Palliative Medicine Curriculum 2022

DRAFT v20 SEPTEMBER 2019

Section 2: Description of Proposed Changes

Describe the impact of delivering the proposed curriculum or assessment on current resources

This curriculum represents a major change from the existing palliative medicine curriculum, as palliative medicine becomes a dual accrediting specialty with internal medicine. Dual accreditation offers significant opportunities for the specialty but implementation of the new curriculum will lead to a reduction in specialty training time of approximately 25% (although there will be an overlap between internal medicine and palliative medicine knowledge and skills), which will significantly affect palliative care service delivery in all settings.

Palliative Medicine as a specialty is unique in that much of the training takes place in organisations outside of the NHS (hospices and community palliative care teams). The most significant impact on service delivery is likely to be on specialty on call / out of hours services for hospital, community and specialist palliative care units, including hospices. These services currently play a significant role in managing patients outside of acute hospital settings and in facilitating rapid discharge from hospital back into community or non-acute settings. Innovative models of implementation are in the process of development by JRCPTB and the palliative medicine SAC, which are necessary to prevent destabilisation of palliative care services and ensure continuity of service provision and specialty on calls.

The 2010 (2014 amendment) curriculum was a competence-based curriculum; this new curriculum represents a move to high level learning outcomes via the assessment of capabilities in practice (CiPs), which has necessitated a review of the core knowledge and skills required by a doctor practising palliative medicine. Since the 2010 curriculum was developed, the specialty has changed, with palliative care services seeing patients with a wider range of life-limiting illnesses. The new curriculum has been developed to recognise the changing patient demographics now impacting on palliative care services, including:

- the impact of frailty, dementia, organ failure and multi-morbidity;
- an increasing population of teenage and young adult patients moving from paediatric to adult services, including palliative care;
- increasing evidence for early palliative care involvement to improve outcomes and cost-utilisation;
- expanding evidence for the role of health promotion in palliative and end of life care; and the development of models of supportive care for cancer patients.

Trainees will therefore be exposed to and expected to develop confidence in caring for a greater range of patients across health and social care settings and the interface with internal medicine will be important to allow trainees to fully develop the range of skills required to practice as a

consultant. Palliative care services, clinical and educational supervisors will all need support to distil the new curriculum and consider how they will support trainees to meet the broader learning outcomes. Training materials will be developed by the SAC to support this process.

This implementation of this curriculum will also introduce two new methods of assessment to the palliative medicine curriculum – the LEADER and the patient survey. The LEADER is a formative assessment that focuses on clinical leadership and team working capabilities; the assessor is likely to focus on one or two of the following domains:

- Leadership in a team
- Effective services
- Acting in a team
- Direction setting
- Enabling improvement

The LEADER is part of the assessment portfolio for trainees at the Royal College of Paediatrics and evaluated by the South Thames Foundation School[1].

As part of the consultation towards the new curriculum, the SAC, interested consultants and our national virtual trainee consultation group were asked what they felt was required to "future proof" this curriculum. This has led to a range of additions, some of which are discussed above, but with further additions including the recognition of digital legacies and opportunities for digital information sharing across settings and consultations.

The main curriculum changes can be summarised as follows:

2.1 Curriculum learning outcomes have been amended to reflect the change from competence assessments to high level learning outcomes (capabilities in practice, CiPs). Existing curriculum competencies have been mapped across to the CiPs

2.2 There has been a rebalancing of clinical presentations to better represent the patient population now seen in palliative care (thereby retaining the knowledge and skills to manage cancer patients but enhancing knowledge and skills to support people with a wide range of life limiting illnesses, including frailty, dementia, organ failure and multi-morbidity)

2.3 The addition of the concept of health promotion at the end of life (public health), to reflect the emerging evidence to support the positive outcomes of community engagement and development, and health promotion at the end of life

2.4 Recognition of the emerging importance of palliative care services in supporting transitional care for teenagers and young adults

2.5 Recognition of the new discipline of supportive care in cancer

2.6 Recognition of challenges of access to palliative care services and of meeting the needs of hard to reach groups

2.7 Change to work place-based assessments

a. Removal of existing DOPS: paracentesis, central or peripheral intravenous catheter management and NG tube (represented in IM curriculum) and TENS machine application

[1] Hadley L et al. Encouraging formative assessments of leadership for foundation doctors. The Clinical Teacher 2015; 12: 231–235

b. Change to existing DOPS (tracheostomy, NIV and spinal lines) to enable greater formative learning, leading to summative assessment as a minimum in a skills lab setting
c. Requirement to demonstrate sustained competence in syringe pump set up across training (via DOPS)
d. Addition of LEADER assessment to enable formal review of management and leadership skills
e. Addition of patient survey (to include feedback from those close to patients, in view of the challenges of obtaining direct feedback in our patient population)

2.8 Further clarity provided regarding the range of training settings, including hospital, hospice/inpatient unit and community

2.9 Removal of requirement for specialist inpatient unit / hospice to have 10 beds – focus changed to training in a specialist unit, defined as "a unit that is consultant-led, with the appropriate skills and training in specialist palliative care to manage and support the complex symptom control, psychological and social needs of patients that cannot be managed in other settings"

2.10 Additional detail is provided regarding the range clinical settings and contacts contributing to community experience and the outcomes to be demonstrated via community training

2.11 Additional detail is provided regarding the outcomes to be demonstrated from participation in specialty work on call / out of hours

Section 3. Content of Learning

3.1 High Level Curriculum Outcomes: Capabilities in Practice

Capabilities in practice (CiPs) describe the professional tasks or work within the scope of the doctor. CiPs are based on the format of entrustable professional activities[2], which are a method of using the professional judgement of appropriately trained, expert assessors as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated by internal medicine doctors throughout their training. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, those close to them, colleagues and others. Good doctors work in

