# Implementation of the new Palliative Medicine curriculum – Essential Requirements for Service Delivery and Specialty On Call

## Context

In 2013, the national review of training "Shape of Training" (SoT) was published. This was commissioned by seven joint UK-wide sponsors, including Royal Colleges, HEE & GMC with a remit to review the way we educate and train doctors in the UK, in response to changing population needs, such as growing number of people with multiple co-morbidities, the ageing population, health inequalities and increasing patient expectations. One of the recommendations was that "patients and public need more doctors who are capable of providing general care in broad specialties across a range of different settings". The Royal Colleges were tasked with implementing SoT and a UK steering group set up to oversee progress.

Following extensive discussions within the RCP and external review by the UK Shape of Training Steering Group, Palliative Medicine was confirmed as a group 1 specialty in 2017, along with neurology and genitourinary medicine. This means that with the implementation of the new specialty curriculum in August 2022, palliative medicine trainees will dual accredit in Internal Medicine (IM). The move to dual accreditation raises significant issues for service delivery and the provision of specialty on call for palliative care services in all settings. Over the four-year specialty training, trainees will spend 25% of their time in Internal Medicine (and therefore 25% less time in Palliative Medicine).

## Service Provision and Specialty On Call

The majority of palliative medicine training takes place in small multiprofessional teams, working in acute and specialist hospitals, community and specialist palliative care inpatient units (the majority being independent/third sector hospices.) Clinicians outside of the NHS deliver a significant proportion of training and most Palliative Medicine trainees will spend half of their training time in third sector services.

Specialist palliative care services are required to provide access to face-to-face assessments seven days a week and 24-h telephone advice.[1] On call doctors will frequently cover multiple sites across different settings. For example, a survey conducted by the Palliative Medicine Specialty Advisory Committee (SAC) in 2014 identified that 42% of trainees covered more than one site on call. Managing the specialty on call rotas has become more challenging over recent years, particularly since the introduction of the 2016 junior doctor contract.

The Association for Palliative Medicine (APM) and the Palliative Medicine SAC have real concerns that unless mitigated, the loss of trainee workforce to IM will have a major impact on service provision during the working week and put the delivery of specialty on call at risk, leading to some services withdrawing from training.

[1] https://www.nice.org.uk/guidance/csg4

Hospice UK has highlighted significant concerns from CEOs and Medical Directors about escalating medical staff costs for hospices and the sustainability of involvement in specialty training. Whilst Health Education England funds the majority of training posts in hospices in England, some training posts are funded by hospices, community or hospital teams, particularly where there was no central pick-up funding available when new (Hewitt) posts were pump-primed to support an expansion in training numbers in 2007-2008. For centrally funded posts, funding does not usually include on call, which is funded by the individual hospices. Shape of Training poses a very real risk to those locally funded posts.

The loss of trainee workforce would have a major impact on our ability to deliver specialty training across different settings, but would also have a longer-term impact in a number of areas:

- patient flow across the whole system – including community and hospice, which is vital to support patients remaining in their preferred place of care and to reduce pressure on the acute sector, in line with national recommendations [2] [3]
- workforce challenges, including the ability of community palliative care services and hospices to recruit consultant staff (leading to consultant vacancies) and manage the most complex patients in hospice and community settings
- the future of hospices as providers of specialist care, which depends on a consultant-led workforce

## Workforce Challenges in Palliative Medicine

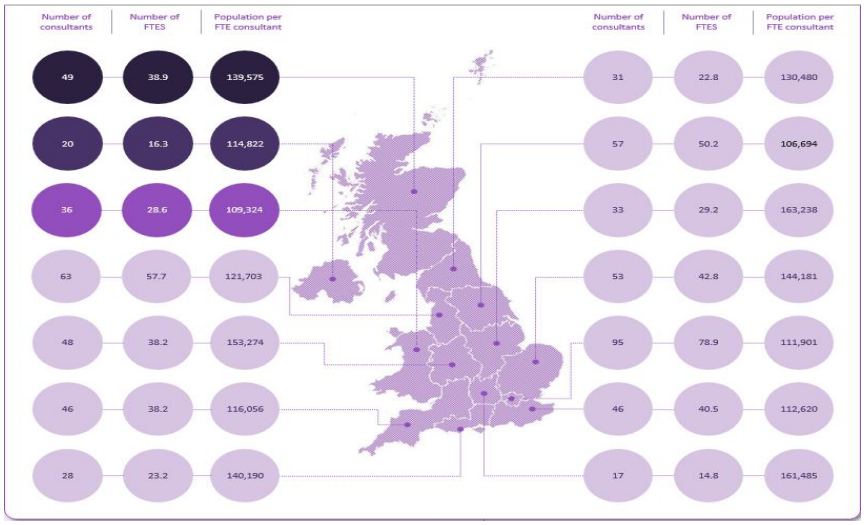
The palliative medicine consultant workforce is unique, in that consultants work across a range of settings, including acute hospitals, community hospitals, care homes, hospices/specialist palliative care units and with community palliative care teams. Like other medical specialties, palliative medicine and the wider specialty of palliative care is facing workforce challenges, with increasing workforce gaps, challenges meeting junior doctor rota requirements and sustaining seven-day services.

