Purpose Statement Palliative Medicine

Rationale (Need)

The Shape of Training (SoT) review[1] was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission[2] and the Francis report[3]. With an ageing population, elderly patients exhibit co-morbidities and increasing complexity so acute medical and palliative medicine services need a revised approach to training the physician of the future in order to meet these needs.

A further driver for change was the GMC review of the curricula and assessment standards and introduction of the GPC framework[4]. From May 2017, all postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making. To this end, communication skills are emphasised throughout all of the IM and palliative medicine capabilities in practice (see below) and evidenced through all work based assessments (and especially in the use of multi-source feedback – MSF). Expert communication is seen as fundamental to the role of the palliative medicine physician and advanced communication skills have been built into the palliative medicine capabilities in practice. Trainees are encouraged to reflect on their communication skills throughout every stage of their training and the record of reflective practice has been embedded into palliative medicine physicians' assessment since 2010.

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training that consists of an indicative seven year (dual) training period leading to a CCT in a specialty (palliative medicine) and internal medicine. Candidates will be selected to enter specialist palliative medicine training following completion of stage 1 training in internal medicine, during which there will be increasing responsibility for the acute medical take and the MRCP(UK) Diploma will be achieved. After this, there will be competitive entry into specialty plus internal medicine dual training. A minimum of three years will be spent training in the specialty and there will be a further one year of internal medicine integrated flexibly within the programme. This will ensure that CCT holders are competent to practice independently at consultant level in both palliative medicine and internal medicine.

This model will enhance the training of palliative medicine physicians, by enabling the management of the acutely unwell patient with an increased focus on chronic disease management, comorbidity and complexity. For palliative medicine doctors, there will be a significant focus on identifying reversibility (or lack of) in acutely unwell patients with life-limiting conditions and in promoting safe

[1] Shape of Training: Securing the future of excellent patient care
[2] Future hospital: Caring for medical patients
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

[4] Standards and guidance for postgraduate curricula

management in non-acute settings, e.g. community and hospice. Enhanced IM skills will also better equip palliative medicine physicians to work as members of the wider multidisciplinary team and alongside physicians in the acute hospital to most effectively manage patients with complex palliative care needs and those approaching the end of their lives.

The curriculum for palliative medicine incorporates and emphasises the importance of the generic professional capabilities. Common capabilities will promote flexibility in postgraduate training in line with the recommendations set out in the GMC's report to the four UK governments[5]. We believe a flexible approach is essential to deliver a sustainable model for physician training agile enough to respond to evolving patient need.

The curriculum for palliative medicine has been developed with the support and input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the Palliative Medicine Specialist Advisory Committee and its subgroups, with input from specialist societies (e.g. Association of Palliative Medicine). This curriculum replaces the previous version dated 2010 (amended 2014.)

Purpose and Objectives

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 all care settings in the UK (including acute hospital, hospice, care homes and community), and within the NHS and charitable sectors.

The model for palliative medicine training will:

- 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 palliative medicine doctors develop and demonstrate a range of essential capabilities for managing patients with a range of life-limiting, progressive conditions
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including advanced communication skills
- 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,

[5] Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training

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
- Build on the knowledge, skills and attitudes acquired during stage 1 IM training
- Ensure the flexibility to allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities

Scope of Practice

Palliative medicine specialty training will be managed by the Joint Royal College of Physicians Training Board (JRCPTB). Doctors in training will for the first time dual train in internal medicine and palliative medicine with the award of CCT (IM and Palliative Medicine) on completion of training. Palliative medicine doctors completing training will be required to work independently in all healthcare settings to enable to deliver of palliative care services where most appropriate for the patient. As a minimum, doctors completing training will be required to have developed skills in managing patients in the acute hospital (working in advisory palliative care teams and / or managing specialist inpatient units); inpatient palliative care units (e.g. hospice) and community (working in advisory palliative care teams) and ideally in a mix of NHS and charitable sector services.