[2] Nuts and bolts of entrustable professional activities https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3613304/

partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of the GMC's Good Medical Practice and General Professional Capabilities.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor
Specialty CiPs: Internal Medicine
1. Managing an acute unselected take
2. Managing an acute specialty-related take
3. Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions
5. Managing medical problems in patients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient

8. Managing end of life and palliative care skills

Specialty CiPs – Palliative Medicine	
1. Managing patients with life limiting conditions across all care settings	
Descriptors	• Demonstrates ability to undertake a holistic palliative care assessment; and to formulate, prioritise, communicate and deliver an effective palliative care plan • Demonstrates ability to manage complex palliative care problems across a range of care settings and with other service providers, in and out of hours • Demonstrates ability to recognise the deteriorating patient whose recovery is uncertain and to assess reversibility and the appropriateness of interventions • Demonstrates ability to develop flexible, person-centred advance care plans, based on the needs of individual patients and their care setting • Demonstrates an understanding of the impact of multi-morbidity, advanced ageing and frailty in people with life-limiting conditions • Demonstrates effective management of medical emergencies across all palliative care settings, including determining when intervention is inappropriate • Demonstrates ability to promote coordinated care and manage a caseload of patients in and out of hours and across settings • Demonstrates effective use of information sharing between services, for example using electronic record systems, electronic care coordination systems and practice registers • Demonstrates ability to support patients and those close to them to identify meaning in their lives, enhance well-being and where appropriate support people to focus towards realistic hope and goals • Demonstrates understanding of and application of the ethical and legal frameworks of decision-making in young adults, including the ability to support patients and those close to them in navigating the changes in responsibility through the spectrum of childhood, Gillick competence and the application of the mental capacity act in adults, taking into account the family unit and often well-established patterns of communication • Demonstrates awareness of the specific needs of those in hard to reach or marginalised groups that traditionally struggle to access palliative care services, e.g. the homeless, prisoners, traveller communities, people with learning disabilities and mental health issues, teenagers and young adults

	• Demonstrates an understanding of the context in which palliative medicine is practiced, recognising the benefits of the biomedical approach of harm reduction and opportunities of health and well-being promotion of the public health approach for patients, those close to them and communities • Demonstrates an understanding of health and well-being promotion at the end of life to improve access, experience and outcomes, including positive aspects of caring and support at end of life • Demonstrates awareness of opportunities for promoting health and well-being in patients and those close to them, e.g. make 'every contact count'
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills Domain 3: Professional knowledge • National legislative requirements • The health service and healthcare systems in the four UK countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement
Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR ES report Summary of clinical activity logs of patients reviewed and /or description of range of experience in different settings (e.g. out of hours work; range of hospital, community and palliative care inpatient experience)
2. Ability to manage complex pain in people with life-limiting conditions across all care settings	
Descriptors	• Demonstrates up-to-date knowledge, understanding and skills to assess and manage complex pain secondary to life-limiting progressive disease • Demonstrates knowledge of the pathophysiology of pain • Demonstrates ability to formulate clear, individualised management plans taking into account patient preferences and reversibility • Demonstrates evidence-based, applied knowledge and skill in the effective use of non-pharmacological management, opioid & non-opioid analgesics to manage complex pain, including safe prescribing in

	patients with organ failure, frailty and low body weight or who are in the last hours or days of life • Demonstrates knowledge of managing pain whilst minimising longer term adverse effects in those with progressive disease but longer prognoses • Demonstrates appropriate knowledge of interventional pain techniques to effectively manage complex pain that is not responding to conventional interventions • Demonstrates ability to refer to and share care with other pain services • Demonstrates ability to safely manage pain in the context of drug misuse and dependence
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills Domain 3: Professional Knowledge Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 9: Capabilities in research and scholarship
Evidence to inform decision	SCE CbD mini-CEX DOPs Reflective practice MCR ES report Summary of clinical activity patient log, e.g. community and interventional pain experience
3. Demonstrates the ability to manage complex symptoms secondary to life-limiting conditions across all care settings	
Descriptors	• Demonstrates advanced skills in the identification and assessment of physical, psychological and psychiatric symptoms in patients with progressive life-limiting illnesses and ability to formulate clear, individualised management plans taking into account patient preferences and reversibility • Demonstrates advanced understanding of the pathophysiology of symptoms • Demonstrates evidence-based knowledge and skills to manage physical symptoms in life-limiting illness across a range of systems, including:

	respiratory, cardiac, gastrointestinal, genitourinary, neurological, musculoskeletal and dermatological • Demonstrates appropriate knowledge and skills in managing mental health/psychiatric issues in patients with life limiting conditions, including awareness of when to refer to specialist mental health services • Demonstrates appropriate knowledge and skills to manage symptoms caused by complications of cancer (including paraneoplastic syndromes) and oncological treatments • Demonstrates the ability to effectively use non-pharmacological interventions for symptoms to treat patients with life-limiting progressive disease • Demonstrates detailed understanding of pharmacology and therapeutics of drugs used for managing physical and psychiatric symptoms, including safe prescribing in patients with organ failure, frailty and low body weight or who are actively dying • Demonstrates appropriate knowledge of the use of drugs outside their product license and the legislation relevant to safe prescribing in NHS and third sector organisations
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills Domain 3: Professional Knowledge Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 9: Capabilities in research and scholarship
Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR ES report Summary of clinical activity patient log, e.g. community experience
4. Ability to demonstrate effective advanced communication skills with patients with life-limiting conditions, those close to them and colleagues across all care settings	
Descriptors	• Demonstrates the ability to work with supportive networks of care as an essential component of palliative and end of life care • Demonstrate the ability to focus on the positive goals for patients and their families, to make the most of time remaining

