six month rotation in a PED and this has largely been as a result of an expressed interest in PEM as a subspecialty career.

All General Paediatric higher trainees must complete a 'Gen Paeds' year, and this not uncommonly occurs in a regional unit, where many children who attend that hospital's ED will be seen directly by the paediatric registrar on call, either in the ED or on a General Paediatric ward. While this may appear to offer PEM 'experience', it is not doing so because this care is not supervised by a Consultant with subspecialty training in PEM.

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