SPECIALTY TRAINING CURRICULUM

FOR

PALLIATIVE MEDICINE

2010
(AMENDMENTS 2014)
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Joint Royal Colleges of Physicians Training Board

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1 Introduction

Palliative medicine is the branch of medicine involved in the treatment of patients with advanced, progressive, life-threatening 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. Palliative medicine specialists may work in hospital, in the community and in hospices or other specialist palliative care units. The curriculum describes the competences required to gain a Certificate of Completion of Training (CCT) and to be registered on the Specialist Register in Palliative Medicine. A doctor with a CCT in Palliative Medicine will be able to work as a consultant within the National Health Service and charitable sector and will have the knowledge, skills and attitudes required to do this.

2 Rationale

2.1 Purpose of the curriculum

The purpose of this curriculum is to define the process of training and the competencies needed for the award of a certificate of completion of training (CCT) in Palliative Medicine

The specialty curriculum follows on from the core training curriculum (CMT or ACCS(M)) and core general practice, anaesthetic or surgical training curricula.

This curriculum will provide the competences to the level of CCT in palliative medicine. It will also provide the basis for revalidation of consultants in palliative medicine, where it will be adapted to the context of their current practice.

The curriculum covers training for all four nations of the UK.

2.2 Development

This curriculum was developed by the Specialty Advisory Committee for Palliative Medicine under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). It replaces the previous version of the curriculum dated May 2007, with changes to ensure the curriculum meets GMC's standards for Curricula and Assessment, and to incorporate revisions to the content and delivery of the training programme. Major changes from the previous curriculum include the incorporation of generic, leadership and management of health inequalities competences.

The basis for this curriculum was developed initially by the Curriculum Working Group of the Association for Palliative Medicine of Great Britain and Ireland (APM) in 2001, which comprised consultants from a variety of regions and backgrounds, who were all educational supervisors working in Palliative Medicine. A trainee representative was also an active member of this group. The content of the curriculum was based on a syllabus developed by experts in the field at the inception of Palliative Medicine as a specialty in 1987. The chair of the Curriculum Working Group participated in several workshops, alongside other specialties in medicine, to develop the content and style of the curriculum, with assistance from the Education Department at the Royal College of Physicians. The content was refined by wide consultation with doctors at all levels within the specialty and from professionals in closely aligned specialties, such as pain medicine and oncology. All educational supervisors in palliative medicine were asked for comment through their Regional Specialty Advisers (RSAs) and all trainees were asked to comment through their association. A workshop was held, to which all RSAs, the Executive Committee of

the APM and a trainee representative were invited to feed back on the draft curriculum. The curriculum was then approved by the JCHMT at the Royal College of Physicians in 2003. It has since been modified and updated by the Specialty Advisory Committee (SAC) in Palliative Medicine at the Royal College of Physicians (UK) to comply with the standards set by GMC.

The curriculum was updated in June 2006 and the assessments were included in May 2007 in line with GMC standards. The consultation process was repeated with the above groups.

For the review in 2009, there has again been wide ranging consultation on curriculum development. This process has benefited from input from a variety of specialists and from our lay committee member. A full list of contributors to the 2009 review is included in appendix 1

Following the introduction of our previous curriculum, feedback has been obtained systematically using a variety of methods:

- Within each Deanery, educational and clinical supervisors provide feedback to the Heads of Specialty Training (HoST), through the specialty training committees (STC).
- Trainee feedback is gained from representation on each STC. In addition, officers of the Specialty Advisory Committee (SAC) are available to trainees in person, twice a year, to hear and respond to feedback and concerns. A flow diagram for trainees has been published to streamline feedback on training and is available on the JRCPTB and specialty society websites. Appendix 2
- Curriculum matters are discussed formally three times a year at SAC meetings, where all HoSTs are members. The SAC also includes three trainee representatives from the 4 countries of the UK who channel trainee feedback, and a lay representative.
- Our co-opted SAC member from the British Pain Society has contributed to the relevant section of the curriculum.
- The Association for Palliative Medicine (APM) Executive Committee has been invited to comment, with subcommittees working on specific areas, such as research and ethics.
- Charitable sector employers have provided comments following an invitation to Help the Hospices

The curriculum was modified in the light of this feedback, with clarifications and minor additions to the content of learning, and some revision of required assessments.

A further minor amendment has been made in 2014 to allow entry to the specialty from trainees completing early years of emergency medicine (ACCS route) – please see below.

2.3 Training Pathway

Specialty training in Palliative Medicine consists of core and higher speciality training. Core training provides physicians with: the ability to investigate, treat and diagnose patients with acute and chronic medical symptoms; and with high quality review skills for managing inpatients and outpatients. Higher speciality training then builds on these core skills to develop the specific competencies required to practise independently as a consultant Palliative Medicine.

The core training curricula, Core Medical Training (CMT) or Acute Care Common Stem Medicine – Acute Medicine (ACCS-AM) follow on from the Foundation Curriculum. Completion of core training will be evidenced by satisfactory:

- Foundation competences
- Completion of CMT or ACCS-AM

Assessments to ensure completion of CMT or ACCS will include success in the full MRCP(UK) .

Doctors who have undertaken alternative career pathways, including general practice, core training in anaesthetics, core or early years of run through training in emergency medicine or surgery, will also be eligible to apply for higher specialty training if they can demonstrate that they have adequate experience in the diagnosis and ongoing inpatient management of patients with a broad range of general medical problems to a level equivalent to the experience gained in CMT or ACCS-AM. Doctors must be able to manage concurrent general medical problems in their patients, within the context of advanced, progressive disease, without immediate recourse to other specialists and in isolated units.

Doctors who have **not** completed CMT/ACCS-AM must therefore meet the following criteria:

- Satisfactory completion of early years of training in emergency medicine (ST1-3 of run through programme or ACCS), surgical training (core or early years of a pilot run through programme in surgery eg ST1 and ST2), anaesthetics or general practice and success in the relevant examination: MRCP(UK), MCEM, MRCS, FRCA, MRCGP.
- A minimum of 12 months experience in a range of acute medical specialties that admin acutely ill adult medical patients and manage their immediate follow-up.
- A minimum of four months' experience of managing patients on unselected medical take that involves ongoing patient management (this four-month period can form part of the 12 months' acute adult hospital medical experience required above).
- A further 12 months of relevant post-foundation experience. This may include any of the physicianly specialties as defined by the JRCPTB. Other experience, aside from medical specialties, which may count towards eligibility includes experience in any of the following: anaesthetics, clinical oncology, emergency medicine, general paediatrics, general practice, HIV medicine, intensive care medicine, psychiatry and surgery. Up to **a maximum of six months' experience in any one specialty can be counted** towards the total experience required.
- Core medical competencies including the following practical procedures: pleural tap and aspiration, ascetic tap, advanced cardiorespiratory resuscitation (as evidenced by a current ALS certificate or equivalent), abdominal paracentesis. Acceptable evidence is only permitted via the standard palliative medicine specific 'Alternative certificate of core competence'.

Doctors will then undergo competitive selection into palliative medicine specialty training using a nationally agreed person specification.

2.4 Enrolment with JRCPTB

Trainees are required to register for specialist training with JRCPTB at the start of their training programmes. Enrolment with JRCPTB, including the complete payment of enrolment fees, is required before JRCPTB will be able to recommend trainees for a CCT. Trainees can enrol online at www.jrcptb.org.uk

2.5 Duration of training

Although this curriculum is competency based, the duration of training must meet the European minimum of 4 years for full time specialty training adjusted accordingly for less than full time training (EU directive 2005/36/EC). The SAC has advised that training from ST1 will usually be completed in 6 years in full time training (2 years core plus 4 years specialty training).

2.6 Less Than Full Time Training (LTFT)

Trainees who are unable to work full-time are entitled to opt for less than full time training programmes. EC Directive 2005/36/EC requires that:

- LTFT shall meet the same requirements as full-time training, from which it will differ only in the possibility of limiting participation in medical activities.
- The competent authorities shall ensure that the competencies achieved and the quality of part-time training are not less than those of full-time trainees.

The above provisions must be adhered to. LTFT trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

EC Directive 2005/36/EC states that there is no longer a minimum time requirement on training for LTFT trainees. In the past, less than full time trainees were required to work a minimum of 50% of full time. With competence-based training, in order to retain competence, in addition to acquiring new skills, less than full time trainees would still normally be expected to work a minimum of 50% of full time. If you are returning or converting to training at less than full time please complete the LTFT application form on the JRCPTB website www.jrcptb.org.uk .

Funding for LTFT is from deaneries and these posts are not supernumerary. Ideally therefore 2 LTFT trainees should share one post to provide appropriate service cover.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed during annual appraisal by their TPD and chair of STC and Deanery Associate Dean for LTFT training. As long as the statutory European Minimum Training Time (if relevant), has been exceeded, then indicative training times as stated in curricula may be adjusted in line with the achievement of all stated competencies**.**

3 Content of learning

3.1 Programme content and objectives

The training programme aims to produce physicians with a breadth and depth of experience and competence to work safely as a consultant in palliative medicine in any care setting in the UK, and within the NHS and charitable sectors. The programme content is set out in the tables below.

3.2 Good Medical Practice

Good medical practice is the GMC's core guidance for doctors. It sets out the values and principles on which good practice is founded.

The guidance is divided into the following four domains:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

Good medical practice is supported by a range of explanatory guidance which provides more detail on various topics that doctors and others ask us about.
The "GMP" column in the syllabus defines which of the 4 domains of Good Medical Practice are addressed by each competency.

3.3 Syllabus

In the tables below, the "Assessment Methods" shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used. See section 5.2 for more details.

"GMP" defines which of the 4 domains of the Good Medical Practice Framework for Appraisal and Assessment are addressed by each competency. See section 3.2 for more details.