	• Demonstrates advanced communication skills, including ability to consult, negotiate and involve patients and those close to them in their care • Demonstrates ability to manage complex and challenging situations with patients, those close to them and colleagues • Demonstrates ability to facilitate effective communication of complex issues and information as patients transfer across settings • Demonstrates ability to identify obstacles to communication and skills in overcoming these • Demonstrates the ability to enhance communication skills across organisations and care settings to support the multi-professional team managing people with life-limiting illness, including the ability to develop multi-professional colleagues' skills in effective and sensitive communication • Demonstrates awareness of and advantages of using technology to aid clinical assessment and communication in the palliative care population, e.g. telemedicine, virtual clinics and remote consultations, remote teaching and peer support • Demonstrates awareness of opportunities and limitations for people in creating and managing digital legacies via social media platforms • Demonstrates ability to support clinicians to care for patients with life-limiting illness across all care settings, through integrated care, expert communication and education • Demonstrates ability to advocate for vulnerable patients with life-limiting conditions and those close to them and to navigate ethical and legally challenging situations, such as end of life decision making • Demonstrates ability to provide an expert opinion for other specialties on complex ethical or legal issues relevant to palliative care, including communicating decisions effectively; managing professional and family meetings; using expert communication as a form of treatment/intervention • Demonstrates an awareness of the skills needed to communicate with teenagers and young adults and to support development of self-determination/emerging autonomy in the context of the family unit and often well-established patterns of communication • Demonstrates an awareness of the skills needed to support teenage and young adult patients and those close to them when transitioning from paediatric to adult services, including navigating the changes in the way that consultations are undertaken in the adult sector, in the context of the family unit and often well-established patterns of communication
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills

	• Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	Mini CEX CbD MSF Reflective practice MCR ES report Simulation training Patient survey Evidence of advanced communication skills training (as agreed by local training programme)
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them	
Descriptors	• Demonstrates an ability to recognise dying, including an understanding of clinical uncertainty and limited reversibility in people with progressive life-limiting conditions • Demonstrates the ability to consider anticipatory care for patients who are approaching the last days of life, including prescribing, advance care planning, escalation plans and establishing priorities for care • Demonstrates ability to proactively support other professionals in developing effective management strategies and plans for caring for dying patients • Demonstrates ability to use medication safely and effectively in the dying phase to manage common and complex symptoms • Demonstrates ability to judge the appropriateness of interventions in dying patients • Demonstrates ability to identify patient preferences at the end of life, in conjunction with those close to them, to support achievement of realistic goals • Demonstrates an understanding of the role environment plays in caring for the dying patient and ability to adapt accordingly e.g. hospital, own home, hospice/inpatient unit, care home or other community setting/place of residence • Demonstrates ability to identify and manage distress at the end of life in patients (and those close to them) and colleagues • Demonstrates detailed understanding and application of the ethical and legal frameworks and legislation supporting decision making at the end

	of life, including mental capacity and withholding and withdrawal of treatment • Demonstrates development of expert skills in ethical reasoning and decision-making in end-of-life care • Demonstrates awareness of the positive impacts of health-promotion and community development in end of life care • Demonstrates awareness of dying as a social process; appreciates and facilitates the role of a wider social network and non-professional support at this time and understands the positive impacts of health-promotion and community engagement in end of life care
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR ES report Summary of clinical activity patient log, e.g. community experience
6. Manages delivery of holistic psychosocial care of patients and those close to them, including loss and grief; and religious, cultural and spiritual care across all care settings	
Descriptors	• Demonstrates ability to identify, assess and manage complex psychosocial issues affecting patients and those close to them and healthcare professionals in the context of life-limiting disease • Demonstrates ability to utilise the multi-professional team, across care settings and between services, to provide customised patient-centred care for patients with complex psychosocial issues • Demonstrates appropriate knowledge and skills to support patients and those close to them in dealing with distress, loss and grief, including support for those at risk of prolonged or abnormal bereavement and the needs of children (including siblings) at different developmental stages, teenagers and young adults • Demonstrates awareness of the range of psychological interventions that can be used to support patients and those close to them

	• Demonstrates awareness of the positive and negative impacts of caring on those close to patients with life-limiting illness, including ability to work, life-style changes and managing concurrent physical and mental illness • Demonstrates awareness of need for people and those close to them to maintain social participation and support networks; to support informal carers in both the positive and enriching and challenging aspects of care giving; and of the potential for empowered, supportive informal networks to improve outcomes • Demonstrates knowledge of the responses and needs of children or adults with learning difficulties • Demonstrates knowledge of and skills in recognising and managing mental illness in patients with life limiting conditions, including the ability to differentiate between appropriate sadness and depression • Demonstrates ability to recognise and manage disturbed, violent and/or suicidal patients and/or those close to them, including liaison with psychological/psychiatric services and use of appropriate legal frameworks • Demonstrates ability to sensitively discuss issues around preferred place of care and death, including ability to facilitate a rapid discharge/transfer to a person's preferred place of care • Demonstrates ability to liaise with primary care, social services, palliative care, third sector and NHS-funded care providers when facilitating complex discharges for patients at the end of life • Demonstrates an awareness of rehabilitation approaches to maximise physical and social functioning in the context of advanced life-limiting illness • Demonstrates knowledge of financial and welfare benefits available • Demonstrates awareness of and ability to work alongside the community and social resources available to support vulnerable people, e.g. those that are homeless, in custody, without recourse to public funds, or those with learning or physical disability • Demonstrates knowledge and skills to elicit spiritual concerns and to recognise and respond to spiritual distress; and respects differing spiritual beliefs and practices • Demonstrates an understanding of the impact of culture, ethnicity and sexuality in response to life-limiting conditions and at the end of life, including an awareness that this may affect equity of access to services
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills

