JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Implementation

Palliative Medicine Curriculum

Guidance for training programme directors, supervisors and trainees

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide for Palliative Medicine is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the Palliative Medicine SAC with additional help from many external stakeholders especially trainees. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2022 Palliative Medicine curriculum?

Background

There have been two major drives to the need for change. Firstly the move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high level learning outcomes. The new curriculum has a relatively small number of 'capabilities in practice' (CIPs), which are based on the concept of entrustable professional activities (EPAs). Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the Generic Professional Capabilities (GPC) framework.

Duration of training

Palliative Medicine higher specialty training will usually be completed in four years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

The Palliative Medicine curriculum

The purpose of the Palliative Medicine curriculum is to produce doctors with the generic professional and specialty specific capabilities to manage patients with advanced, progressive, life-limiting disease, for whom the focus of care is to optimise their quality of life through expert symptom management and psychological, social and spiritual support as part of a multi-professional team. The curriculum aims to produce physicians with the breadth and depth of experience and competence to work safely and effectively as a consultant in Palliative Medicine in all care settings in the UK (including acute hospital, hospice, care homes and community), and within the NHS and third sector.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

The model for Palliative Medicine training will:

- Build on the knowledge, skills and attitudes acquired during stage 1 Internal Medicine training and ensure that Palliative Medicine doctors develop and demonstrate a range of essential capabilities for managing patients with a range of life-limiting, progressive conditions
- Ensure trainee physicians can provide safe, high quality, holistic palliative care in all settings (including acute hospital, ambulatory, community, care home and hospice / specialist palliative care unit) during and on completion of their postgraduate training
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including advanced communication skills
- Ensure that Palliative Medicine doctors are capable of providing and enabling palliative care for those in harder to reach community settings such as psychiatric units, hostels and prisons.
- Allow flexibility between specialties through GPCs and higher-level learning outcomes
- Further develop the attributes of professionalism, particularly recognition of the primacy of patient welfare that is required for safe and effective care of those with life-limiting, progressive conditions, and develop physicians who ensure patients' views are central to all decision making, which needs to be robust, individualised and incorporates a thorough understanding of medical ethics
- Ensure that Palliative Medicine physicians have advanced communication skills to manage complex and challenging situations with patient, carers and colleagues
- Provide the opportunity to further develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team to enable them to make independent clinical decisions on completion of training
- Ensure the flexibility to allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities

By the end of their final year of training, the trainee will receive a dual CCT in Palliative Medicine and Internal Medicine (IM).

Capabilities in Practice (CiPs)

The **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The **clinical CiPs** describe the capabilities required for Internal Medicine. The **specialty CiPs** describe the professional tasks or work within the scope of Palliative Medicine

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 for an entrustment decision to be made.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all clinical and specialty CiPs.

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 to be assessed by DOPS

Internal Medicine Clinical CiPs

1. Managing an acute unselected take
2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, 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 inpatients 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 applying palliative care skills

Specialty CiPs

1. Managing patients with life limiting conditions across all care settings
2. Ability to manage complex pain in people with life limiting conditions across all care settings
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings
4. Ability to demonstrate effective advanced communication skills with patients with life-limiting conditions, those close to them and colleagues across all care settings
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings
6. Manages delivery of holistic psychosocial care in patients with life-limiting conditions and those close to them, including religious, cultural and spiritual care across all care settings

7. Demonstrates the ability to lead a palliative care service in any setting, including those in the third sector

Please refer to the curriculum for the descriptors accompanying the clinical and specialty CiPs (section 3.2 to 3.4).

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee's capability (please see the CiPs tables and the assessment blueprint as outlined in the curriculum). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi-disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Presentations and Conditions

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. 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.

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.

Please refer to the curriculum for the range of presentations and clinical issues required for training (section 3.5)

Public Health Palliative Care

The curriculum expands on the public health components of palliative care, including:

- Civic, compassionate city charter
- Community, circles of care, relationships and health
- Bereavement
- Positive and negative outcomes
- Vulnerable groups and equity
- Health promotion, harm reduction, early intervention
- Service redesign
- Clinical compassionate community skills

As clinical leaders of the future, trainees 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. Community initiatives such as compassionate communities and integrated care 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.