Syllabus Contents

1. Introduction to Palliative Care

1.1 History, Philosophy and Definitions

To discuss the history, philosophy and definitions of palliative care

To demonstrate that this knowledge and understanding informs clinical practice and decision-making, management practice and teaching

Knowledge	Assessment Methods	GMP
Discuss the definitions of: palliative care approach; general palliative care; specialist palliative care; hospice; specialist palliative care unit; palliative medicine; supportive care	CbD, SCE, mini-CEX, MCR	1,2
Describe the changing role of, and definitions within, palliative care over time (including extension to diseases other than cancer)	CbD, SCE, MCR	1,2
Discuss the evolving nature of palliative care over the course of illness, including integration with active treatment, and the significance of transition points	CbD, MCR	1,2
Recognise the principles of transition of care for teenagers and young adults between paediatric and adult palliative care services including knowledge of the differences between adult and children's hospices and the conditions they usually care for	SCE, CbD, MCR	1, 2, 3
Know about re-adaptation and rehabilitation	CbD, MCR	1,2
Discuss societal expectations and perceptions in progressive and advanced disease, and death	CbD, MCR	1,2,3,4
Know about differing concepts of what constitutes quality of life (including measurement) and a "good death"	CbD, SCE, MCR	1,2,3
Describe social and clinical concepts of suffering, its complexities and different articulations within different sectors of society.	CbD, MCR	1,
Skills		
Management of patients in the context of the evolving nature of palliative care over the course of illness, including integration with active treatment, and the significance of transition points	CbD, mini-CEX, MCR	1,3
Enable patients to maximise their function using principles of re-adaptation and rehabilitation	CbD, MCR	
Behaviours		
Recognise issues of health and health beliefs that are related to social class	CbD, MCR	1

1.2 Personal Qualities and Behaviours of Palliative Medicine Physicians

To develop the behaviours that will enable the doctor to become a senior leader able to deal with complex situations and difficult behaviours and attitudes amongst staff and the public.

To work increasingly effectively with many teams and to be known to put the quality and safety of patient care as a prime objective

To develop the attributes and analytical skills of someone who is trusted to be able to manage complex human, legal and ethical problem

To become someone who is trusted and is known to act fairly in all situations

To develop the personal and professional qualities, skills, and attributes required for the

effective practice of palliative medicine		
Knowledge	**Assessment Methods**	**GMP**
Recall and build upon the competencies defined in the Foundation Programme Curriculum: Discuss the main methods of ethical reasoning as laid out in subsequent sections such as: casuistry, deontology, consequentialism and narrative methods, and how they should form part of moral reasoning Know about the overall approach of value based practice and how this relates to ethics, law and decision-making	SCE,CbD, mini-CEX, MSF, MCR	1,2,3,4
Outline the relevance of professional bodies (Royal Colleges, JRCPTB, GMC, Postgraduate Dean, BMA, specialist societies, medical defence societies)	CbD, SCE, MCR	1
Skills		
Practise with professionalism to develop characteristics that include: • Integrity • Compassion • Altruism • Commitment to continuous improvement • Aspiration to excellence • Respect for cultural and ethnic diversity • Regard to the principles of justice, equality, fairness and equity	mini-CEX, MSF, MCR	1,2,3,4
Adopt an approach to eliminate discrimination against patients from diverse backgrounds including age, gender, race, culture, disability and sexuality	mini-CEX, CbD, MCR	1,2
Work in partnership with patients and members of the wider healthcare team	CbD, mini-CEX, MSF, MCR	3
Liaise with colleagues to plan and implement work rotas	MSF, MCR	3
Promote awareness of the doctor's role in utilising healthcare resources optimally and within defined resource constraints	CbD, mini-CEX, MSF, MCR	1,3
Recognise and respond appropriately to unprofessional behaviour in others	CbD, MCR	1
Deal with inappropriate patient and family behaviour	CbD, MCR	1,2,4
Handle enquiries from the press and other media effectively	CbD, MCR	1,3
The further development of those aspects of good medical practice particularly pertinent to the practice of palliative care: • Ability to work with, motivate and lead a team • Ability to balance (often subtle) therapeutic benefits and burdens in an ethical and technically coherent way • Excellent communication and liaison skills with a variety of other multi-professional teams, patients and carers • Judgement regarding when to act swiftly • Reflective practice	CbD, mini-CEX, MSF, MCR	1,3
Recognise in routine practice the doctor's role as advocate and manager	CbD, mini-CEX, MCR	1,2,3,4

Advocate and facilitate appropriate self-care	CbD, mini-CEX, MCR	1,2
Behaviours		
Behave with honesty and probity	MSF, mini-CEX, MCR	2,4
Act with tact, empathy, respect and compassion for patients and their families	CbD, mini-CEX, MSF, MCR	1,2
Place the needs of patients above one's own convenience	MSF, MCR	1,2,4
Act with honesty and sensitivity in a non-confrontational manner	MSF, MCR	1,2,4
Respect the rights of children, elderly, people with physical, mental, learning or communication difficulties	MSF, MCR	1,2,4
Recognise the need to use all healthcare resources prudently and appropriately	CbD, mini-CEX, MCR	1,2
Recognise the need to improve clinical leadership and management skills	CbD, mini-CEX, MCR	1
Recognise situations when it is appropriate to involve professional and regulatory bodies	CbD, mini-CEX, MCR	1,2,4
Willing to act as a leader, mentor, educator and role model	CbD, mini-CEX, MSF, MCR	1
Willing to accept mentoring as a positive contribution to promote personal professional development	CbD, mini-CEX, MCR	1,2
Participate in professional regulation and professional development	CbD, mini-CEX, MSF, MCR	1,2,4
Recognise the right for equity of access to healthcare	CbD, mini-CEX, , MCR	1
Recognise need for reliability and accessibility throughout the healthcare team	CbD, mini-CEX, MSF, MCR	1
Recognise one's personal beliefs and biases, and recognise their potential impact on the delivery of health services	CbD, mini-CEX, MSF, MCR	1,2
Where personal beliefs and biases impact negatively upon professional practice, ensure appropriate referral of the patient		
Show respect for social and religious values and practices which differ from one's own	CbD, mini-CEX, MSF, MCR	1
Recognise issues of health that are related to social class	CbD, MCR	1
Identify the opportunities and challenges of working in different ways in different environments, such as home, hospice, hospital	CbD, mini-CEX, MCR	1,3
Demonstrate self-awareness in regard to personal coping strategies and management / leadership style	CbD, MCR	1
Acknowledge the implications of what it means to be a specialist, to have standards of excellence and to apply them to oneself in reflective practice and the development of personal virtues and characteristics, such as respectfulness, fairness, and humility alongside assertiveness and sound judgment	MSF, MCR	1,2,4
Demonstrate appropriate self confidence tempered by critical self-appraisal and the recognition of one's limitations	CbD, mini-CEX, MSF, MCR	1,2

1.3 Communication with Colleagues and Cooperation

To recognise and accept the role and the responsibilities of the doctor in relation to other

healthcare professionals **To communicate succinctly and effectively with other professionals as appropriate**		
Knowledge	**Assessment Methods**	**GMP**
Demonstrate a familiarity with the section in "Good Medical Practice" on Working with Colleagues, in particular: The roles played by all members of a multi-disciplinary team The features of good team dynamics	CbD, MSF , MCR	1
Discuss the principles of effective inter-professional collaboration to optimise patient, or population, care	CbD, MSF, MCR	1
Recognise the principles and scope of confidentiality that provide the boundaries to communication	SCE, MSF, MCR	1
Skills		
Communicate accurately, clearly, promptly and comprehensively with relevant colleagues by means appropriate to the urgency of a situation (telephone, email, letter etc), especially where responsibility for a patient's care is transferred	CbD, mini-CEX, MCR	1,3
Utilise the expertise of the whole multi-disciplinary team as appropriate, ensuring when delegating responsibility that appropriate supervision is maintained	CbD, mini-CEX, MSF, MCR	1,3
Participate in and co-ordinate an effective hospital at night or hospital/hospice out of hours team where relevant; or participate in General Practice out of hours effectively	CbD, mini-CEX, MSF, MCR	1
Communicate effectively with administrative bodies and support organisations	CbD, mini-CEX, MSF, MCR	1,3
Employ behavioural management skills with colleagues to prevent and resolve conflict and enhance collaboration	CbD, mini-CEX, MSF, MCR	1,3
Behaviours		
Recognise the importance of and take part in multi-disciplinary teamwork, including adoption of a leadership role when appropriate but also recognising where others are better equipped to lead	CbD, mini-CEX, MSF, MCR	3
Foster a supportive and respectful environment where there is open and transparent communication between all team members	CbD, mini-CEX, MSF, MCR	1,3
Ensure appropriate confidentiality is maintained during communication with any member of the team	CbD, mini-CEX, MSF, MCR	1,3
Recognise the need for a healthy and effective work/life balance for the whole team, including oneself, but take any leave only after giving appropriate notice to ensure that cover is in place	CbD, mini-CEX, MSF, MCR	1
Be prepared to accept additional duties in situations of unavoidable and unpredictable absence of colleagues ensuring that the best interests of the patient are paramount	CbD, MSF, MCR	1

1.4 Communication Between Services

To demonstrate the knowledge, attitudes and skills required to foster timely and effective communication between services **To communicate with other professionals, both medical and non-medical, in a timely, effective and appropriate manner necessary for a smooth continuum of patient care**		
	Assessment	**GMP**

Knowledge	Methods	
Describe specific techniques and methods that facilitate effective and empathic communication	CbD, MCR	1,2,3
Discuss how decisions are made by individuals, teams and the organisation	CbD, MCR	1,3
Know about effective communication strategies within organisations	CbD, MCR	1,3
Skills		
Recognise the need for clear, timely communication between different service providers to provide a continuum of care for the patient between different settings e.g. home/hospice/hospital/nursing home	CbD, mini-CEX, MSF, MCR	1,3
Demonstrate communication skills relevant to negotiating these roles	mini-CEX, MSF, MCR	1,3
Develop effective working relationships with colleagues and other staff through good communication skills, building rapport and articulating one's own view in an accessible and measured way	MSF, MCR	1,2,3
Enable individuals, groups and agencies to implement plans and decisions	CbD, MSF, MCR	1,3
If appropriate and permitted, be able to provide specialist support to hospital and community-based services	CbD, MSF, MCR	1
Behaviours		
Facilitate shared care with other multi-professional teams, with specialist palliative care taking either the leading or a supportive role in both hospital and community settings	mini-CEX, MSF, MCR	1,2,3
Recognise good advice and promote values based non prejudicial practice	MSF, MCR	2,3,4
Use authority appropriately and assertively; willing to follow when necessary	MSF, MCR	2,3

2. Physical Care

2.1 History Taking

To develop the ability to elicit a relevant focused history from patients with increasingly complex issues and in increasingly challenging circumstances

To record the history accurately and synthesise this with relevant clinical examination, establish a problem list increasingly based on pattern recognition including differential diagnosis (es) and formulate a management plan that takes account of likely clinical evolution