	• Dealing with complexity and uncertainty Domain 3: Professional knowledge Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	SCE CbD mini-CEX MSF Reflective practice MCR ES report Summary of clinical activity patient log, e.g. community experience
7. Demonstrates the ability to lead a palliative care service in any setting, including the third sector	
Descriptors	• Demonstrates ability to synthesise complex clinical and psychosocial information leading to patient centred clinical decision making in all settings • Demonstrates ability to provide an expert opinion in situations where there is clinical uncertainty or conflict with patients and /or those close to them • Demonstrates ability to collate information from all members of the multidisciplinary team and, if necessary, appropriately challenge other senior healthcare professionals in multi-professional discussions to support decision making across all care settings • Demonstrates ability to support, educate, influence and develop members of the wider multi-professional team to deliver high quality generalist palliative care across all care settings • Demonstrates engagement with palliative care research, audit and quality improvement to inform service development and evaluation across settings • Demonstrates awareness of understanding population needs, including remote or rural communities, when developing and delivering palliative care services • Demonstrates an understanding of the role of community as a rich asset of resources to help support the experiences of death, dying, loss and care giving. • Demonstrates understanding of the principles of financial management of palliative care services in the NHS and third sector • Demonstrates understanding of the management of pharmacy budgets and regulatory aspects of controlled drugs, particularly in third sector organisations

	• Demonstrates effective leadership, negotiation and management skills, including involvement in strategy and management of palliative care services across care settings in the NHS and third sector, including engagement with commissioners and the broader health economy, e.g. Sustainability and Transformation Partnerships • Demonstrates understanding of the structures that support effective leadership and management in NHS & third sector organisations, including the role of volunteers, fundraising teams and trustees • Demonstrates awareness of the wider role of palliative care services in supporting health-promotion at the end of life and community engagement and development, including working in partnership with local communities and recognising the potential impact on improving equity of access and outcomes for a diverse population • Recognises signs of stress and burnout in self and others and takes action to seek or offer support where appropriate • Demonstrates awareness of the range of strategies that could be utilised to deliver sustainable healthcare services across all settings, including third sector
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge • National legislative requirements • The health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working
Evidence to inform decision	SCE CbD mini-CEX MSF Reflective practice MCR ES report Management course LEADER WPBA Quality improvement project / research experience Summary of clinical activity patient log, e.g. community or out of hours experience Reflections on incidents and complaints

3.2 Presentations and Conditions

Palliative care as a speciality focusses on making the most of the time left for living for those undergoing the experiences of death, dying, loss and care giving at the same time as managing the negative impacts of terminal illnesses. The scope of presentations and conditions seen by a palliative medicine doctor are broad and cannot be encapsulated by a finite list of presentations and conditions. Palliative medicine is also a needs-based specialty, rather than one focussing solely on diagnosis. It provides expertise in the physical and psychosocial management of people with a wide range of life-limiting conditions and is not limited to any specific diseases. Whereas traditionally, palliative medicine was associated with cancer and end of life care, doctors completing training in palliative medicine are now expected to be able to manage palliative care issues for patients with a wide range of diagnoses and at different stages of people's disease trajectory, including short-term interventions for patients with treatment options and reversibility. Increasingly, palliative medicine specialists are also consulted to provide specialist advice on patients with complex physical and psychosocial needs in the context of significant, but not necessarily life-threatening illness; trainees need to develop skills that support a needs and case-based approach to best support colleagues, patients and families with complex needs.

Trainees will develop advanced palliative medicine assessment skills, including information gathering, history taking and examination, focussing on a person's palliative care needs in the context of their overall clinical condition and taking into account their preferences. These assessments need to be tailored to the setting of the patient – hospital, community or inpatient unit – and will require trainees to identify key issues and problems and formulate individualised and appropriate management plans. Across all settings trainees will need to demonstrate expert communication with patients, families and colleagues.

In developing appropriate management plans, trainees must develop skills to help identify what is most important to patients and their families and to recommend interventions (both non-pharmacological and pharmacological) that are most likely to improve well-being and minimise harm through the expert management of symptoms and other problems related to life-limiting illness. In doing so trainees need to take into account the potential for reversibility of new problems and judge which interventions are most likely to benefit individuals. Recognition of the unstable, deteriorating patient where recovery is uncertain in all care settings and the ability to identify when active interventions are and are not appropriate is a core skill.

The table below outlines the range of presentations and clinical issues managed by palliative medicine doctors. Knowledge of these conditions is essential to the practice of palliative medicine. This table needs to be interpreted in conjunction with the capabilities in practice.

Table 1: Range of palliative medicine knowledge & skills encompassing common disease processes

Range of presentations / disease processes / clinical issues	Examples of areas to be explored
Cancer	• Understanding of the presentation and current management of all major malignancies • Management of common complications of cancer and cancer treatments • Management of cancer emergencies • Interface with acute oncology and supportive care
Organ failure	Palliative management of people with cardiac failure, renal failure, liver failure, chronic respiratory disease; including the interface between primary, secondary and tertiary care and importance of advance care planning
Progressive neurological conditions	Including stroke, MND, Parkinson's disease, multiple sclerosis
Dementia and frailty	Including interface with care of the elderly, old age psychiatry and primary care
Impact of multi-morbidity	Including cross-specialty working and management of complexity across all care settings
Other potentially life-limiting conditions	Including HIV, progressive auto-immune and inflammatory conditions
Life-limiting illnesses in Teenagers and Young Adults (TYA)	• Including young people moving from paediatric to adult palliative care services • Life-limiting illnesses in teenagers and young adults, such as Duchenne Muscular Dystrophy, Cystic Fibrosis, malignancies affecting the teenage and young adult population, neuro-disability • Awareness of services offered and models of care delivered by paediatric palliative care services across all settings • Awareness of specific needs of TYA group and ability to access specialist help and support • Awareness of the complexity of prognostication in these patients
Survivorship and Supportive Care	Understand the principles of supportive care and the interface between oncology,