Many of these concepts are relative new in palliative care. To support implementation of this component of the curriculum, specific training will be coordinated nationally (including study days and webinars), supported by signposting to local projects and resources (e.g. textbooks and relevant websites.) Please see appendix 1 for further detail.

Practical Procedures

The curriculum and ARCP decision aid list the practical procedures required and the minimum level of competency. The curriculum requires only two DOPS (syringe pump set up and management of an indwelling pleural or peritoneal catheter) to be undertaken in a clinical setting. Trainees need to demonstrate sustained competence for the syringe pump DOPS, which must therefore be repeated three times during training in a range of clinical settings and with different assessors.

The three other DOPS – management of patients with spinal lines, NIV and tracheostomies – can all be assessed by DOPS in a simulated setting. The focus of the simulation training should be on enabling the trainee to manage a patient with a spinal line, tracheostomy or NIV in a non-acute setting, including basic troubleshooting of any potential complications.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below level expected for the current year of training. For the IM clinical and specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). Palliative Medicine supervisors will not be expected to assess IM CiPs. For each of these CiPs there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below and in the ARCP decision aid.

What the trainee needs to do

The Palliative Medicine curriculum has changed to integrate Internal Medicine (IM) training, leading to award of a dual CCT. Trainees will need to meet the requirements of both the Palliative Medicine and IM curricula. The revised SLEs and DOPS take into account dual training and are intended to be both pragmatic and achievable. This curriculum introduces two new assessments: the LEADER and a patient survey.

Trainees still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics or community/ambulatory sessions they have attended and how many patients they have been involved with on the Acute Unselected Take (when doing IM placements) in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of two reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self- assessment allows

the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors. It is anticipated that trainees will have supervisors in both IM and Palliative Medicine.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the Palliative Medicine Specialty Certificate Examination
- a discussion about what resources are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS), if different to the ES, to discuss the opportunities in the current placement including;

- develop a PDP including SMART objectives for the placement
- access to Palliative Medicine training that across all settings (hospital, hospice inpatient and community) in order to meet the curriculum requirements
- access to non-Palliative Medicine clinics/community experience and how to meet the learning objectives
- expectations for the IM component of their post (as appropriate), including medical on-call and expectations for inpatient experience

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to

have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do prior to ARCP

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR). As a Palliative Medicine ES cannot assess the IM components of the curriculum, it is anticipated there will be separate ES reports for Palliative and Internal Medicine.

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following 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

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the **IM clinical** and **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

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
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

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss trainees' progress. The purpose is not only to make an

assessment of a trainee but to determine and plan on-going training. It is recommended again as an optimal way of providing information about trainees' progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units, such as hospices, the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. LFGs may be incorporated into other meetings in smaller units, such as consultant meetings. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of trainees in specialty training. Consideration of the trainee's performance in the acute medicine/on-call setting will be devolved to the local trust LFG.

The LFG should meet regularly to consider the progress of each trainee and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to trainee's Educational Supervisor and hence to the trainee. A mechanism for this to happen should be established.

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is two from Palliative Medicine, reflecting the national picture that many palliative care services have a limited number of consultants. By completion of IM training, trainees are required to have a minimum of four MCRs providing feedback on IM CiPs, completed by a consultant who has supervised the trainee in an acute unselected take/post-take setting; these will be additional to the indicative minimum requirement for Palliative Medicine.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care, particularly the acute medical take. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". Each ACAT should cover the care of a minimum of five patients.

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Out Patient Care Assessment Tool (OPCAT)

The outpatient care assessment tool (OPCAT) is designed to assess outpatient capability in IM or specialty clinics. It is designed to be used in a single clinic, whether face to face or virtual, and may be used during a direct observation if the trainer is present or as an assessment at the end of the clinic. There is no minimum number of patients that should be seen, although for a post clinic assessment it would be unusual if the trainee has seen fewer than three patients. It is unlikely that a single assessment could provide all the evidence required for an ES to make an entrustment decision on outpatient capability.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this link.

LEADER

The LEADER is a tool that assesses 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 leadership skills, e.g. chairing multidisciplinary and non-clinical meetings is required.

Patient Survey

Patient survey: this 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. Only one patient survey is required across training; as gaining feedback in the palliative care setting is challenging, an indicative minimum of 15 responses will be required (but the trainee should aim for 30.)