Knowledge	Assessment Methods	GMP
Recognise the importance of different elements of a history. Be aware of both narrative and reductive elements to a patient's story	mini-CEX, MCR	1
Recognise that patients do not present their history in structured fashion	mini-CEX, MCR	1,3
Know likely causes and risk factors for conditions relevant to mode of presentation	mini-CEX, MCR	1
Recognise that the patient's agenda and the history should inform examination, investigation and management	mini-CEX, MCR	1
Skills		
Identify and overcome possible barriers to effective communication	mini-CEX, MCR	1,3
Manage time and draw consultation to a close appropriately	mini-CEX, MCR	1,3
Recognise that effective history taking in non-urgent cases may require several discussions with the patient and other parties, over time	mini-CEX, MCR	1,3
Supplement history with standardised instruments or questionnaires when relevant	mini-CEX, MCR	1,3
Manage alternative and conflicting views from family, carers, friends and members of the multi-professional team	mini-CEX, MCR	1,3
Assimilate history from the available information from patient and other sources including members of the multi-professional team	mini-CEX, MCR	1,3
Recognise and interpret appropriately the use of non verbal communication from patients and carers	mini-CEX, MCR	1,3
Focus effectively on relevant aspects of history	mini-CEX, MCR	1,3
Manage time and draw consultation to a close appropriately	mini-CEX, MCR	1,3
Maintain focus despite multiple and often conflicting agendas	mini-CEX, MCR	1,3
Recognise and evaluate sensitively the possible influence of, and sensitively include questions about, socio-economic status, household poverty, employment status and social capital in taking a medical history	CbD, mini-CEX, MCR	1,3
Recognise the stigmatising effects of some illnesses and social settings and work to help in overcoming stigma	CbD, mini-CEX, MCR	1
Behaviours		
Show respect and behave in accordance with Good Medical Practice	mini-CEX, MCR	3,4

2.2 Clinical Examination

To develop the ability to perform focused, relevant and accurate clinical examination in patients with increasingly complex issues and in increasingly challenging circumstances

To relate physical findings to history in order to establish diagnosis(es) and formulate a management plan

Knowledge	Assessment Methods	GMP
Recognise the need for a targeted and relevant clinical examination	CbD, mini-CEX, MCR	1
Recognise the basis for clinical signs and the relevance of positive and negative physical signs	CbD, mini-CEX, MCR	1
Recognise constraints to performing physical examination and strategies that may be used to overcome them	CbD, mini-CEX, MCR	1
Recognise the limitations of physical examination and the need for adjunctive forms of assessment to confirm diagnosis	CbD, mini-CEX, MCR	1
Recognise when the offer/ use of a chaperone is appropriate or required	CbD, mini-CEX, MCR	1
Skills		
Perform an examination relevant to the presentation and risk factors that is valid, targeted and time efficient	CbD, mini-CEX, MCR	1
Recognise the possibility of deliberate harm (both self harm and harm by others) in vulnerable patients and report to appropriate agencies	CbD, mini-CEX, MCR	1,2
Actively elicit important clinical findings	CbD, mini-CEX, MCR	1
Perform relevant adjunctive examinations	CbD, mini-CEX, MCR	1
Behaviours		
Show respect and behave in accordance with Good Medical Practice	CbD, mini-CEX, MSF, MCR	1,4
Ensure examination, whilst clinically appropriate, considers social, cultural and religious boundaries to examination. Communicate appropriately and make alternative arrangements where necessary	CbD, mini-CEX, MSF, MCR	1,4

2.3 Decision Making and Clinical Reasoning

To develop the ability to formulate a diagnostic and therapeutic plan for a patient according to the clinical information available

To develop the ability to prioritise the diagnostic and therapeutic plan

To communicate a diagnostic and therapeutic plan appropriately

Knowledge	Assessment Methods	GMP
Define the steps of diagnostic reasoning:	CbD, mini-CEX, MCR	1
Interpret history and clinical signs	CbD, mini-CEX, MCR	1
Conceptualise clinical problem in a medical, social and moral context	CbD, mini-CEX, MCR	1
Recognise the psychological component of disease and illness presentation	CbD, mini-CEX, MCR	1
Generate hypothesis within context of clinical likelihood	CbD, mini-CEX, MCR	1
Test, refine and verify hypotheses	CbD, mini-CEX, MCR	1
Develop problem list and action plan	CbD, mini-CEX, MCR	1

Recognise how to use expert advice, clinical guidelines and algorithms	CbD, mini-CEX, MCR	1
Recognise and appropriately respond to sources of information accessed by patients	CbD, mini-CEX, MCR	1
Recognise the need to determine the best value and most effective treatment both for the individual patient and for a patient cohort	CbD, mini-CEX, MCR	1,2
Define the concepts of disease natural history and assessment of risk	CbD, mini-CEX, MCR	1
Recall methods and associated problems of quantifying risk e.g. cohort studies	CbD, SCE, MCR	1
Outline the concepts and drawbacks of quantitative assessment of risk or benefit e.g. numbers needed to treat	CbD, SCE, MCR	1
Describe commonly used statistical methodology	CbD, mini-CEX, MCR	1
Know how relative and absolute risks are derived and the meaning of the terms predictive value, sensitivity and specificity in relation to diagnostic tests	CbD, mini-CEX, MCR	1
Skills		
Interpret clinical features, their reliability and relevance to clinical scenarios, including a recognition and appreciation of the breadth of presentation of common disorders	CbD, mini-CEX, MCR	1
Incorporate an understanding of the psychological and social elements of clinical scenarios into decision making through a robust process of clinical reasoning	CbD, mini-CEX, MCR	1
Use both reductive and narrative methods of history taking	mini-CEX, CbD, MCR	1
Recognise how the use of language and the underlying beliefs within different social and professional cultures may influence understanding between disciplines and communities and their approach to problems	CbD, MCR	1,2,3
Apply the principles of the Mental Capacity Act in promoting, assessing and contextualising the patient's capacity in discerning his/her best interest	CbD, mini-CEX, MCR	1,2,3,4
Recognise critical illness and respond with due urgency	CbD, mini-CEX, MCR	1
Generate plausible hypothesis(es) following patient assessment	CbD, mini-CEX, MCR	1
Construct a concise and applicable problem list using available information	CbD, mini-CEX, MCR	1
Construct an appropriate management plan in conjunction with the patient, carers and other members of the clinical team and communicate this effectively to the patient, parents and carers where relevant	CbD, mini-CEX, MCR	1,3,4
Define the relevance of an estimated risk of a future event to an individual patient	CbD, mini-CEX, MCR	1
Use risk calculators appropriately	CbD, mini-CEX, SCE, MCR	1
Consider the risks and benefits of screening investigations	CbD, mini-CEX, MCR	1
Apply quantitative data of risks and benefits of therapeutic intervention to an individual patient	CbD, mini-CEX, MCR	1
Search and comprehend medical literature to guide reasoning	AA, CbD, MCR	1
Behaviours		
Recognise the difficulties in predicting occurrence of future events	CbD, mini-CEX, MCR	1

Willing to discuss intelligibly with a patient the notion and difficulties of prediction of future events, and benefit/risk balance of therapeutic intervention	CbD, mini-CEX, MCR	3
Willing to adapt and adjust approaches according to the beliefs and preferences of the patient and/or carers	CbD, mini-CEX, MCR	3
Respect patient autonomy. Willing to facilitate patient choice	CbD, mini-CEX, MCR	3
Willing to search for evidence to support clinical decision making	CbD, mini-CEX, MCR	1,4
Able to identify one's own biases and inconsistencies in clinical reasoning	CbD, mini-CEX, MCR	1,3

2.4 Disease Process and Management

To describe the scientific basis and clinical manifestations of disease processes that are life limiting and to demonstrate the skill to implement this knowledge in the diagnosis and management of patients with life-limiting progressive disease

Knowledge	Assessment Methods	GMP
Demonstrate an appropriate level of understanding of the scientific basis of health and disease	CbD, SCE, MCR	1,2
Know about the principles of cancer management	SCE, CbD, MCR	1
Describe the presentation, paths of spread and current management of all major malignancies	SCE, CbD, MCR	1
Describe the presentation, usual course and current management of other life limiting, progressive illnesses treated within adult specialist palliative care	SCE, CbD, MCR	1
Know about the presentation, usual course and current management of common, life limiting, progressive illnesses in teenagers and young adults treated within paediatric palliative care who are likely to need adult palliative care services, such as Duchenne Muscular Dystrophy, Cystic Fibrosis	SCE, CbD, MCR	1
Skills		
Conduct initial patient assessment – detailed history (using narrative and reductive approaches) and examination; assessment of impact of situation on patient and family	CbD, mini-CEX, MCR	1,3
Judgement of prognosis and the margins of uncertainty in a disease trajectory	CbD, mini-CEX, MCR	1
Consideration of wide range of management options	CbD, mini-CEX, MCR	1
Judgement of benefits and burdens of investigations, treatments, and intervention or non intervention	CbD, mini-CEX, MCR	1
Acknowledgement of the need for and skills in reassessment and review	CbD, mini-CEX, MCR	1
Anticipation and pre-emption of problems	CbD, mini-CEX, MCR	1
Recognition of transition points during course of illness	CbD, mini-CEX, MCR	1
Recognition of dying process	CbD, mini-CEX, MCR	1
Crisis management	CbD, mini-CEX, MCR	1
Shared care with other specialties – benefits, difficulties, facilitation	CbD, mini-CEX, MCR	1, 3
Behaviours		

Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MSF, MCR	1
Involve patients actively in care planning and evaluation of options to understand, formulate and implement their best interests where possible and appropriate.	CbD, mini-CEX, MCR	1
Appreciate that treatments, in the context of progressive and fatal diseases are not ends in themselves, but means for a patient and the family to minimise the impact of the pathology upon their lives	CbD, MCR	1

2.5 Management of Concurrent Clinical Problems

To describe the scientific basis and clinical manifestations of concurrent clinical problems presenting in patients with life limiting illness and to diagnose and manage them in the context of patients with life-limiting progressive disease