	rehabilitation and other supportive care services Awareness of evolving need for palliative care over the course of life-limiting illness, including • Integration with active treatment • Significance of transition points • Interface with rehabilitation • Ability to manage patients at all stages of a disease trajectory (from curative treatment to end of life care) • Ability to work with primary care and other specialists
Management of the dying patient	• Development of advanced skills in the identification and management of patients that are dying and their families – both to manage complex dying and to support primary and secondary care teams in the management of non-complex dying • Awareness of societal expectations and perceptions in progressive and advanced disease and death, including an awareness of what constitutes quality of life and a "good death" • Ability to support patients, those close to them and colleagues in normalising death as an outcome, to recognise the possibility of death and plan proactively • Awareness of context in which palliative medicine is practiced, including impact of demographic changes in society; role of community networks in supporting patients and those close to them; opportunities for health promotion; awareness of societal views and law relating to physician assisted suicide and euthanasia
Management of concurrent clinical problems in people with life-limiting conditions	• Management of multi-morbidity • Safe management of specific conditions at the end of life, e.g. diabetes, epilepsy/seizures, cognitive impairment, gastro-intestinal failure

	• Management of psychiatric conditions • Management of psychological and spiritual distress
Management of the complex, acutely unwell, unstable patient across all palliative care settings, including hospice and community and including anticipatory planning for emergency situations	• Identification and management of acute oncology emergencies, e.g. MSCC, SVCO, neutropenic sepsis, tracheal obstruction, bowel obstruction and hypercalcaemia • Identification and management of non-oncological emergencies, e.g. anaphylaxis, severe sepsis, pulmonary embolism, acute pulmonary oedema, seizures, ACS, stroke, hyperglycaemia, hypoglycaemia, hyponatraemia, major haemorrhage and cardiac tamponade • Ability to assess the complex, unstable, acutely unwell patient to determine reversibility and preferences to support the development of appropriate individualised treatment escalation plans, to enable people to be managed in the most appropriate setting, including community • Ability to work across the acute – community interface (e.g. ED, AMU, ambulatory units, community liaison, care homes) to support the management of palliative care patients in the most appropriate setting and support admission avoidance where appropriate • Ability to deliver integrated care for people across all care settings
Loss, grief and bereavement	• Awareness of bereavement theories including the process of grieving, adjustment to loss and the social model of grief in adults and children • Ability to support and empower individuals facing loss and to support the acutely grieving person and/or family, including the ability to anticipate and/or recognise abnormal grief and access specialist help • Awareness of factors associated with prolonged or abnormal grief e.g.

	multiple losses, those in disenfranchised positions or complex family structures • Awareness of interface with religion, spiritual care and cultural influences on loss and grief • Awareness of the range of services and social support available to support the bereaved and the role of communities in resolving grief • Awareness of the opportunities for positive outcomes from bereavement through community engagement
Health promotion in end of life care	• Awareness of the role of community engagement and development in improving health and well-being for patients with life-limiting conditions and those close to them • Awareness of the range of community engagement initiatives nationally, including compassionate communities and how these interface with formal services • Awareness of the role of palliative care services in promoting and supporting community engagement, including: (i) working in partnership with communities; (ii) understanding local needs and resources and (iii) meeting these needs through a combination of professional and community support

In addition to the clinical skills outlined above, trainees will be expected to develop skills to work as part of highly specialised multi-professional teams and be able to support the development of newer roles, such as advanced nurse practitioners and physician associates, to support the delivery of sustainable palliative care services across all settings. As consultant leaders of such teams, trainees will be expected to develop skills in quality improvement, service development and evaluation throughout training.

As clinical leaders of the future, trainees also need to develop an awareness of the potential for broader community engagement, development and health promotion in end of life care, in which palliative care services have an important facilitatory role. There is evidence that community engagement initiatives improve a range of health and social care outcomes at the end of life. These include improving the relevance of services; development of knowledge, skills and capacity in communities; support for self-management and resilience in the face of death, dying and loss; reduced social isolation and its negative health consequences; reduced admissions to secondary care; improved outcomes for informal carers; and support for developing healthier attitudes to

death, dying and loss[3] [4] [5]. Community development initiatives such as compassionate communities will be important in delivering sustainable services in the future and in addressing current inequalities in access to specialist palliative care services, which will become more marked as the potential need for palliative, supportive and end of life care increases in line with the predicted population changes.

The curriculum has been developed to ensure that doctors in palliative medicine have developed the requisite skills to work in both the NHS and third sector. Most palliative care inpatient units (hospices) and community teams have developed in the third sector and consultants working in these settings often need to take on significant management responsibility early in their careers, as medical directors of these organisations. Trainees therefore need to work in such organisations, develop an understanding of organisational structures outside of the NHS and develop skills such as negotiation, to enable them to work within hospice management teams.

3.3 Practical Procedures

By completion of specialty training, trainees need to be proficient in setting up and managing patients with a portable infusion (syringe) pump.

The curriculum recognises that complex palliative care patients are cared for in non-hospital settings and this is reflected in the remaining curriculum DOPS. Trainees should be able to manage patients with spinal lines, a tracheostomy and non-invasive ventilation within a specialist palliative care or community setting (taking into account local guidelines and governance arrangements in that setting) but not to be proficient in the procedure itself.

For the purposes of assessment, a specialist palliative care setting can include:

- consultant-led hospice / palliative care inpatient units
- palliative medicine outpatient clinics
- palliative care day centres
- within a patient's home when supported by community palliative care teams
- hospital palliative care team

Trainees are expected to seek advice from appropriate specialists if needed.