Examination

Trainees need to pass the Specialty Certificate Examination in order to complete training.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events.

Palliative Medicine trainees will be required to complete an indicative minimum of two records of reflective practice for each year of training.

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that trainees do not

need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged, including:
  - Arrangements for LFGs or equivalent
  - Arrangements for professional development meetings
  - Arrangements to meet IM requirements of curriculum

At the meeting the following need to be considered:

- Review the placements for the year, including IM component
- Review the training year elements of the generic educational work schedule or its equivalent
- Construct the personalised educational work schedule for the year or its equivalent
- Construct the annual PDP and relevant training courses
- Discuss the trainee's career plans and help facilitate these
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss the teaching programme
- Discuss procedural simulation
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs
- Planning of SLEs and WPBA
- Arrangements for MSF
- Review the ARCP decision aid
- Arrangements for Interim Review of Competence Progression (IRCP)
- Arrangements for ARCP and the writing and discussion of the ESR
- Pastoral support
- Arrangements for reporting of concerns

- Plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- Prepare for the meeting
- Make sure that knowledge of the curriculum is up-to-date
- Set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the placement or its equivalent
- Construct the set of placement-level SMART objectives in the PDP
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP

- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

Transition arrangements for trainees already in programme

Trainees in programme up to and including those recruited in 2020 and commencing training before August 2021 will have the option to transfer to the 2022 curriculum. However, it is anticipated that as the change to dual training is so significant, this will only be appropriate for a small number of trainees.

Trainees appointed in 2021 will transfer to the new curriculum in 2022. Together with IM TPDs, a gap analysis will be undertaken for each trainee to determine whether they require further IM training to complete IM stage 1 (IMS1). Some trainees may require a period out of programme to complete their IMS1 requirements.
See https://www.jrcptb.org.uk/training-certification/shape-training-and-physician-training-model/transition-new-curricula-jrcptb for more detailed guidance, including a template form to be used to support the gap analysis.

Trainees who have come from alternative entry pathways

Trainees that have entered specialty training from non-physician alternative, e.g. General Practice in 2021: If it is considered neither safe nor practical for a trainee to transfer to the new curriculum, the postgraduate dean must be consulted as they will be able to consider the merits of individual cases and, potentially, allow the trainee to remain on the 'old' curriculum.

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

Palliative Medicine training and the ARCP

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: "Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should

seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor, but should allow supervisors to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- All appropriate certificates have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection has been documented
- As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
- MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- The trainee has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular, it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

ARCP Decision Aid for Palliative Medicine

Evidence / requirement	Notes	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5)	ARCP year 6 (End of ST6 = PYR)	ARCP year 7 (End of ST7 = CCT)
Educational supervisor (ES) report	One per year to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns; confirms requirements to complete training	Confirms has met all curriculum requirements and will complete training
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training
Specialty capabilities in practice (CiPs)	See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each individual CiP	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm level 4 in all CiPs by end of training
Multiple consultant report (MCR)	Minimum number. Each MCR is completed by a Palliative Medicine consultant who has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee Trainees also need a minimum of four MCRs completed by an IM consultant by completion of training	2	2	2	2

Evidence / requirement	Notes	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5)	ARCP year 6 (End of ST6 = PYR)	ARCP year 7 (End of ST7 = CCT)
Multi-source feedback (MSF)	An indicative minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). In a year that has included IM training, at least 4 raters should be from IM. A separate MSF for IM is not required	1	1	1	1
Supervised learning events (SLEs): Acute care assessment tool (ACAT)	An indicative minimum number to be carried out by consultants. Each ACAT must include a minimum of 5 cases. ACATs should be used to demonstrate global assessment of trainee's performance on take or presenting new patients on ward rounds, encompassing both individual cases and overall performance (eg prioritisation, working with the team). It is not for comment on the management of individual cases	Included within IMS2 requirements of four per year – aim for at least one IM ACAT to reflect palliative care work, either ward round or on call experience			
Supervised Learning Events (SLEs): Case-based discussion (CbD), outpatient care assessment tool (OPCAT) or mini-clinical evaluation exercise (mini-CEX)	An indicative minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback	3	3	3	3