Knowledge	Assessment Methods	GMP
Know about the presentation and usual management of concurrent clinical problems that may arise in patients with life limiting illness	SCE, MCR	1
Know about infection control measures in palliative care	SCE, CbD, MCR	1
Describe alternative methods of nutrition and hydration	SCE, CbD, MCR	1
Skills		
Management of infections and compliance with infection control measures	mini-CEX, CbD, MCR	1
Management of renal failure	mini-CEX, CbD, MCR	1
Management of COPD and common respiratory disorders	mini-CEX, CbD, MCR	1
Diagnosis and management of thromboembolic disease	mini-CEX, CbD, MCR	1
Management of anaemia, bleeding disorders, coagulopathies	mini-CEX, CbD, MCR	1
Management of diabetes mellitus in the context of patient prognosis and goals of treatment	mini-CEX, CbD, MCR	1
Diagnosis and management of hyper and hypothyroidism, adrenal failure, pituitary failure	mini-CEX, CbD, MCR	1
Management of ischaemic heart disease, heart failure, arrhythmias, hypotension	mini-CEX, CbD, MCR	1
Management of peripheral vascular disease	mini-CEX, CbD, MCR	1
Management of peripheral neuropathy	mini-CEX, CbD, MCR	1
Diagnosis and management of autonomic neuropathy	mini-CEX, CbD, MCR	1
Management of dermatological problems	mini-CEX, CbD, MCR	1
Diagnosis and management of liver failure	mini-CEX, CbD, MCR	1
Diagnosis and management of anxiety and depression, psychoses	mini-CEX, CbD, MCR	1
Management of fractures, osteoporosis, Paget's disease	mini-CEX, CbD, MCR	1
Management of patients with pre-existing drug dependence	mini-CEX, CbD, MCR	1
Management of patients with pre-existing chronic pain	mini-CEX, CbD, MCR	1
Behaviours		
Accept own limitations and seek specialist advice when needed	MSF, CbD, mini-CEX, MCR	1

2.6 Principles of Pain and Symptom Management

To have the knowledge, understanding and skills to manage symptoms and other clinical problems secondary to life limiting progressive disease		
Knowledge	**Assessment Methods**	**GMP**
Describe the wide range of therapeutic options available for symptom management – disease-modifying treatments and symptom-modifying treatments (palliative surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy, drugs, physical therapies, psychological interventions, complementary therapies)	CbD, SCE, mini-CEX, MCR	1,2
Skills		
Ability to take a clinical history and perform appropriate examination of patients with advanced illness	mini-CEX, MCR	1,2,3
Recognise the need for a diagnosis of the pathophysiology of a symptom (due to concurrent disorders and treatment related, as well as cancer related aetiology)	CbD, mini-CEX, MCR	1
Appropriate choice of treatment/non-treatment, considering burdens and benefits of all options	CbD, mini-CEX, MCR	1, 2
Management of the adverse effects of treatment	CbD, mini-CEX, MCR	1, 2
Recognise the need for regular review of symptom response	CbD, mini-CEX, MCR	1, 2
Use of appropriate methods in evaluating and assessing the response of symptoms	SCE, CbD, mini-CEX, MCR	1, 2
Management of intractable symptoms – recognition and support for patients, carers, multi-professional teams and oneself	CbD, mini-CEX, MCR	1, 2, 3
Ability to apply clinical reasoning to evaluate, judge and discriminate between competing demands using factual evidence and moral principles	CbD, MCR	1,2, 3
Assist patients and families to decide between options within an increasingly rights driven culture	mini-CEX, CbD, MCR	1,2,4
Assist patients and colleagues to see the distinctions between needs and wants, the moral and legal differences between demands and refusals and the differences for clinicians between acts and omissions.	mini-CEX, CbD, MCR	1,2,3,4
Referral to other agencies when needed	CbD, mini-CEX, MCR	1, 2, 3
Behaviours		
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MSF, MCR	1
Recognise symptoms within a physical, psychological and social context for patients and the impact this has on their carers	CbD, MCR	1
Appreciate the individuality of good and harm and the complexity of the concepts of futility, benefits and burdens.	CbD, MCR	1

2.7 Pain Management

To have the knowledge, understanding and skills to manage pain secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the physiology, pathophysiology and neuropharmacology of pain including peripheral and central sensitisation	SCE, MCR	1,2
Describe pain assessment tools used in clinical practice and research	SCE, CbD, mini-CEX, MCR	1
Describe different characterisations of pain- nociceptive, visceral, neuropathic, incident, myofascial	SCE, MCR	1
Know about recognised pain syndromes	SCE, CbD, mini-CEX, MCR	1
Know about drug treatment of pain – WHO analgesic ladder and appropriate use of adjuvant drugs	SCE, CbD, mini-CEX, MCR	1, 2
Describe the range of opioids available, relative benefits and indications in malignant and non-malignant disease	SCE, CbD, MCR	1, 2
Know about the long term effects of opioids	SCE, MCR	1, 2
Describe Indications for an appropriate use of opioid switching	SCE, CbD, MCR	1, 2
Describe the management of side effects of drug treatments	SCE, CbD, mini-CEX, MCR	1, 2
Know about non- drug treatment of pain – TENS, acupuncture, physiotherapy, immobilisation	SCE, CbD, MCR	1, 2, 3
Describe common nerve blocks and other neurosurgical procedures	SCE, CbD, MCR	1, 2, 3
Know about principles of spinal delivery of analgesics	SCE, CbD, MCR	1, 2, 3
Know about psychological interventions in pain management	SCE, CbD, MCR	1, 2, 3
Skills		
History taking, physical examination and investigations in pain assessment	CbD, mini-CEX, MCR	1
Assessment of burdens and benefits of treatments, including radiotherapy	CbD, mini-CEX, MCR	1, 2
Appropriate referral to and shared care with pain management service	CbD, mini-CEX, MCR	1,3
Management of epidural / intrathecal catheters (using local guidelines)	DOPS, CbD, MCR	1, 2
Be able to apply TENS machines	DOPS, MCR	1,2
Behaviours		
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MSF, MCR	1

2.8 Management of Gastrointestinal Symptoms

To have the knowledge, understanding and skills to manage gastrointestinal symptoms secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the causes of sore mouth	SCE, mini-CEX, CbD, MCR	1
Describe the causes of nausea and vomiting	SCE, mini-CEX, CbD, MCR	1
Describe the causes of swallowing problems	SCE, mini-CEX, CbD, MCR	1
Know about the causes of constipation / faecal impaction	SCE, mini-CEX, CbD, MCR	1
Know about the causes of diarrhoea	SCE, mini-CEX, CbD, MCR	1
Know about the causes of tenesmus	SCE, mini-CEX, CbD, MCR	1
Describe the causes of ascites	SCE, mini-CEX, CbD, MCR	1
Describe the causes of intestinal obstruction	SCE, mini-CEX, CbD, MCR	1
Know about the causes of jaundice	SCE, mini-CEX, CbD, MCR	1
Describe the causes of anorexia, cachexia	SCE, mini-CEX, CbD, MCR	1
Know about the management of stomas and gastrostomy tubes	SCE, CbD, MCR	1, 3
Skills		
Assessment and management of sore mouth	SCE, CbD, mini-CEX, MCR	1
Assessment and management of nausea and vomiting	SCE, CbD, mini-CEX, MCR	1
Assessment and management of swallowing problems	SCE, CbD, mini-CEX, MCR	1, 3
Assessment and management of constipation / faecal impaction	SCE, CbD, mini-CEX, MCR	1
Assessment and management of diarrhoea	SCE, CbD, mini-CEX, MCR	1
Assessment and management of tenesmus	SCE, CbD, mini-CEX, MCR	1, 3
Assessment and management of ascites	SCE, CbD, mini-CEX, MCR	1, 3
Assessment and management of intestinal obstruction	SCE, CbD, mini-CEX, MCR	1, 3
Assessment and management of jaundice	SCE, CbD, mini-CEX, MCR	1, 3
Assessment and management of anorexia, cachexia	SCE, mini-CEX, CbD,	1, 3

	MCR	
Be competent to pass a nasogastric tube	DOPS, MCR	1,2
Be competent to perform paracentesis	DOPS, MCR	1, 2
Behaviours		
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MSF, MCR	1
Seek advice from colleagues where necessary	MSF, MCR	1,3

2.9 Management of Respiratory Symptoms

To have the knowledge, understanding and skills to manage respiratory symptoms secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the causes of breathlessness	SCE, mini-CEX, CbD, MCR	1
Know about the causes of cough	SCE, mini-CEX, CbD, MCR	1
Describe the causes of hiccups	SCE, mini-CEX, CbD, MCR	1
Describe the causes of airways/ SVC obstruction	SCE, mini-CEX, CbD, MCR	1
Know about the causes of pleural and pericardial effusion	SCE, mini-CEX, CbD, MCR	1
Describe the causes of haemoptysis	SCE, mini-CEX, CbD, MCR	1
Know about management of tracheostomies	SCE, CbD, MCR	1,3
Skills		
Assessment and management of breathlessness	mini-CEX, CbD, MCR	1,3
Assessment and management of cough	mini-CEX, CbD, MCR	1, 3
Assessment and management of hiccups	mini-CEX, CbD, MCR	1, 3
Assessment and management of airways/ SVC obstruction	mini-CEX, CbD, MCR	1, 3
Assessment and management of pleural and pericardial effusion	mini-CEX, CbD, MCR	1, 3
Assessment and management of haemoptysis	mini-CEX, CbD, MCR	1, 3
Be able to manage a tracheostomy	DOPS, MCR	1.2
Be able to manage non invasive ventilation (where available and appropriate)	CbD, DOPS, MCR	1,2
Behaviours		
Be aware that respiratory symptoms may be frightening to patients and carers	MSF, CbD, mini-CEX, MCR	1
Accept own limitations and seek specialist advice when needed	MSF, CbD, mini-CEX, MCR	1

2.10 Management of Genitourinary Symptoms

To have the knowledge, understanding and skills to manage genitourinary symptoms secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the presentation and causes of bladder spasm	SCE, CbD, MCR	1
Know about the causes and diagnosis of urinary obstruction	SCE, CbD, MCR	1
Know about the impact of body image and sexual problems	SCE, CbD, MCR	1

Skills		
Recognise and manage bladder spasm	mini-CEX, CbD, MCR	1,3
Management of urinary obstruction	CbD, MCR	1, 3
Be able to elicit and respond to concerns about body image and sexuality	mini-CEX, CbD, MCR	1, 3
Behaviours		
Deal with patients with tact, empathy and respect	MSF, MCR	1
Seek advice from colleagues where necessary	MSF, MCR	1,3

2.11 Management of Musculoskeletal and Skin Problems

To have the knowledge, understanding and skills to manage musculoskeletal and skin symptoms secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the causes of lymphoedema	SCE, CbD, MCR	1
Know about the causes and presentation of fistulae	SCE, CbD, MCR	1
Know about the causes of wound breakdown	SCE, CbD, MCR	1
Describe the causes and management of offensive odour	SCE, CbD, MCR	1, 3
Know about the causes and management of pressure sores	SCE, CbD, MCR	1, 3
Describe the causes, diagnosis and management of pathological fractures	SCE, CbD, mini-CEX, MCR	1, 3
Know about the causes of itching	SCE, CbD, MCR	1
Skills		
Assessment and management of lymphoedema	mini-CEX, CbD, MCR	1,3
Assessment and management of bleeding / fungating lesions	mini-CEX, CbD, MCR	1,3
Assessment and management of fistulae	mini-CEX, CbD, MCR	1,3
Assessment and management of itching	mini-CEX, CbD, MCR	1,3
Behaviours		
Manage the patient with tact, sensitivity and respect	MSF, MCR	1, 4
Awareness of the impact of these conditions on social and family relationships	MSF, MCR	1