[3] Sallnow L and Paul S. Understanding community engagement in end of life care: developing conceptual clarity. Critical Public Health 2015; 25(2):231-238 https://doi.org/10.1080/09581596.2014.909582

[4] Sallnow L, Richardson H, Murray S and Kellehear A. The impact of a new public health approach to end of life care: a systematic review. Palliative Medicine 2016;30(3):200-211 https://doi.org/10.1177/0269216315599869

[5] Abel J, Kingston H, Scally A, Hartnoll J, Hannam G, Thomson-Moore A and Kellehear A. Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities. Br J Gen Pract 2018;68(676):e803-e810. DOI: https://doi.org/10.3399/bjgp18X699437

Procedural Skill	Proficient in skills Lab	Proficient in Clinical Practice (assess with patient)	Assessment during training
Syringe pump set up	Yes	Yes	3 x DOPS – range of settings and assessors
NIV set up and troubleshooting, e.g. checking the machine is set up according to the initiating team's advice, ensuring correct mask position and patient comfort, and be able to assess common problems/potential emergencies and know who to contact for advice	Yes	Optional	1 x DOPS
Spinal lines: principles, indications and likely complications in relation to spinal lines e.g. how to recognise a problem, what to inspect and who to call for advice	Yes	Optional	1 x DOPS
Tracheostomy care: management of common complications, e.g. secretions and a simple tube / tracheostomy change	Yes	Optional	1 x DOPS

Section 4. Learning and Teaching: educational approaches, learning opportunities and breadth of experience necessary to meet the outcomes of the curriculum

4.1 Training Programme: the educational approaches, learning opportunities and breadth of experience necessary to meet the outcomes of the curriculum.

The organisation and delivery of postgraduate training is the responsibility of Health Education England (HEE) and its Local Education and Training Boards (LETBs), NHS Education for Scotland (NES),

Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA). A training programme director will be responsible for coordinating the Palliative Medicine training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the Annual Review of Competence Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the Palliative Medicine ARCP decision aid (available on the JRCPTB website). The successful completion of Palliative Medicine training will be dependent on achieving the expected level in all CiPs, GPCs and DOPS. The programme of assessment will be used to monitor and determine progress through the programme. Training will normally take place across a range of settings, including acute hospitals, inpatient palliative care units (e.g. hospices or specialist units in acute or community hospitals) and community settings (such as people's homes, care homes, outpatient clinics, General Practice and other ambulatory settings).

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the entire syllabus is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. However, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest or to focus senior training on the setting(s) in which they wish to work as a consultant.

The following provides a guide on how training programmes should be focussed in each training year in order for trainees to gain the experience and develop the capabilities to the level required.

4.1.1 Mandatory Training

The core features that must be provided for any training programme to deliver this curriculum are:

- Training in a sequence of posts which provides experience of palliative medicine for patients with any diagnosis, in a full range of settings, including: patients' own homes, care homes (nursing and residential), day hospice, inpatient specialist palliative care units, and cancer centres and /or cancer units in acute general hospitals
- A *minimum* indicative time of 2 years must be spent in specialist palliative care, working with a full multi-professional specialist palliative care team as defined in the NICE Guidance on Supportive and Palliative Care (2004).
    - At least 1 year of this will be in an inpatient specialist palliative care unit. A specialist palliative care unit is defined as a unit that is consultant-led, with the appropriate skills and training in specialist palliative care to manage and support the complex symptom, psychological and social needs of patients that are not able to be managed in other settings
    - At least 6 months cumulative experience will be in a hospital specialist team (this can include work within a specialist hospital inpatient unit, but not exclusively). Hospital palliative medicine experience must include working as part of an advisory or liaison hospital palliative care team and trainees must demonstrate the ability to manage patients in a consultative capacity in a hospital setting independently by the end of training

    - At least 6 months cumulative experience is expected in community specialist palliative care. The term community includes a range of settings, e.g. outpatients, day hospice, home visits (including care homes), ambulatory units, joint working with Primary Care and community specialist palliative care teams. Blocks of training, where the trainee works predominantly in the community, may be appropriate, but a flexible approach is encouraged to ensure that trainees gain adequate experience. Trainees should demonstrate the ability to work across the range of community settings, to develop skills to assess and manage patients both with colleagues and independently and gain a comprehensive understanding of the range of community services available. Trainees need to have the depth and range of experience to be able to consider the benefits and challenges of service delivery in community settings
- Exposure to a range of oncology experience during training. This may include:
    - Knowledge of the use of systemic anticancer therapies (including likely benefits and toxicities); participating in cancer site specialist MDTs;
    - Working alongside acute oncology services;
    - Awareness of and ability to recognise the range of acute oncology presentations in all care settings;
    - Ability to assess patients presenting with new metastatic cancer, including cancer of unknown primary, and to support clinical teams in investigation and management, based on patient preferences and performance status;
    - Knowledge of indications for radiotherapy, likely toxicity and outcome of palliative treatments;
    - Awareness of the complications of radical treatments in order to support oncology teams in managing severe symptoms.
- Exposure to a range of non-cancer conditions across different palliative care settings during their training; this may include experience of joint working with other medical specialties in joint clinics or undertaking joint visits in the community
- Experience of working in all palliative care setting out of hours. By the end of training trainees need to
    - Demonstrate the ability to undertake face to face assessments of new patient and those with new problems;
    - Formulate effective and safe management plans
    - Manage problems independently (as clinically appropriate) over the course of the on-call period. This should include safe mechanisms for handover and handback of patients, especially where trainees are covering several palliative care services on call.
    - Demonstrate the ability to provide telephone advice to healthcare professionals out of hours across hospital, specialist inpatient and community settings;
    - Demonstrate ability to prioritise and effectively manage workload when working across multiple settings on call;
    - By the end of training be able to manage a caseload independently out of hours
- Experience of working alongside primary care and with other specialist clinicians, delivering shared care and undertaking joint assessments across all settings

- Training in advanced communication skills (attendance at a locally-approved course, in addition to demonstration of expert communication via CiPs and workplace-based assessments, particularly MSF and the patient survey)
- Training in teaching to enable trainees to develop their skills to independently enhance, facilitate and educate the wider multi-professional team in the delivery of palliative and end of life care across settings
- Training in management and leadership, including the core knowledge and skills required to lead palliative care services in the third sector