Evidence / requirement	Notes	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5)	ARCP year 6 (End of ST6 = PYR)	ARCP year 7 (End of ST7 = CCT)
	should be given to aid the trainee's personal development and reflected on by the trainee				
Supervised Learning Events (SLEs): Palliative Record of Reflective Practice (RRP)	An indicative minimum number to be carried out by consultants. Trainees are encouraged to undertake further reflection on the ePortfolio. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee	2	2	2	2
Practical Procedures	Minimum level of competence for Palliative Medicine training as outlined in table below				
SCE	Passed SCE to obtain CCT				
Advanced life support (ALS)	Valid				
Quality improvement Assessment Tool(QIPAT)	Active involvement in audit and quality improvement. Aim to lead minimum of one audit/QIP and supervise another by the end of training, assessed via QIPAT				
Communication skills	Evidence of completion of locally approved advanced communication skills training by the end of training				
Patient Survey	Completion of one satisfactory patient survey by end of training, with indicative minimum 15 respondents (patient or those close to them; can include patients seen in IM). One survey will meet the requirements of the Palliative Medicine and IM curricula.				
Teaching	Evidence of a range of teaching, including audience, topic and type of teaching; role in organising teaching; evidence of formal training in teaching and learning Summary of attendance at and involvement in teaching to be recorded in ePortfolio	Evidence of participation in and evaluation of teaching medical students, junior doctors, nurses and AHPs	Evidence of participation in and evaluation of teaching medical students, junior doctors, nurses and AHPs	Evidence of participation in and evaluation of a range of teaching activities. Evidence of basic understanding of principles of adult education and learning.	Portfolio evidence of ongoing participation in teaching across a range of settings. Evidence of training in an implementation of principles of adult education and learning

Evidence / requirement	Notes	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5)	ARCP year 6 (End of ST6 = PYR)	ARCP year 7 (End of ST7 = CCT)
Teaching Observation		1	1	1	1
Clinical Management	Many palliative medicine doctors take on significant clinical management responsibilities early in their consultant careers, so trainees should demonstrate involvement in a range of activities to build experience and confidence. Evidence can be collated in the ePortfolio and include: details of meetings attended (local, regional, national), including experience in chairing meetings; engagement in management, e.g. organising rotas, involvement in recruitment; evidence of working at a senior level (ST7); any formal management training	Evidence of participation in and awareness of some aspects of management – e.g. responsibility for organising on call rotas, organising and managing own workload effectively; supervision of more junior doctors	Evidence of participation in and awareness of some aspects of management, e.g. designing rotas; organising and leading teams; organising teaching sessions or journal clubs	Evidence of awareness of NHS and third sector management structures and how local services link to these. Attendance at relevant local management meetings and evidence of participation in management-related activities.	Evidence of understanding of management structures within NHS and third sector services and awareness of a range of clinical management activities, e.g. understanding budgets; liaison with commissioners and senior management; business planning
LEADER	Trainees should complete two LEADER assessments by the end of training	1 LEADER satisfactorily completed		1 LEADER satisfactorily completed	

Practical procedural skills

The 2022 Curriculum requires only two DOPS (syringe pump set up and management of an indwelling pleural or peritoneal catheter) to be undertaken in a clinical setting. Trainees need to demonstrate sustained competence for the syringe pump DOPS, which must therefore be repeated three times during training in a range of clinical settings and with different assessors.

The three other DOPS – management of patients with spinal lines, NIV and tracheostomies – can all be assessed by DOPS in a simulated setting. The focus of the simulation training should be on enabling the trainee to manage a patient with a spinal line, tracheostomy or NIV in a non-acute setting, including basic troubleshooting of any potential complications.

Trainees are expected to complete a minimum of one DOPS annually; however, the total number of DOPS required to complete training is seven; this decision aid has been designed to allow flexibility as to when during training the DOPS are undertaken.

Trainees must be able to outline the indications for the procedures listed in the table below and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthesia, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the trainee must be able to appreciate and recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Please see table below for minimum levels of competence expected in each training year.