2.12 Management of Neurological and Psychiatric Problems

To have the knowledge, understanding and skills to manage neurological and psychiatric symptoms secondary to life limiting progressive disease

Knowledge	Assessment Methods	GMP
Describe the causes of raised intracranial pressure	SCE, CbD, MCR	1
Know about the presentation of depression and other mood disorders in advanced illness	SCE, CbD, MCR	1
Know the relevance and applicability of the Mental Capacity Act and the Mental Health Act	SCE, CbD, MCR	1

Describe the causes of confusional states	SCE, CbD, MCR	1
Skills		
Recognise and manage raised intracranial pressure	CbD, mini-CEX, MCR	1, 3
Be able to broach and discuss possible future loss of mental capacity with sensitivity	CbD, mini-CEX, MCR	1,3
Assess mental capacity	CbD, mini-CEX, MCR	1,3
Develop and maintain an Advance Care Plan	CbD, mini-CEX, MCR	1,3
Recognise and manage depression and other mood disorders	CbD, mini-CEX, MCR	1, 3
Recognise and manage confusional states and hallucinations	CbD, mini-CEX, MCR	1, 3
Recognise and deal with communication problems eg difficulties speaking or hearing, English as a second language	CbD, mini-CEX, MCR	1,2, 3
Manage anxiety, fear and insomnia	CbD, mini-CEX, MCR	1,3
Adjust management plans for those with pre-existing drug dependence	CbD, mini-CEX, MCR	1, 2, 3, 4
Behaviours		
Act in a non-prejudicial fashion, treating all patients with respect	MSF, MCR	1
Act to maximise independence and mental capacity	mini-CEX, CbD, MCR	1

2.13 Management of Other Symptoms

To have the knowledge, understanding and skills to manage other symptoms secondary to life limiting progressive disease

Knowledge	**Assessment Methods**	**GMP**
Know about treatment induced symptoms – radiotherapy, chemotherapy, immunotherapy, drugs	SCE, CbD, MCR	1,2
Describe the presentation, diagnosis and management of paraneoplastic syndromes	SCE, CbD, MCR	1
Describe the presentation, diagnosis and management of inappropriate ADH secretion	SCE, CbD, MCR	1
Describe the causes and management of electrolyte disturbances e.g. hypercalcaemia, hyponatraemia, hypomagnesaemia	SCE, CbD, MCR	1
Skills		
Assess and manage weakness and lethargy	CbD, SCE, MCR	1,3
Recognise and manage symptoms occurring in the last few days of life	CbD, mini-CEX, SCE, MCR	1
Be competent to set up a syringe driver	DOPS, MCR	1,2
Be competent in the care of Peripherally Inserted Central Catheters (PICC) and Hickman lines.	DOPS, MCR	1,2
Behaviours		
Be aware of the limits of one's own competence and willingness to refer to colleagues	MSF, MCR	1, 2, 3

2.14 Management of Emergencies in Palliative Medicine

To have the knowledge, understanding and skills to manage emergencies in palliative medicine

Knowledge	Assessment Methods	GMP
Describe the presentation and management of emergencies that occur in the context of palliative care	SCE, CbD, MCR	1,2
Skills		
Recognition, diagnosis and management of SVC obstruction	CbD, mini-CEX, SCE, MCR	1,2,3
Recognition and management of hypercalcaemia	CbD, mini-CEX, SCE, MCR	1,2
Diagnosis and management of spinal cord compression	CbD, mini-CEX, SCE, MCR	1,2,3
Diagnosis and management of cardiac tamponade	CbD, mini-CEX, SCE, MCR	1,2,3
Diagnosis and management of acute dystonia, oculogyric and serotonergic crises	CbD, mini-CEX, SCE, MCR	1,2
Diagnosis and management of neuroleptic malignant syndrome	CbD, mini-CEX,SCE, MCR	1,2
Recognition and management of terminal delirium / agitation	CbD, mini-CEX, MCR	1,2
Recognition and management of alcohol and drug withdrawal	CbD, mini-CEX, MCR	1,2
Recognition and management of stridor	CbD, mini-CEX, MCR	1,2,3
Diagnosis and management of pulmonary embolism	CbD, mini-CEX, SCE, MCR	1,2,3
Diagnosis and management of pneumothorax	CbD, mini-CEX, MCR	1,2
Diagnosis and management of acute CCF	CbD, mini-CEX, MCR	1,2,3
Recognition and management of epileptic fits	CbD, mini-CEX, SCE, MCR	1,2,3
Management of overwhelming pain and distress	CbD, mini-CEX, MCR	1,2
Management of pathological fractures	CbD, mini-CEX, MCR	1,2,3
Management of cardiopulmonary arrest	CbD, mini-CEX, MCR	1,2
Management of massive haemorrhage	CbD, mini-CEX, MCR	1,2
Management of anaphylaxis	CbD, mini-CEX, SCE, MCR	1,2
Recognition and management of hypoglycaemia	CbD, mini-CEX, MCR	1,2
Recognition and management of acute urinary retention	CbD, mini-CEX, MCR	1,2
Management of bronchospasm	CbD, mini-CEX, MCR	1,2
Management of acute renal failure	CbD, mini-CEX, MCR	1,2,3
Management of predictable complications of therapeutic inventions or procedures including advanced life support if appropriate	CbD, mini-CEX, MCR	1,2
Management of acute confusional states	CbD, mini-CEX, MCR	1,2
Management of acute suicidal ideation	CbD, mini-CEX, MCR	1,2,3
Management of overdose	CbD, mini-CEX, MCR	1,2
Behaviours		

Promote and preserve a patients dignity, confidence and trust	MSF, MCR	1, 3,4
Maintaining a calm demeanour while acting with speed as the situation demands	MSF, mini-CEX, MCR	1,2

2.15 Public Health Related to Palliative Care

To develop the ability to work with individuals and communities to improve access to and provision of palliative care

To recognise ways to influence and improve the general health of a community in relation to relevant preventive, supportive and end of life care

Knowledge	Assessment Methods	GMP
Incidence and prevalence of common life limiting and progressive conditions	CbD, SCE, MCR	1
Factors which influence health and illness – psychological, biological, social, cultural and economic	CbD, MCR	1
Influence of culture and beliefs on perceptions of health, illness and end of life care	CbD, mini-CEX, MCR	1
Factors which influence access to and uptake of palliative care eg culture, poverty, education	CbD, SCE, MCR	1
The influence of lifestyle on health and the factors that influence an individual to change their lifestyle	CbD, SCE, MCR	1
Relationship between the health of an individual, their family and community	CbD, SCE, MCR	1
Role of other agencies and factors in strategic management of disease and promoting health eg screening programmes, public health, PCTs	CbD, SCE, MCR	1
Principles of mapping service provision and gaps	SCE, MCR	1
Effect of addictive and self harming behaviours on personal health, response to palliative intervention and symptom management	CbD, MCR	1
Skills		
Identify opportunities to promote understanding of and improve access to palliative care	CbD, MCR	1,2
Work collaboratively with professional colleagues and other agencies to improve understanding of and access to palliative care	CbD, MCR	1
Recognise the interaction between mental, physical and social factors in relation to health, illness and bereavement	CbD, mini-CEX, MCR	1
Counsel patients appropriately about the benefits and risks of lifestyle and choices relevant to palliative intervention	CbD, mini-CEX, MCR	1,3
Identify patient's ideas, concerns and health beliefs and is capable of appropriately responding to these	CbD, mini-CEX, MCR	1,3
Recognise and be able to balance autonomy and social justice	CbD, MCR	1
Behaviours		
Recognise the responsibility as a doctor for promoting healthy approach to life and work	CbD, MSF, MCR	1,3
Engage in effective team-working to enable development of palliative care and availability of services	MSF, MCR	1,3

Engage with service development and education to promote understanding of and access to palliative care	CbD, MSF, MCR	1,3

2.16 Infection Control

To develop the ability to manage and control infection in patients, including controlling the risk of cross-infection, appropriately managing infection in individual patients, and working appropriately within the wider community to manage the risk posed by communicable diseases

Knowledge	Assessment Methods	GMP
Recognise the principles of infection control as defined by the GMC	CbD, mini-CEX, MCR	1
Recognise the principles of preventing infection in high risk groups (eg managing antibiotic use to reduce Clostridium difficile infection), including understanding the local antibiotic prescribing policy	CbD, SCE, mini-CEX, MCR	1
Recognise the role of notification of diseases within the UK and identify the principle notifiable diseases for UK and international purposes	CbD, SCE, mini-CEX, MCR	1
Recognise the role of the Health Protection Agency and Consultants in Health Protection (previously Consultants in Communicable Disease Control – CCDC)	CbD, SCE, MCR	1
Recognise the role of the local authority in relation to infection control	CbD, mini-CEX, MCR	1
Skills		
Recognise the potential for infection in patients being cared for	CbD, mini-CEX, MCR	1,2
Counsel patients on matters of infection risk, transmission and control	CbD, mini-CEX, MCR	2,3
Actively engage in local infection control procedures	CbD, MCR	1
Actively engage in local infection control monitoring and reporting processes	CbD, MCR	1,2
Prescribe antibiotics according to local antibiotic guidelines and work with microbiological services where this is not possible	CbD, mini-CEX, MCR	1
Recognise potential for cross-infection in clinical settings	CbD, mini-CEX, MCR	1,2
Practice aseptic technique whenever relevant	DOPS, MCR	1
Behaviours		
Encourage all staff, patients and relatives to observe infection control principles	CbD, MSF, MCR	1,2, 3
Recognise the risk of personal ill-health as a risk to patients and colleagues in addition to its effect on performance	CbD, MSF, MCR	1,2, 3

2.17 Therapeutics and Safe Prescribing

To develop the ability to prescribe, review and monitor appropriate therapeutic interventions relevant to clinical practice including non – medication based therapeutic and preventative indications