4.1.2 Recommended Training

- Experience of working in a cancer centre is strongly recommended, as it is recognised that the complexity of patients managed in a tertiary setting will be different to those managed in other settings
- It is recommended that trainees undertake a block of community palliative care to allow better immersion and integration with community services (rather than a fully integrated model spending time in the community whilst based in a hospital or inpatient unit setting.) It is recognised that this may not be feasible for all trainees nationally but is strongly recommended
- Experience of joint working with chronic pain services (including observation of nerve blocking techniques and of the management of epidural and/or intrathecal catheters for cancer pain)
- Experience of working closely with other specialist services, including: care of the elderly; liaison psychiatry/psychology services; social services; chaplaincy services; pharmacy; rehabilitation services; primary care; discharge teams and bereavement services. This list is not exhaustive and should be integrated into palliative care placements.
- Exposure to paediatric palliative care and TYA services to support the care of patients transitioning from paediatric to adult services
- Experience of working with NHS and third sector providers within the training programme
- Awareness of the development of genomics and personalised medicine and potential impact on patients' care and treatment
- Development of strategies to support self-awareness/self-management, via reflection, feedback and the use of supervision, to enable trainees to develop the coping skills and resilience to sustain a career in the speciality
- Training in health-promotion and community engagement in end of life care to increase awareness of the possibilities to be realised through working in partnership with local communities

4.3 Describe the responsibilities, capabilities and expected levels of performance of trainers

Changes to Palliative Medicine DOPs

The new curriculum reduces the number of DOPs required of palliative medicine trainees, taking account of the DOPs that are mandated within the internal medicine curriculum. The focus of the palliative medicine DOPs has shifted to support palliative medicine doctors to manage complex

patients in any setting and it is recognised that trainees will have enhanced exposure to complex patients whilst dual training in internal medicine. Therefore only one DOP is mandated in a clinical setting (syringe pump set up), with the other DOPs able to be assessed in a simulated setting. This provides enhanced opportunities to explore the range of issues that might arise in non-specialist settings for patients requiring interventional pain techniques and those with NIV, tracheostomies and indwelling central venous catheters. It is anticipated that clinical and educational supervisors will be involved in developing simulation training to support the delivery of these DOPs.

Integration with Internal Medicine

Trainers will need to work with their local training programmes to develop effective integration with internal medicine to allow the delivery of dual training. It is anticipated that the IM component of the specialty curriculum (years 4 to 7) will mostly be delivered in blocks.

4.5 Assessment: Describe the rationale for the choice of assessment and its role within the wider programme of assessment

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

4.5.1 Assessment methods

Summative assessment	**Formative assessment**
Examinations and certificates: • The MRCP(UK) Specialty Certificate Examination (Palliative Medicine)	**Supervised Learning Events (SLEs):** • Acute Care Assessment Tool (ACAT) • Case-Based Discussions (CbD) • mini-Clinical Evaluation Exercise (mini-CEX) • Clinical Leadership Development (LEADER)
Workplace-based assessment (WPBA): • Direct Observation of Procedural Skills (DOPS) - summative	**Work Place Based Assessments:** • Direct Observation of Procedural Skills (DOPS) – formative and summative • Multi-Source Feedback (MSF) • Patient Survey (PS) • Quality Improvement Project Assessment Tool (QIPAT) • Teaching Observation (TO) • Record of reflective practice (RRP)
	Supervisor reports: • Multiple Consultant Report (MCR) • Educational Supervisor Report (ESR)

The only change to the current assessment framework will be the addition of two new assessments,

the LEADER and a patient survey.

More information and guidance for trainees and assessors are available in the ePortfolio and on the JRCPTB website (www.jrcptb.org.uk .

Decisions on progress for all assessments will be made via the ARCP process.

Details of new assessment tools

Clinical Leadership Development (LEADER)

The LEADER is an assessment that has been in use by the Royal College of Paediatrics, to assess clinical leadership skills. The domains assessed are Leadership in a team; Effective services; Acting in a team; Direction setting; and Reflection. Palliative medicine consultants usually have to take on clinical leadership roles early in their careers and a more formal assessment of the development of leaderships skills, e.g. chairing multidisciplinary and non-clinical meetings is required. The tool is being piloted prior to use in the new curriculum.

Patient Survey (PS)

The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation; these areas are seen as critical for the effective practice of a palliative medicine doctor. As patient surveys can be challenging in palliative medicine, as the patients are so unwell, responses from those close to patients (including relatives and informal carers) will be accepted. As feedback in the palliative care setting is challenging, a minimum of 15 responses will be required (but the trainee should aim for 30.)

4.5.2 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

- Below expectations for this year of training; may not meet the requirements for critical progression point
- Meeting expectations for this year of training; expected to progress to next stage of training
- Above expectations for this year of training; expected to progress to next stage of training

The educational supervisor (ES) will review the evidence in the ePortfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For generic CiPs, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For specialty CiPs, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgment that has clinical meaning for assessors.

Level descriptors for specialty CiPs

Level	Descriptor
Level 1	Entrusted to observe only – no provision of clinical care
Level 2	Entrusted to act with direct supervision: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision. Out of hours, the supervising physician should be immediately available by telephone and able to return to the site of patient care if required to support the trainee, depending on local on call arrangements
Level 3	Entrusted to act with indirect supervision: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	Entrusted to act unsupervised

The ARCP will be informed by the ES report and the evidence presented in the ePortfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held in ST4, ST5, ST6 and ST7. Whilst there will only be one critical progression point at the end of ST7, decisions on progress will be of particular importance in ST6, at the time of the penultimate year assessment, to ensure that trainees are on course to progress to level 4 for all CiPs by the end of ST7.