Practical procedures – minimum requirements	**ST4**	**ST5**	**ST6**	**ST7**
Total Requirement	Minimum 1	Minimum 1	Minimum 1	Minimum 1 Evidence of completion of all mandatory DOPS (minimum total 7 by end of training)
Syringe pump set up	Limited supervision (formative)			Competent to set up independently (summative DOPS)
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	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative DOPS)

Practical procedures – minimum requirements	ST4	ST5	ST6	ST7
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	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative DOPS)
Tracheostomy care: management of common complications, e.g. secretions and a simple tube / tracheostomy change	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative DOPS)
Indwelling pleural/peritoneal catheter: identification of appropriate patients; day to day management and troubleshooting of complications, e.g. displacement, infection, blockage	Skills lab or satisfactory supervised practice/ limited supervision (formative)			Competent to manage complications and advise patients re: management (summative DOPS)

Supplementary guidance for Palliative Medicine ARCP decision aid – 2022 Curriculum

Events giving concern:
The following events occurring at any time may trigger review of trainee's progress and possible remedial training: issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; issues arising from supervisor report; issues of patient safety

Summary of Clinical Activity
Trainees are expected to record the range of clinical experience relevant to the portfolio using the summary of clinical activity forms. These are not meant to be onerous but to allow the trainee to demonstrate the range of activities undertaken to support the ES report and ARCP panel. Examples include:

- **Out of hours:** including details of all on-call /out of hours clinical activity, e.g. emergency admissions, routine and unplanned follow ups, telephone advice across all clinical settings

- **Hospital, palliative care inpatient/hospice and community:** number and range of patients seen in different settings to evidence sampling across range of curriculum. The majority of ST4 trainees will benefit from starting their specialty training in an inpatient unit, to provide the foundation stone for developing the core skills that are then transferrable to hospital and community settings.

Study leave: list of courses attended, use of CPD diary

Teenagers and Young Adults: please reference JRCPTB guidance and target workplace based assessments as outlined in the JRCPTB guidance on training in Adolescent and Young Adult Health Care (Curriculum Extract, pages 7-8)[1]

Evidence to support experience across settings and specialty on call
To aid evaluation of progression, trainees will be encouraged to keep a summary log of experience across different care settings and including specialty on call, to demonstrate that they have the range of experience required as outlined in the curriculum. Educational supervisors will be asked to comment on these areas in the educational supervisor reports and these areas will be reviewed at the time of PYR, to help identify any gaps in training.

Outline grid of levels expected for Palliative Medicine specialty capabilities in practice (CiPs)

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

Specialty CiP	C	R	ST4	ST5	ST6	ST7	C	R

[1] JRCPTB. Guidance on training in Adolescent and Young Adult Health Care (Including transition), 2018.
https://www.jrcptb.org.uk/sites/default/files/Guidance%20on%20training%20in%20Adolescent%20and%20Young%20Adult%20Health%20Care%20August%202018.pdf

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 across all care settings		2	3	3	4	
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings		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 those close to them across all care settings		2	3	4	4	
6. Manages delivery of holistic psychosocial care including religious, cultural and spiritual care across all care settings 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 third sector		2	2	3	4	

Training programme

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/hospice, and in acute and/or specialist hospitals
- Trainees must undertake the specialist palliative care training components of the curriculum through placements in services across a range of settings (inpatient, community and hospital), working with a full multiprofessional specialist palliative care team as defined in the NICE Guidance on Supportive and Palliative Care (2004)
- The majority of trainees will benefit from starting their training in an inpatient unit to develop their core palliative medicine knowledge and skills, which are then transferrable when working in an advisory capacity in hospital or community settings
- The minimum indicative training times allow for significant flexibility within training to allow individuals to meet training requirements; training programme directors and ARCP panels will provide oversight to ensure that training is balanced across the programme

Inpatient specialist palliative care (IPU)

- A minimum indicative period of 6 months cumulative experience will be in an inpatient specialist palliative care unit, usually in a hospice setting. A specialist palliative care unit is defined as a unit that is consultant-led, working with a multidisciplinary team that has the skills and training in specialist palliative care to manage and support the complex symptom, psychological and social needs of patients and families that cannot be managed in other settings.
- Blocks of training in an IPU are strongly recommended, however a flexible approach is needed, recognising that some placements will include concurrent experience in hospital or community
- Training in more than one IPU is recommended, to ensure experience across the training years and with a range of patient groups and service models
- Trainees will develop increasing capability to manage inpatients independently, both in and out of hours and over a consistent period as a senior trainee. They should be capable to manage certain acute and longstanding medical co-morbidities within the specialist inpatient setting but recognise when escalation to the acute sector may be necessary and appropriate
- Trainees will develop expert skills in patient-centred care, advance care planning, complex decision making and discharge planning, and the support of patients and families in crisis.