Knowledge	Assessment Methods	GMP
Indications, contraindications, side effects, drug interactions and dosage of commonly used drugs	CbD, SCE, mini-CEX, MCR	1
Recall range of adverse drug reactions to commonly used drugs, including complementary medicines	CbD, SCE, mini-CEX, MCR	1
Recall drugs requiring therapeutic drug monitoring and interpret results	CbD, SCE, mini-CEX, MCR	1

Outline tools to promote patient safety and prescribing, including electronic clinical record systems and other IT systems	CbD, mini-CEX, MCR	1,2
Define the effects of age, body size, organ dysfunction and concurrent illness on drug distribution and metabolism relevant to the trainee's practice	CbD, SCE, mini-CEX, MCR	1,2
Recognise the roles of regulatory agencies involved in drug use, monitoring and licensing (e.g. National Institute for Clinical Excellence (NICE), Committee on Safety of Medicines (CSM), and Medicines and Healthcare Products Regulatory Agency (MHRA)) and hospital formulary committees	CbD, SCE, mini-CEX, MCR	1,2
Skills		
Review the continuing need for, effect of and adverse effects of long term medications relevant to palliative medicine	CbD, mini-CEX, MCR	1,2
Anticipate and avoid defined drug interactions, including complementary medicines	CbD, mini-CEX, MCR	1
Advise patients (and carers) about important interactions and adverse drug effects	CbD, mini-CEX, MCR	1,3
Prescribe appropriately in pregnancy, and during breast feeding	CbD, mini-CEX, MCR	1
Make appropriate dose adjustments following therapeutic drug monitoring, or physiological change (e.g. deteriorating renal function)	CbD, mini-CEX, MCR	1
Use IT prescribing tools where available to improve safety	CbD, mini-CEX, MCR	1,2
Employ validated methods to improve patient concordance with prescribed medication	mini-CEX, MCR	1,3
Provide comprehensible explanations to the patient, and carers when relevant, for the use of medicines and recognise the principles of concordance in ensuring that drug regimes are followed	CbD, mini-CEX, MCR	1,3
Recognise the importance of non-medication based therapeutic interventions including the legitimate role of placebos	CbD, mini-CEX, MCR	1,3
Where involved in "repeat prescribing," ensure safe systems for monitoring, review and authorisation	CbD, mini-CEX, MCR	1
Behaviours		
Recognise the benefit of minimising number of medications taken by a patient to a level compatible with best care	CbD, mini-CEX, MCR	1
Appreciate the role of non-medical prescribers	CbD, mini-CEX, MCR	1,3
Remain open to advice from other health professionals on medication issues	CbD, mini-CEX, MCR	1,3
Recognise the importance of resources when prescribing, including the role of a Drug Formulary and electronic prescribing systems	CbD, mini-CEX, MCR	1,2
Ensure prescribing information is shared promptly and accurately between a patient's health providers, including between primary and secondary care	CbD, MCR	1,3
Participate in adverse drug event reporting mechanisms	CbD, mini-CEX, MCR	1, 2
Remain up to date with therapeutic alerts, and respond appropriately	CbD, MCR	1, 2

2.18 Pharmacology and Therapeutics in Palliative Medicine

To demonstrate knowledge, understanding and experience of treatment methods and use of drugs necessary to treat patients with life limiting progressive disease

Knowledge	Assessment Methods	GMP
Know about relevant national guidelines and protocols	CbD, SCE, MCR	1,2
Describe the roles and limitations of drugs, physical therapies, psychological interventions and complementary therapies in palliative care	CbD, SCE, MCR	1,2
Discuss concordance and non-concordance with treatments – reasons for non-concordance and ways of increasing concordance	CbD, SCE, MCR	1,2
Describe general principles of pharmacodynamics and pharmacokinetics	CbD, SCE, MCR	1,2
Know about pharmacogenetics	CbD, SCE, MCR	1,2
Describe the role of hospital and community pharmacy services	CbD, SCE, MCR	1
Know about drug formularies in palliative care	CbD, SCE, MCR	1,2
Know about managing a pharmacy budget; issues of cost versus benefit	CbD, SCE, MCR	1
Discuss prescribing – legal issues, generic prescribing	CbD, SCE, MCR	1
Describe legal and ethical issues relating to the prescription of controlled drugs	CbD, SCE, MCR	1,2
Know about use of drugs on a named patient basis	CbD, SCE, MCR	1,2
Know about use of drugs outside their product licence	CbD, SCE, MCR	1,2
Know about use of drugs in clinical trials	CbD, SCE, MCR	1,2
Discuss problems of polypharmacy	CbD, SCE, MCR	1,2
For drugs commonly used in palliative medicine or commonly taken by patients presenting to palliative care, describe: • Routes of administration • Absorption, metabolism, excretion • Half-life, usual frequency of administration • Adverse effects and their management • Opioid switching - rationale and dose conversions • Use in syringe drivers, stability and miscibility • Interactions with other drugs • Possibility of tolerance, dependence, addiction and discontinuation reactions • Availability in the community	CbD, SCE, MCR	1,2
Describe the adjustment of dosage in frail, elderly and children	SCE, CbD, MCR	1,2
Describe the adjustment of dosage in altered metabolism, organ failure, disease progression and in dying patients	SCE, CbD , MCR	1,2
Skills		
The application of evidence based medicine to palliative care. Communication about the above with others in the clinical team	CbD, mini-CEX, MCR	1,2,3,4
The use of appropriate measurement tools when assessing treatment	CbD, mini-CEX, MCR	1,2

response		
Analysis of therapeutic possibilities, weighing up benefits and burdens of treatment or intervention	CbD, mini-CEX, MCR	1,2
Communication about therapeutic goals and possible adverse effects with patients and carers; enabling their input to decision making	CbD, mini-CEX, MCR	1,2
Managing a pharmacy budget; issues of cost versus benefit	CbD, mini-CEX, MCR	1,2
Prescribing – legal issues, generic prescribing	CbD, mini-CEX, MCR	1,2
Use of drugs on a named patient basis	CbD, mini-CEX, MCR	1,2
Use of drugs outside their product licence	CbD, mini-CEX, MCR	1,2
Adjustment of dosage in frail, elderly and children	CbD, mini-CEX, MCR	1,2
Adjustment of dosage in altered metabolism, organ failure, disease progression and in dying patients	CbD, mini-CEX, MCR	1,2
Helping patients and carers to understand and manage tablets	CbD, mini-CEX, MCR	1,2
Reporting adverse drug reactions to CSM	CbD, mini-CEX, MCR	1,2,3
Management of adverse effects of drugs commonly used in palliative medicine or commonly taken by patients presenting to palliative care	CbD, mini-CEX, MCR	1,2,3
Ability to switch opioids using appropriate rationale and dose conversions	CbD, mini-CEX, MCR	1,2
Use of drugs in syringe drivers taking account of stability and miscibility	CbD, mini-CEX, MCR	1,2
Behaviours		
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	MSF, MCR	1

2.19 Long Term Conditions in Palliative Care

To demonstrate the ability to define and provide appropriate supportive and palliative care in long term conditions in conjunction with patients and other specialists

Knowledge	Assessment Methods	GMP
Know about the natural history of diseases that run a chronic course including neurodegenerative disorders, cardiac failure, respiratory disease and renal failure	CbD, SCE, mini-CEX, MCR	1
Discuss symptom management relevant to long-term conditions	CbD, mini-CEX, MCR	1
Describe the role of rehabilitation services and multi-disciplinary teams to facilitate long-term care	CbD, mini-CEX, MCR	1
Discuss the concept of quality of life and how this can be measured whilst recognising the limitations of such measures for individual patients	CbD, SCE, MCR	1
Describe the concept of patient self-care and the role of the expert patient	CbD, mini-CEX, MCR	1
Recognise and be able to compare and contrast the medical and social models of disability	CbD, SCE, MCR	1
Key provisions of disability discrimination legislation		
Recognise the relationship between local health, educational and social service provision including the voluntary sector	CbD, MCR	

Understand the experience of adolescents and young adults with long term conditions and/or disability diagnosed in childhood requiring transition into adult services and the potential implications on psychological, social and educational/vocational development (including awareness of the Disability Discrimination Act) and how developmental stage may impact on self management	CbD, mini-CEX, MCR	1
Skills		
Develop and agree a management plan with the patient (and carers) to enable self-care where relevant	CbD, mini-CEX, MCR	1,3
Able to define the role and limitations of palliative care in the management of patients with long term conditions	CbD, MCR	
Provide relevant evidenced-based information and, where appropriate, effective patient education with support of the multi-disciplinary team	CbD, mini-CEX, MCR	1,3,4
Promote and encourage involvement of patients in appropriate support networks	CbD, mini-CEX, MCR	1,3
Encourage and support patients in accessing appropriate information	CbD, mini-CEX, MCR	1,3
Behaviours		
Enable patient autonomy and choice within the constraints of available resources, taking account of their best interests	CbD, mini-CEX, MCR	3,4
Recognise the potential impact of long term conditions on the patient, family and friends	CbD, mini-CEX, MCR	1
Demonstrate an holistic approach to assessment and management of palliative care needs in long-term conditions	CbD, mini-CEX, MCR	1
Refer to appropriate agencies for support, equipment and devices relevant to the patient's care	CbD, mini-CEX, MCR	1, 3
Encourage appropriate level of patient self care and independence	mini-CEX, MCR	1, 4
Work collaboratively with other members of the multi-disciplinary team in primary and secondary care	CbD, mini-CEX, MSF, MCR	1, 3
Recognise the role of expert patients and representatives of charities or networks that support patients and their families/carers	CbD, mini-CEX, MCR	3
Recognise and respect the role of family, friends and carers in the management of the patient with a long term condition	CbD, mini-CEX, MCR	1,3

2.20 Rehabilitation

To demonstrate knowledge of the principles of rehabilitation in progressive illness and the skills to appropriately initiate rehabilitation for patients receiving palliative care

Knowledge	Assessment Methods	GMP
Describe principles of rehabilitation related to illnesses with gradually increasing disability	CbD, SCE, MCR	1,2,3
Describe the concept of maintenance of function through exercise and therapies	CbD, MCR	1
Know about facilities available for rehabilitation	CbD, SCE, MCR	1, 2
Know about appliances available in the home	CbD, SCE, MCR	1, 2
Describe support services available in the home	CbD, SCE, MCR	1, 2, 3