4.5.3 Critical progression points

There will be one key progression point during Palliative Medicine training, which is the completion of specialty training at the end of ST7. All trainees will need to demonstrate satisfactory progress in both the specialty and IM curriculum each year in order to progress prior to this. The outline grid below sets out the expected level of supervision and entrustment for the specialty CiPs and the critical progression point for the whole of Palliative Medicine training.

Table 1: Outline grid of levels expected for Internal Medicine clinical CiPs

Level descriptors
Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine Stage 1				Selection	Internal Medicine Stage 2 + Specialty				CCT
Specialty CiP	**IMY1**	**IMY2**	**CRITICAL PROGRESSION POINT**	**IMY3**	**CRITICAL PROGRESSION POINT**	**ST4**	**ST5**	**ST6**	**ST7**	**CRITICAL PROGRESSION POINT**
Managing an acute unselected take		**3**		**3**					**4**	
Managing an acute specialty-related take		**2**		**2**			**3**		**4**	
Providing continuity of care to medical inpatients		**3**		**3**					**4**	
Managing outpatients with long term conditions		**2**		**3**					**4**	
Managing medical problems inpatients in other specialties and special cases		**2**		**3**					**4**	
Managing an MDT including discharge planning		**2**		**3**					**4**	
Delivering effective resuscitation and managing the deteriorating patient		**3**		**4**					**4**	
Managing end of life and applying palliative care skills		**2**		**3**					**4**	

Table 2: Outline grid of levels expected for Palliative Medicine specialty CiPs

Levels to be achieved by the end of each training year for specialty CiPs

Level descriptors

Level 1: Entrusted to observe only – no provision of clinical care; Level 2: Entrusted to act with direct supervision; Level 3: Entrusted to act with indirect supervision; Level 4: Entrusted to act unsupervised

Specialty CiPs	ST4	ST5	ST6	ST7	CRITICAL PROGRESSION POINT
1. Managing patients with life limiting conditions across all care settings	2	2	3	4	
2. Ability to manage complex pain in people with life limiting conditions	2	3	3	4	
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions	2	3	3	4	
4. Ability to demonstrate effective advanced communication skills with patients, those close to them and colleagues across all care settings	2	3	3	4	
5. Ability to manage, lead and provide optimal care of the complex dying patient and his/her family	2	3	4	4	
6. Manages delivery of holistic psychosocial care including religious, cultural and spiritual care across all care settings	2	3	3	4	
7. Demonstrates the ability to lead a palliative care service in any setting, including those in the charitable sector	2	2	3	4	

5.0 Implementation

5.1 Transition to Dual Accreditation with IM

The GMC states that "all doctors, except those in the final year of training or for whom it would otherwise be unreasonable or impractical to move, must transfer to the latest version of the curriculum within two years. Trainees should, where possible, not have to duplicate work or extend training time."

Palliative Medicine trainees will be dual accrediting for the first time. Trainees starting specialty training prior to 2022 will not have completed IM3 and will be on a single accrediting curriculum; it would therefore be very difficult for these trainees to transition to the new curriculum prior to CCT. The specialty also has a high proportion of female trainees, who are more likely to work less than full time (LTFT). Annual workforce data from the SAC demonstrates that consistently 40% of trainees work LTFT and these trainees, following the 2010 (2014 amendments) curriculum, will take longer to CCT in palliative medicine. This is also true for single accreditation trainees starting prior to 2022 that have time out of training for clinical experience or research, or who need to have a career break. Further discussion with the GMC will be required as to how to manage transition for these groups.

5.2 Managing Service and Specialty On Call Requirements

One of the major concerns raised during specialty consultation is the impact on palliative care services, many of which are in the charitable sector, of an effective 25% reduction in trainee workforce after implementation of the new curriculum, as Palliative Medicine trainees are released to fulfil the requirements of the IM curriculum.

The IM curriculum has palliative and end of life care as a learning outcome (CiP8), with palliative medicine experience strongly recommended during IM training. This provides an opportunity, which has been endorsed by JRCPTB, the Palliative Medicine Lead Dean, HEE, GMC (Via the COG) and the Heads of Schools of Medicine, to develop locally agreed models for backfill, whereby when a Palliative Medicine trainee undertakes a block of IM, their post is backfilled by an IM trainee on rotation. This will enable IM trainees to gain hands-on clinical exposure to palliative care across all settings, with support and supervision in place to enable them to achieve agreed learning outcomes pertinent to inform entrustment decisions for CiP8 (palliative and end of life care.)

This concept of reciprocity between Palliative Medicine and IM training meets the specialty vision, as initially defined by Dame Cicely Saunders, of extending education and training outside of hospices and palliative care services, such that non-palliative care staff in all care settings have the knowledge and skills to meet the needs of patients and those close to them. This is critical at a time when population demographic changes mean that the number of patients with potential palliative and end of life care needs are increasing, and nationally palliative care services are not funded, staffed or configured to meet whole population needs. Enhanced palliative medicine training for doctors training in IM will facilitate a cohort of consultants that will be able to work alongside palliative care services to best meet the needs of patients across care systems.

5.3 Communication

Trainees have been engaged in the development of the new curriculum, via the virtual trainee consultation group and via dissemination from the SAC trainee representatives. Once the curriculum is approved, it will be available on the JRCPTB specialty website and will be distributed to all educational and clinical supervisors and trainees via email (through TPDs and trainee representatives.) The new curriculum will require extensive changes to the e-portfolio, which will be undertaken in conjunction with the e-portfolio team at JRCPTB. A Rough Guide to the new Palliative Medicine curriculum will be developed to support implementation, following the successful launch of the 'Rough Guide to IMT' in 2019.

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FOR INFORMATION

Generic Professional Capabilities Framework
https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

The GMC has developed the Generic professional capabilities (GPC) framework with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

Good medical practice (GMP) is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with an associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The 20 domains and subsections of the GPC framework are directly identifiable in the IM and palliative medicine curriculum. They are mapped to each of the generic and specialty CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.
This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.