- Trainees will become aware of the pivotal role of the specialist in-patient unit as a point of access to expertise for primary and secondary care, delivering joined up and co-ordinated care for its local population
- Many IPU teams have a range of junior medical staff providing opportunities to support and supervise junior medical colleagues and physician associates, and work with specialty doctors, nursing colleagues, professions allied to medicine and therapists.
- Trainees will gain an understanding of IPU/hospice management, including the contribution of the third sector to NHS care; budget management and commissioning services; working with volunteers (including Trustees); involvement in governance and medicines management; and have the opportunity to be involved in service improvement.

Hospital Palliative Care

- A minimum indicative period of 6 months cumulative experience will be with an advisory/liaison hospital specialist palliative care team in an acute and/or specialist hospital (this can include work within a specialist hospital inpatient unit, but not exclusively), ideally with experience of managing patients in and out of hours
- By completion of training, trainees will be expected to be confident to triage, prioritise and assess new referrals; give telephone advice to colleagues; provide continuity of care to patients on a team's caseload; support other members of the multiprofessional team in managing their caseloads through application of expert medical knowledge and skill; liaise and negotiate safe and effective care plans with parent teams; and ensure the safe discharge of patients from hospital, including effective handover to community services
- Trainees need to be confident in a range of areas relating to hospital palliative medicine practice, including:
    - safely managing complex palliative care issues in hospital inpatients under the care of a parent team and in recognising the opportunities and limits of interventions in the acute setting
    - identification of those patients with more complex needs that would benefit from transfer to a specialist palliative care IPU
    - supporting parent clinical teams in recognising clinical uncertainty, including escalation and de-escalation of treatment/ interventions
    - supporting parent clinical teams in complex decision-making towards the end of life, including in intensive care, where there is conflict and where expert application of ethical and legal frameworks for people at the end of life is needed
    - managing patients in a consultative capacity in a hospital setting independently by the end of training

Community palliative care

- The term community includes a range of settings and services, e.g. community specialist palliative care teams, outpatient clinics, day hospice and wellbeing services, home visits including care homes, ambulatory units and joint working

with Primary Care and other community providers such as community geriatricians, learning disability and community mental health teams
- A minimum indicative period of 6 months cumulative experience is expected in community specialist palliative care to reflect the complexity of providing responsive palliative care, including acute intervention and rapid response, as well as coordinating longer term management for those with multi-morbidity, frailty and palliative care needs outside the acute hospital sector
- Trainees will develop capability to manage acute and unpredictable care needs in the patient's usual setting to avoid acute admission where this is inappropriate or unwanted by the patient, as well as working with community teams and primary care networks to anticipate and coordinate care in long-term conditions. Trainees should gain experience of providing palliative care to disadvantaged groups such as homeless, displaced and traveller groups; those in secure community units and prisons; and those with specific needs such as learning disability and drug and alcohol misuse
- Blocks of training, working predominantly in the community are strongly recommended, but a flexible approach is needed to ensure that trainees gain adequate experience across the training years and with a range of patient groups and service models. Trainees should demonstrate the ability to work across different community settings, develop skills to assess and manage patients independently and with primary care and other health and social care professionals and gain a comprehensive understanding of the range of community services available.
- Trainees should have exposure to service commissioning and development in the community setting, understand how services are adapted to meet evolving patient needs, political and public health priorities and the challenge of integrating patient centred care across acute and community settings both in and out of hours.

Cancer and oncology training

- Exposure to a range of oncology experience during training. This may include:
    - 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 the use of systemic anticancer therapies (including likely benefits and toxicities); participating in cancer site specialist multidisciplinary teams; working alongside acute oncology services
    - 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
- Experience of working in a cancer centre is highly recommended, as it is recognised that the complexity of patients managed in a tertiary setting will be different to those managed in other settings

Non-cancer training

- Exposure to a range of non-cancer conditions across different palliative care settings during training; including experience of joint working with other medical specialties, e.g. care of the elderly, e.g. in joint clinics or undertaking joint visits in the community

Out of hours palliative care

- 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

Communication Skills

- 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)

Other Requirements

- 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
- 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 it is recommended that specialist experience is 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

Recommended courses to support training

It is strongly recommended that trainees undertake formal courses or study to support their experiential learning, including:

- Training in Public Health Palliative Care (see Appendix 1)
- Advanced communication skills
- Simulation to support development of procedural skills and DOPS

Developing capability to work in third sector services in a senior role is important and may be achieved by attending relevant courses (e.g. third sector-focussed management course); attending senior hospice meetings and shadowing trustees and members of the executive team.