Discuss specific skills of AHPs and disease/cancer site specific specialist nurses in rehabilitation	CbD, SCE, MCR	1, 2, 3
Know about concepts such as self transcendence in the engagement with disability and suffering.	CbD, MCR	1,2
Skills		
Recognise changing goals during the course of an illness	CbD, MCR	1,3
Deal with patient / family conflict in relation to unrealistic goals	CbD, mini-CEX, MCR	1,3
Use of disablement centre for artificial limbs and appliances	CbD, MCR	1,3
Behaviours		
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MSF, MCR	1
Acknowledge the particular challenges of mental and cognitive frailty as part of neurodisabilities	CbD, MCR	1,2

2.21 Delivering Shared Care

To demonstrate a positive attitude towards shared medical care

To be able to deliver palliative care whatever the environment (hospital, hospice, nursing homes, day-care and the patient's home)

Knowledge	Assessment Methods	GMP
Knowledge of the benefits and difficulties of facilitation of shared care with other specialities	CbD, MCR	1,2
Knowledge of services available in each setting	CbD, MCR	1,3
Knowledge of models of care co-ordination and key workers in community and hospital practice	CbD, MCR	1,3
Delivery of care out of hours - knowledge of services available in each setting, including equipment and medication, and systems for efficient handover of patient information	CbD, MCR	1,2,3
Know about patients'/carers' entitlements to care and professionals' obligations to provide it	SCE, CbD, MCR	1,2,4
Describe the ethical and legal aspects of patient refusal of treatment and/or care or demands within limited resource	SCE, CbD, MCR	1,2,4
Discuss the complexities of multi-professional care in respect of individual and collective responsibility and duties	CbD, MCR	1,2,3,4
Skills		
Delivery of appropriate treatment within each setting. In the community, this will include: Planning home visits vs outpatient attendance, Managing the "doctors bag", Examination of patients in the home setting, Planning for emergencies in the home, Planning for end-of-life care, Anticipating and managing risks to personal safety	CbD, mini-CEX, MCR	1,3
Delivery of care out of hours - how to access services, equipment and medication, and use of systems for efficient handover of patient information	CbD, mini-CEX, MCR	1, 2, 3

Behaviours		
Demonstrate a commitment to shared care with other specialities in each setting	CbD, MSF, MCR	1,2,3

2.22 Care of the Dying Patient and his/her Family

To have the knowledge, understanding and skills to provide optimal care for the dying patient and his/her family

Knowledge	Assessment Methods	GMP
Knowledge of major cultural and religious customs which relate to medical practice, dying and bereavement	CbD, SCE, MCR	1
Recognise the role of care pathways in improving care of the dying	CbD, mini-CEX, MCR	1,2
Recognise the concept of prolonged dying and its causes	CbD, MCR	1
Skills		
Recognition of the dying phase	CbD, mini-CEX, MCR	1,2,3,4
Initial assessment of the dying patient	mini-CEX, MCR	1, 3
Providing ongoing care for dying patients and their families	mini-CEX, CbD, MCR	1, 2, 3, 4
Assessment of required medications	mini-CEX, CbD, MCR	1,2
Recognise when to discontinue further investigations and treatment	mini-CEX, CbD, MCR	1,2
Manage symptoms in the dying phase – pain, agitation, nausea and vomiting, respiratory tract secretions, delirium, massive haemorrhage	mini-CEX, CbD, MCR	1,2
Management of mouth care and bowel care	mini-CEX, CbD, MCR	1,2
Psychological care of the family	mini-CEX, CbD, MCR	1,2,4
Recognise and engage with ethical dilemmas in the dying phase: Manage the distress and suffering that may lead to requests for assisted suicide	mini-CEX, CbD, MCR	1,2,4
Use of care pathways in improving care of the dying	mini-CEX, CbD, MCR	1,2
Behaviours		
Recognise when to discontinue further investigations and treatment	mini-CEX, CbD, MCR	1,2
Understand the role environment plays in caring for the dying patient and being able to adapt accordingly eg hospital, home, hospice	CbD, MCR	1,2

3. Communication

3.1 The Patient as the Central Focus of Care

To develop the ability to prioritise the patient's agenda encompassing his/her beliefs, concerns, expectations and needs

Knowledge	Assessment Methods	GMP
Outline health needs of particular populations eg adolescents / young adults, ethnic minorities and recognise the impact of health beliefs, culture and ethnicity in presentations of physical and psychological conditions	CbD, MCR	1
Skills		
Give adequate time for patients and carers to express their beliefs, ideas, concerns and expectations	mini-CEX, MCR	1,3,4
Respond to questions honestly and seek advice if unable to answer	CbD, mini-CEX, MCR	3,4
Encourage the healthcare team to respect the philosophy of patient focussed care	CbD, mini-CEX, MSF, MCR	3
Develop a self-management plan with the patient	CbD, mini-CEX, MCR	1,3
Support patients, parents (where applicable) and carers where relevant to comply with management plans	CbD, mini-CEX, MCR	3
Encourage patients to voice their preferences and personal choices about their care	mini-CEX, MCR	3
Behaviours		
Support patient self-management	CbD, mini-CEX, MCR	3
Recognise the duty of the medical professional to act as patient advocate	CbD, mini-CEX, MSF, MCR	3,4

3.2 Relationships with Patients and Communication within a Consultation

To recognise the need, and develop the abilities, to communicate effectively and sensitively with patients, relatives and carers

Knowledge	Assessment Methods	GMP
Know how to structure a consultation appropriately	CbD, mini-CEX, MCR	1
Describe the importance of the patient's background, culture, education and preconceptions (beliefs, ideas, concerns, expectations) to the process	CbD, mini-CEX, MCR	1
Understand the importance of the developmental stage when communicating with adolescents and young adults	ACAT, CbD, mini-CEX, PS, MCR	1
Skills		
Establish a rapport with the patient and any relevant others (eg carers)	CbD, mini-CEX, MCR	1, 3
Listen actively and question sensitively to guide the patient and to clarify information in particular with regard to matters that they may find it difficult to discuss, e.g. domestic violence or other abuse	mini-CEX, MCR	1, 3
Utilise open and closed questioning appropriately	Mini-CEX, MCR	1, 3

Listen actively and question sensitively to guide the patient and to clarify information	mini-CEX, MCR	1, 3
Identify and manage communication barriers, tailoring language to the individual patient and others and using interpreters when indicated	CbD, mini-CEX, MCR	1, 3
Deliver information compassionately, being alert to and managing their and your emotional response (anxiety, antipathy etc)	CbD, mini-CEX, MCR	1,3,4
Use, and refer patients to, appropriate written and other evidence based information sources	CbD, mini-CEX, MCR	1,3
Effectively communicate uncertainty	mini-CEX, MCR	1,2
Check the patient's/carer's understanding, ensuring that all their concerns/questions have been covered	CbD, mini-CEX, MCR	1,3
Indicate when the consultation is nearing its end and conclude with a summary and appropriate action plan; ask the patient to summarise back to check his/her understanding	CbD, mini-CEX, MCR	1,3
Make accurate contemporaneous records of the discussion	CbD, mini-CEX, MCR	1,3
Manage follow-up effectively and safely utilising a variety of methods (eg phone call, email, letter)	CbD, mini-CEX, MCR	1
Ensure appropriate referrals and communications with other healthcare professionals resulting from the consultation are made accurately and in a timely manner	CbD, mini-CEX, MCR	1, 3
Behaviours		
Approach the situation with courtesy, empathy, compassion and professionalism, especially by appropriate body language and endeavouring to ensure an appropriate physical environment - act as an equal not a superior	CbD, mini-CEX, MSF, MCR	1,3,4
Ensure appropriate personal language and behaviour	mini-CEX, MSF, MCR	1,3,4
Ensure that the approach is inclusive and patient centred and respects the diversity of values in patients, carers and colleagues	mini-CEX, CbD, MCR	3,4
Willing to provide patients with a second opinion	CbD, MCR	3,4
Use different methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved	CbD, MCR	1,3,4

3.3 Communication with Patients and Carers

To demonstrate good communication skills and use of reflective practice to ensure these skills are maintained

To be able to identify obstacles to communication and demonstrate skills in overcoming these

To demonstrate a professional attitude to confidentiality

Knowledge	Assessment Methods	GMP
Knowledge of theories and evidence base for communication practice	SCE, MCR	1,2,3
Identify a range of structures and styles of consultation	CbD, mini-CEX, MCR	1,3
A professional recognition of the ethical and legal aspects to confidentiality	CbD, SCE, MCR	1,4
Recognise common barriers to communication for both patients and professionals	CbD, mini-CEX, MCR	1,3

Recognise common communication problems: deafness, expression and learning disabilities	mini-CEX, CbD, MCR	1, 3
Describe the nature of mental capacity	SCE, CbD, MCR	1
Skills		
Demonstrate skills in active listening, open questioning and information giving to: • Elicit concerns across physical, psychological, social and spiritual domains • Establish extent of awareness about illness and prognosis • Manage awkward questions and information giving sensitively and as appropriate to wishes and needs of the individual • Facilitate decision making and promote autonomy of the individual patient • Ensure that the patient is appraised of arrangements for the continuity of their care and who to contact in case of need	mini-CEX, MCR	1,3
Practice of a range of structures and styles of consultation	mini-CEX, MCR	1,3
Communicate about care pathways and prognostic indicators as they apply to individuals	mini-CEX, CbD, MCR	1,4
Where values and perceptions of health and health promotion conflict, facilitate balanced and mutually respectful decision-making	CbD, mini-CEX, MCR	3,4
Enable families and colleagues to distinguish types of rights such as freedoms and entitlements and the attendant duties and obligations that different people have	mini-CEX, CbD, MCR	1,3,4
Communicate effectively with patients from diverse backgrounds and those with special communication needs, such as the need for interpreters	mini-CEX, MCR	3
Communicate effectively and respectfully with parents and carers	mini-CEX, MCR	3,4
When indicated, apply and communicate the principle of "best interests"	mini-CEX, CbD, MCR	1,2,4
Behaviours		
Be self- aware and constructively critical of one's own consulting skills	CbD, MCR	1
Be aware of the challenges within families and professionals of handling emergent autonomy in sick young people and shrinking autonomy in the mentally and cognitively frail	CbD, MCR	1,2,4
Work to promote and preserve mental capacity where possible	mini-CEX, CbD, MCR	1,2,4
Appreciate the value of reflective practice and supervision in difficult cases	CbD, MCR	1,2,4

3.4 Breaking Bad News

To recognise the fundamental importance of breaking bad news

To develop strategies for skilled delivery of bad news according to the needs of individual patients and their relatives / carers