Doctors in palliative medicine training will learn in a variety of settings (e.g. hospital, ambulatory, community, day hospice, care home and hospice / specialist inpatient units) using a range of methods, including workplace-based experiential learning, completing the specialty certificate examination, formal postgraduate teaching and simulation based education.

The generic capabilities and mapping of the curriculum to the GMC's Generic Professional Capabilities (GPC) framework[6] will facilitate transferability of learning outcomes across other related specialties and disciplines. The palliative medicine CiPs reflect the scope of palliative medicine practice and have been developed to complement the GPCs.

There are no notable exclusions to the scope of practice.

High level curriculum outcomes: Capabilities in practice

The capabilities in practice (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

[6] Generic professional capabilities framework

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 in all generic and specialty CiPs.

The six generic CiPs cover the universal requirements of all specialties as described in GPC framework. Assessment of the generic CiPs will be underpinned by the GPC descriptors.

The eight internal medicine specialty CiPs describe the clinical tasks or activities which are essential to the practice of internal medicine. The clinical CiPs have also been mapped to the GPC domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the CiPs, the performance of the doctor in training meets or exceeds the minimum expected level of performance expected for completion of this stage of internal medicine training, as defined in the curriculum.

The seven palliative medicine specialty CiPs describe the clinical tasks or activities which are essential to the practice of palliative medicine, across all care settings. These have been mapped to the GPC domains and to complement the generic and IM specialty CiPs.

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

7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and palliative care skills
Specialty CiPs: Palliative Medicine
1. Managing patients with life limiting conditions across all care settings
2. Ability to manage complex pain in people with life limiting conditions
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions
4. Ability to demonstrate effective advanced communication skills with patients, carers and colleagues across all care settings
5. Ability to manage, lead and provide optimal care of the complex dying patient and his/her family
6. Manages delivery of holistic psychosocial care 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 charitable sector

Four-country Endorsement

The need for a new curriculum that meets the needs of Shape of Training has been recognised by the SAC and by the Association for Palliative Medicine (GB and Ireland, APM.) The move to dual accredited training has been extensively debated via the annual APM conference (workshops and plenary sessions); via email correspondence to APM members and updates in APM bulletins; via trainee groups and the APM junior doctors' forum. A subgroup has been established between the APM and SAC to review the opportunities and service implications of the new curriculum; this subgroup will be consulted at all stages of curriculum development.

Inter-dependencies and accreditation of transferable competencies

When moving from one approved training programme to another, a trainee doctor who has gained relevant competences should not have to repeat training already achieved. The Academy of Medical Royal Colleges (AoMRC) Accreditation of Transferable Competences Framework (ATCF) assists trainees in transferring competences achieved in one training programme, where appropriate and valid, to another. This could save time for trainee doctors who decide to change career path after completing a part of one training programme by allowing them to transfer to the most appropriate place in another training programme.

The ATCF applies only to those moving between periods of GMC approved training and is aimed at the early years of training. The time to be recognised within the ATCF is subject to review at the first Annual Review of Competence Progression (ARCP) in the new training programme.

Palliative medicine as a specialty has traditionally taken doctors in training from a variety of backgrounds in addition to IM (most commonly general practice) and currently each year a small number of doctors transfer from other medical specialties, including oncology, haematology and geriatric medicine. It is anticipated that doctors looking to enter palliative medicine training from General Practice, Acute Care Common Stem (ACCS) Anaesthesia [Anaes], ACCS Emergency Medicine [EM] and Emergency Medicine will be able to transfer to IM stage 1 as outlined in the IM curriculum.

Palliative medicine shares some competencies with other specialty curricula, such as oncology (e.g. awareness of patterns of disease progression in cancer patients; management of symptoms caused by cancer treatment; and assessment and management of oncological emergencies) and geriatric medicine (e.g. management of patients with life-limiting conditions and multi-morbidity, including managing uncertainty and assessing reversibility; multiprofessional team working; advance care planning; interface in community settings, including care homes.) This would allow flexibility for doctors transferring between specialties post IM3 and will present opportunities for cross-specialty training.