Training resources links

NHS e-learning for health (end of life care programme) https://www.e-lfh.org.uk/programmes/end-of-life-care/#:~:text=The%20e-learning%20programme%20End%20of%20Life%20Care%20for,to%20support%20people%20wherever%20they%20happen%20to%20be

Association for Palliative Medicine online resources: https://apmonline.org/ - access to Palliative Care Formulary, journals and education and training resources

SCE: MRCP(UK) – Palliative Medicine https://www.mrcpuk.org/mrcpuk-examinations/specialty-certificate-examinations/specialties/palliative-medicine

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CBME	Competency Based Medical Education
DME	Director of Medical Education
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
GMC	General Medical Council
HoS	Head of School
IMY1-3	Internal Medicine Year 1-3
JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NTN	National Training Number
OPCAT	Out Patient Care Assessment Tool
PDP	Professional Development Plan
PS	Patient Survey
SLE	Supervised Learning Event
WPBA	Workplace Based Assessment

Appendix 1: Specialist Training Public Health Palliative Care

Compassionate Communities UK

Introduction

Public health approaches to palliative and end of life care have been developing over the past 25 years. 2022 will see the publication of the First Oxford Textbook of Public Health Palliative Care. This covers the six topic areas of

1. The case for the public health approach
2. Basic concepts and theory
3. Basic practice methods
4. Population based approaches
5. Evidence base
6. Education and training

The basis for the public health approach draws on the theory, evidence base and practice methods of public health, including community engagement and development, prevention, harm reduction and early intervention.

With the increasing relevance of its application, the training curriculum for Specialist Registrars in palliative care in the UK now includes the public health approach, woven into a number of different aspects of training. In order to help trainees meet the learning requirements of the curriculum, Compassionate Communities UK has developed an educational module covering all the required areas. The training will be delivered by

Professor Allan Kellehear – Clinical Professor, University of Vermont, USA
Dr Julian Abel – Director, Compassionate Communities UK
Dr Libby Sallnow, Consultant in Palliative Medicine, Camden, Islington ELiPSe and UCLH & HCA Palliative Care Service
Dr Joseph Sawyer, SpR Palliative Care and PhD candidate, UCLH
Dr Kerrie Noonan, Director, Death Literacy Institute, Australia

The training will be delivered initially online with the intention of developing face to face regional training days. The individual lectures will all be on line.

Training plan

High Level learning outcome: Understand the theoretical basis for public health palliative care and be able to utilise these principles in clinical practice.

Descriptors

1. Develop a theoretical basis of the history and practice of public health palliative care
2. Apply the principles of public health palliative care in clinical practice
3. Understand the context of death, dying, loss and care giving as a social experience which has medical aspects
4. Understand that death, dying, loss and care giving has positive outcomes in addition to sadness and loss.
5. Understand that a population-based approach gives a different perspective to service provision, particularly where access to services is unequal.
6. Be able to plan services, which provide equity of access.

Specialist Registrar training will have 3 different delivery modes.

1. There will be a training day, delivered in person if possible

2. A series of four 1 hour lectures

3. The practice and application of clinical skills that will be reviewed as part of a group workshop, delivered either online or in person.

a) Training day format

5 lectures, 40 minutes of lecture and 20 minutes of discussion

1. Community, circles of care, relationships and health
2. Health promotion, harm reduction, early intervention
3. Compassionate City Charter
4. Positive and negative outcomes
5. Clinical compassionate community skills

b) Lecture series

1. Vulnerable groups and equity
2. Bereavement
3. Service redesign
4. Research methods

c) Workshop

2 hour Workshop on compassionate community skills to discuss experiences and outcomes of putting them into the clinical setting.

JRCPTB

Joint Royal Colleges of Physicians Training Board

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