The Palliative Medicine SAC undertakes an annual workforce return, which on 1.9.18 took a snapshot of medical workforce in every palliative care service across the four nations. In the 2018 workforce return, services reported 56 (43.95 WTE) vacant consultant posts (out of 628 substantive posts, 472 WTE), with indications that a further 68 consultants are likely to retire in the next five years. With only 32 CCTs expected in 2018 and 28 in 2019, there is a persistent gap between the number of new CCT holders and consultant vacancies with the number of projected retirements increasing.

The workforce challenges are magnified by a female-predominant workforce, a significant proportion of who work less than full time as consultants; and significant regional variations in consultants per population (see figure 1.)

[2] Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan – revised Quality and Outcomes Framework (QOF) – end of life quality improvement module
[3] Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020

**Figure 1: Geographical location of substantive palliative medicine consultants (2017–18 consultant census RCP data tool)[4]**




The APM workforce committee has repeatedly highlighted the need for a national increase in the number of palliative medicine trainees, estimating that 60 CCT holders every year are required to meet the current workforce challenge. As palliative care patients in all settings become more complex, with the impact of increasing medical interventions, ageing and comorbidities, the need for consultant-led palliative care services is crucial.

Palliative Medicine is also a distinct specialty within medicine, traditionally attracting doctors from non-core medical training routes e.g. General Practice, anaesthetics and surgery, and those who completed specialist training in palliative medicine overseas. UK doctors from non-MRCP routes now make up around 5% of palliative medicine trainees nationally. Since Palliative Medicine became a medical specialty in 1987, these doctors have contributed to a richness and breadth of experience within the specialty. The move to dual training makes entry from these non-IM routes more difficult, as doctors would be required to take MRCP and complete the IM3 year prior to being eligible to apply for specialty training after 2022.

There have also been a steady number of doctors pursuing the CESR route, both from specialty doctor posts and from overseas. This route is threatened by the future requirement for CESR applicants to dual-accredit and again may further reduce workforce flexibility.

## Implementation of the new Palliative Medicine Curriculum

The Curriculum Oversight Group, hosted by the General Medical Council, Joint Royal College of Physicians Training Board and Health Education England has asked the Palliative Medicine Specialty Advisory Committee to develop options for the implementation of the new curriculum, to mitigate the anticipated service and workforce challenges.

[4] https://www.rcplondon.ac.uk/file/11458/download?token=B66sa0_H

## Potential Implementation Models

This paper outlines three potential models for delivering "backfill" whilst palliative medicine trainees are undertaking their IM training.

### 1. Model 1: Expansion of palliative medicine training posts by 25%

This model recommends an uplift in palliative medicine training posts of 25%, so that all backfill is provided within the specialty.

*Advantages*

This will enable continuity of service delivery and specialty on call provision and would go some way to addressing the workforce gap between the number of new CCT doctors annually and vacant consultant posts. There is adequate educational and clinical supervision in place to support this expansion and it would significantly reduce concerns of both the APM and Hospice UK about the sustainability of palliative medicine training outside of the NHS.

*Disadvantages*

This model has significant funding implications. Furthermore, it would not allow for increased exposure to palliative medicine for trainees in other IM dual accrediting specialties. As Shape of Training recommends training doctors with increased ability to care for complex patients across a range of settings, including community, the opportunity for IM trainees to gain non-acute experience would be more limited.

Initial discussions with HEE suggest that funding is unlikely to be available to meet the requirements of this model, but local applications for an increase in funded training posts will be considered.

### 2. Model 2: All backfill provided by IM trainees (either stage 1 (IM1 to 3) or stage 2 (IM 4 to 7) trainees in specialty training)

The new internal medicine (IM) curriculum[5] has 'palliative and end of life care' as one of its high-level learning outcomes (capabilities in practice or CiP) with the ***recommendation*** that IM trainees spend some time in a palliative care setting. The IM curriculum does not mandate palliative medicine experience, but placements in palliative care are more likely to up-skill trainees than formal teaching, e-learning and simulation alone.