Flexibility

GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. In addition, the IM CiPs will be shared across all physicianly curricula, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training.

Shape of Training

Meeting the needs of the patient population

In the United Kingdom there are currently around 600,000 deaths each year. With increasing life expectancy, this will increase by about 20% in total over the next 20 years, until an extra 100,000 people are dying each year. Alongside this, the number of people likely to require palliative care at the end of life will rise. More people are living and dying with multiple comorbidities and there is a need to ensure that the palliative medicine physician of the future has the skills to manage complex comorbidity, identify opportunities for reversibility, manage uncertainty and support clinical services to recognise where patients are dying, alongside the core skills of expert symptom control, psychosocial care and care of the dying. These changing demographics in society have also led to more acute palliative medicine being practised in non-hospital settings, such as in ambulatory, community or hospice / specialist inpatient units and to the development of new models of acute care delivery in non-acute settings, e.g. models such as hospital at home. It is therefore crucial for palliative medicine doctors to have the knowledge and skills to effectively and safely manage acutely unwell and deteriorating patients in non-acute settings and to support patient flow across the whole system by managing patients out of hospital where this is identified as appropriate or managing transfer of care between settings when clinically indicated.

Developing generic medical skills

Palliative medicine physicians will undertake training to dual accredit in internal and palliative medicine for the first time from August 2022. Dual training in palliative and internal will support the development of new models of early palliative care involvement in Emergency Departments and ambulatory and acute medical units, developing interfaces with community services to facilitate rapid discharge back to the community where clinically appropriate. Palliative medicine physicians working across the acute and community interface will enhance continuity of care for those patients that are suitable for rapid discharge to their preferred place of care and will be able to role-model cross-site working, thereby optimising continuity of care across care settings.

In addition, palliative medicine physicians working alongside other acute physicians in acute settings will be well-placed to ensure that timely, appropriate decisions regarding goals of care, taking into account patient wishes, are made and to ensure the delivery of high quality end of life care. A significant number of acute hospital complaints relate to end of life care, encompassing themes such as delayed decision making, poor communication and continuity of care; early palliative care involvement can improve patient and carer experience.

Enhancing the delivery of care in the community

Enhanced IM skills will facilitate the management of more medically unstable palliative care patients in non-acute settings and will support community clinical teams in identifying reversibility, managing uncertainty and diagnosing dying. Many patients chose to die in community settings and this is usually cost-effective for the NHS; palliative physicians with enhanced IM skills will be better placed to manage increasingly complex medical problems in

community settings, supporting care homes, community palliative care services and hospices / specialist palliative care units.

By working across acute and community care settings, palliative medicine doctors in training will gaining experience across all care settings; this will facilitate an understanding of how effective individualised care is achieved and support realistic advance care planning, promoting understanding of what can be safely managed in acute and community settings and when acute admission is and is not appropriate.

Credentials post-CCT

All of the palliative medicine curriculum will be mandatory to equip the palliative medicine physicians with the knowledge, skills and attributes to lead specialist palliative care services across all care settings, both NHS and charitable sector. Opportunities for credentialing have been considered and scrutinised by the SAC, including focus groups; but no sections of the existing curriculum currently lend themselves to this. Opportunities for post-CCT training will continue to be explored, e.g. in transition and young adult palliative care and in developing sub-specialty expertise, e.g. renal, dementia or neurology.

There is evidence that appropriately skilled palliative care teams, led by palliative medicine consultants, lead to improved outcomes for patients and families (i.e. better symptom control; improved communication; better emotional well-being, less depression; more satisfaction with care (patients and families); higher quality of life (patients and families)) and that the provision of palliative care can lead to reductions in the overall cost of healthcare, largely through reductions in unplanned hospital admissions and reductions in acute interventions near the end of life.

The curriculum pre-CCT will equip palliative medicine physicians with the knowledge and skills that are integral to the delivery of specialist palliative care across all care settings, working within a range of models of care and able to adapt to new care models as they devlop.

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