This model outlines options for the backfill of palliative medicine training posts by IM trainees. New rotations would be designed, which would enable 'swapping' of trainees from a range of specialties (e.g. geriatrics, respiratory, acute medicine) with palliative medicine trainees, when the latter undertake their IM attachments. This approach has been approved by JRCPTB, SAC chairs, the lead Dean for palliative medicine and the Heads of Schools of Medicine within the LETBs/Deaneries.

[5] https://www.jrcptb.org.uk/imt

The backfill model will require an increase in educational and clinical supervision time to provide adequate support for trainees. There will also be employment considerations for trainees rotating outside of their usual place of work and specifically into the third sector.

*Advantages*
There are several advantages for the IM trainees that undertake a palliative medicine placement

- Immersion in a palliative care setting would allow the IM trainee to gain a broader perspective of the knowledge and skills underpinning the CiP and facilitate a deeper understanding of the possibilities of caring for palliative patients in a range of settings
- Direct exposure to palliative medicine in a non-acute (hospice or community) setting. This may be their only exposure to non-acute medicine during their training
- Immersion in palliative medicine to support achieving the requirements of the CiP, i.e. "to be entrusted to act independently [in relation to] palliative and end of life care skills"
- Ability to develop complementary skills and to work across specialties. Examples include:
    - acute medicine - awareness of palliative patients that might be suitable for management in a non-acute setting;
    - medicine for the elderly - significant co-dependencies and interfaces in both acute and community settings, including proactive support to care homes, Project ECHO, work with hospital at home teams;
    - range of medical specialties – joint management of patients with long term conditions, managing symptoms and psychological needs, increasing confidence in difficult conversations and advance care planning
- Increased confidence in communicating with patients and those close to them towards and at the end of life

*Disadvantages*
Palliative medicine trainees would be backfilled by IM trainees who will have limited palliative medicine experience and will require enhanced supervision. The scope of the work that IM trainees within palliative care can undertake will also be different. By IM3 or specialty training, all IM trainees would be expected to have gained some exposure to palliative medicine during stage 1 of the IM curriculum and should be able to work in a palliative medicine setting with "direct supervision"[6]. However the IM trainees will be less experienced than many of the trainees they are replacing (similar to a new ST3/4 at the start of specialty training.)

**New rotations with backfill of palliative medicine posts**
Several rotation options have been developed, so that when a palliative medicine trainee is undertaking an IM block, local IM trainees from a range of specialties provide the backfill by undertaking a block of palliative medicine training. All options rely on the 'swapping' of

[6] Internal Medicine curriculum, page 42: Outline grid of levels expected for Internal Medicine specialty capabilities in practice (CiPs)

trainees between palliative care services and other IM specialties. There will be complexities to rotation planning and it will be critical to ensure that no service is left with rotation gaps.

It is anticipated that the majority of rotations will be fixed, with trainee swaps built into relevant training programmes such as acute medicine, medicine for the elderly, respiratory and acute medicine. This supports clearer rotation planning and allows trainees to choose rotations that meet their training needs.

There is likely to be regional variation, with the details of the rotations developed by training programme directors and their colleagues in the Schools of Medicine. It is anticipated that rotations will be designed wherever possible so that ST4 palliative medicine trainees at the beginning of specialty training start with a block of palliative medicine and subsequent planning will aim to ensure maximum continuity for trainees.

### 3. Model 3: Hybrid model – uplift in palliative medicine posts supported by backfill from IM

*Advantages*

This option would require some uplift in training numbers, but would be less expensive than option 1 and would allow some trainees from IM to work in a palliative medicine setting. The potential benefits of this model are:

- An increase in posts will go some way to addressing the existing workforce gap between new CCT holders and vacant consultant posts
- An increase in posts coupled with backfill from IM into palliative medicine will allow for continuity of service provision and specialty on call
- The model allows for increased exposure to palliative medicine for IM trainees, facilitating meeting IM curriculum requirements and joint working between specialties and across acute and community settings, to better support care of complex patients
- Recognition of the challenges facing the specialty and sustainable mitigation through this model would provide reassurance to the APM and Hospice UK that specialty training in palliative medicine and the unique contribution of hospices and community palliative care services is valued nationally. This should help to stabilise the availability of medical training posts in hospices and community teams to enable palliative medicine and IM trainees to be trained across all care settings, in line with the recommendations of Shape of Training

*Disadvantages*

This option requires additional funding, which training programme directors will need to bid for regionally and does not fully meet the workforce gap between trainees achieving CCT and consultant vacancies annually.

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