Knowledge	Assessment Methods	GMP
Know that how bad news is delivered irretrievably affects the subsequent relationship with the patient	CbD, mini-CEX, MSF, MCR	1
Know that every patient may desire different levels of explanation and	CbD, mini-CEX, MCR	1,4

have different responses to bad news		
Know that bad news is confidential but the patient may wish to be accompanied	CbD, mini-CEX, MCR	1
Once the news is given, patients are unlikely to take anything subsequent in, so an early further appointment should be made	CbD, mini-CEX, MCR	1, 3
Know that breaking bad news can be extremely stressful for the doctor or professional involved	CbD, mini-CEX, MCR	1,3
Know that the interview at which bad news is given may be an educational opportunity	CbD, mini-CEX, MCR	1
It is important to prepare for breaking bad news: • Set aside sufficient uninterrupted time • Choose an appropriate private environment and ensure that there will be no unplanned disturbances • Have sufficient information regarding prognosis and treatment • Ensure the individual has appropriate support if desired • Structure the interview • Be honest, factual, realistic and empathic • Know of relevant guidance documents	CbD, mini-CEX, MCR	1,3
Know that "bad news" may be expected or unexpected and it cannot always be predicted	CbD, mini-CEX, MCR	1
Know that sensitive communication of bad news is an essential part of professional practice	CbD, mini-CEX, MCR	1
Know that "bad news" has different connotations depending on the context, individual, social and cultural circumstances	CbD, mini-CEX, MCR	1
Know that a post mortem examination may be required and recognise what this involves	CbD, mini-CEX, MCR	1
Know about the local organ retrieval process	CbD, mini-CEX, MCR	1
Skills		
Demonstrate to others good practice in breaking bad news	CbD, MSF, MCR	1,3
Involve patients and carers in decisions regarding their future management	CbD, MSF, mini-CEX, MCR	1,3,4
Recognise the impact of the bad news on the patient, carer, supporters, staff members and self	CbD, MSF, MCR	1,3,4
Encourage questioning and ensure comprehension	CbD, MSF, mini-CEX, MCR	1,3
Respond to verbal and visual cues from patients and relatives	CbD, MSF, mini-CEX, MCR	1,3
Act with empathy, honesty and sensitivity avoiding undue optimism or pessimism	CbD, MSF, mini-CEX, MCR	1,3
Structure the interview e.g. • Set the scene • Establish understanding • Discuss diagnosis(es), implications, treatment, prognosis and subsequent care	CbD, MSF, mini-CEX, MCR	1,3

Behaviours		
Take leadership in breaking bad news	CbD, MSF, MCR	1
Respect the different ways people react to bad news	CbD, MSF, MCR	1
Ensure appropriate recognition and management of the impact of breaking bad news on the doctor	CbD, MSF, MCR	1

4. Psychosocial Care

4.1 Social and Family Relationships

To demonstrate skills in assessing the ill person in relation to family, work and social context

To undertake this assessment with tact and compassion

To have acquired the skills to adapt their approach to care to meet the patient's individual and family needs

Knowledge	Assessment Methods	GMP
Discuss the impact of illness on interpersonal relationships	CbD, MCR	1,2
Describe the impact of illness on body image, sexuality and role	CbD, MCR	1,2
Be familiar with the range of agencies that can support the disabled worker and the disabled job-seeker	CbD, SCE, MCR	1,2
Know about theoretical concepts of individuality and how autonomy is expressed amongst and between individuals and as groups	SCE, CbD, MCR	1,4
Skills		
Recognise and be able to address the social, biological, environmental and spiritual determinants of health (the bio-psycho-social model or the bio-socio- psycho-existentialist model), and collaborate with other professionals and agencies to improve health and wellbeing	CbD, MCR	1,3
Assess the patient's ability to access various services in the health and social system and offer appropriate assistance	CbD, mini-CEX, MCR	1,2,3
Help to empower patients and negotiate complex systems to improve health and welfare including where appropriate the right to work	CbD, mini-CEX, MCR	1,2,3
Construction and use of genograms in taking a family history and understanding family relationships	SCE, mini-CEX, MCR	1
Assessment of the response to illness and expectations among family members	mini-CEX, MCR	1,3
When and how to use family meetings	CbD, MCR	1,3
Create environments that accommodate the needs of partners and families in provision of palliative care both in inpatient units or the home setting	CbD, MCR	1,2
Manage the tensions that may arise when there are conflicts of interest between members of families and what implications this has for professional duties across multidisciplinary teams	mini-CEX, CbD, MCR	1,2,3,4
Provide palliative care in relation to the homeless and those in custody	CbD, MCR	1,2,3
Recognise family dynamics and the use of concepts such as resonance	CbD, SCE, MCR	1
Aware of transference and counter-transference in professional relationships with patients and family members	CbD, SCE, MCR	1,3
Behaviours		
Appreciate the ill person in relation to his/her family, work and social circumstances	CbD, MCR	1
Be inclusive and able to make people from diverse backgrounds to	CbD, mini-CX, MSF,	1

feel at ease in discussing sensitive or painful issues.	MCR

4.2 Psychological Responses of Patients and Carers to Life-Threatening Illness and Loss

To demonstrate knowledge and recognition of psychological responses to illness in a range of situations, and skills in assessing and managing these in practice

Knowledge	Assessment Methods	GMP
Discuss the psychological impact of pain and intractable symptoms	CbD, SCE, MCR	1
Describe responses to uncertainty and loss at different stages in the illness	CbD, SCE, MCR	1
Know about presentation of illness in people with dementia or pre-existing psychological or psychiatric problems	CbD, SCE, MCR	1,2
Describe responses and needs of children (including siblings) at different developmental stages	CbD, SCE, MCR	1
Know about responses and needs of children and adults with learning difficulties	CbD, SCE, MCR	1
Discuss the distinction between sadness and clinical depression	CbD, SCE, MCR	1,2
Skills		
Identify psychological responses as a source of additional problems for patient and family and as potentially obstructing the goals of care	CbD, mini-CEX, MCR	1,3
Behaviours		
Able to deal with: • Anger and strong emotions • Anxious preoccupation • Transference • Collusion and conspiracy of silence • Denial	mini-CEX, MCR	1,2,3

4.3 Interface with Psychology and Psychiatry

To have knowledge of and skills in recognising and managing psychiatric illness and the trainee will use psychological/psychiatric services appropriately

Knowledge	Assessment Methods	GMP
Knowledge of therapeutic interventions including: • Counselling • Behavioural therapy • Cognitive therapy • Group activities	CbD, SCE, MCR	1,2,3
Describe the role and availability of the specialist psychological/psychiatric services and indications for referral in various settings	CbD, SCE, MCR	1,2,3
Discuss the roles of relaxation/hypnotherapy, imagery and visualisation, creative therapies and group work	CbD, MCR	1,2,3
Skills		

Assessment and management of patients with common psychiatric and psychological issues, using pharmacological and non-pharmacological approaches	mini-CEX, CbD, MCR	1,2,4
Appropriate and timely referral to psychology and psychiatry services	CbD, mini-CEX, MCR	1,3
Behaviours		
Willing to engage in therapeutic interventions with patients	MSF, mini-CEX, MCR	1

4.4 Management of Violent/Suicidal Individuals

To be able to deal with violent/suicidal individuals, and demonstrate this directly or indirectly

Knowledge	Assessment Methods	GMP
Know the legal aspects of compulsory treatment (Mental Health Act)	SCE, MCR	1,2
Discuss the relationship between the Mental Health and Mental Capacity Acts	SCE, CbD, MCR	1,2,4
Describe the distinction between mental capacity and mental health	SCE, CbD, MCR	1,2,4
Skills		
Use of compulsory treatment (Mental Health Act)	CbD, MCR	1,3
Behaviours		
Deal with violent/suicidal individuals in an ethical, honest and non-prejudicial manner	CbD, MCR	1

4.5 Grief and Bereavement

To demonstrate the skilful application of knowledge and understanding to prepare individuals for bereavement, to support the acutely grieving person/family. This will include the ability to anticipate/recognise abnormal grief and access specialist help

Knowledge	Assessment Methods	GMP
Describe theories about bereavement including the process of grieving, adjustment to loss and the social model of grief	SCE , MCR	1,2
Know about bereavement support and the organisation of support services	CbD, SCE, MCR	1,2
Describe grief and bereavement in children	CbD, SCE, MCR	1,2
Skills		
Recognition of multiple losses and effects on the individual	CbD, MCR	1,3
Preparation of carers and children for bereavement	CbD, mini-CEX, MCR	1,2,3
Support of the acutely grieving individual or family	mini-CEX, MCR	1,2
Anticipate and identify abnormal and complicated bereavement in adults	CbD, mini-CEX, MCR	1,2
Behaviours		
Identify appropriate bereavement support for an individual or family	CbD, MCR	1

4.6 Patient and Family Finance

To demonstrate an ability to assess the patient's and family's finances and find solutions to issues raised		
Knowledge	**Assessment Methods**	**GMP**
Know about accessing benefits, grants and allowances available to patients and families	CbD, SCE, MCR	1,2,3
Describe the role of the social worker and/or welfare benefits officer	CbD, SCE, MCR	1,3
Recognise the relationship between health inequalities and wealth inequalities	CbD, MCR	1
Skills		
Undertake a financial assessment	CbD, mini-CEX, MCR	1,3
Behaviours		
Respond to people in an ethical, honest, and non-judgmental manner	mini-CEX, MCR	1

5. Attitudes and Responses of Doctors and Other Professionals

5.1 Self Awareness

To demonstrate an attitude of self awareness and insight		
Knowledge	**Assessment Methods**	**GMP**
Knowledge of personal values and belief systems, and how these influence professional judgements and behaviours	CbD, MCR	1,2
Recognise that personal beliefs and biases exist and recognise their impact (positive and negative) on the delivery of health services	CbD, MCR	1
Discuss ways in which individual behaviours impact on others	CbD, MCR	1,3
Describe personality types	SCE, MCR	1
Acknowledge similarities and distinctions between the beliefs and values of the doctor, the patient and the policy-makers	CbD, MCR	1,2,3,4
Skills		
Be able to ask for help or hand over to others where necessary	CbD, MCR	1,2,3,4
Be able to distinguish personal values, conscience and professional duties	CbD, MCR	1,2,4
Be able to challenge colleagues sensitively and effectively	CbD, MCR	1,3,4
Behaviours		
Recognise own skills and limitations, and effect of personal loss or difficulties	MSF, MCR	1,2
Recognise one's own behaviour and how it might impact on patients' health issues	CbD, MCR	1,2
Respect diversity of status and values in patients and colleagues	CbD, MCR	1,2,3
Confident and positive in one's own professional values	MSF, MCR	1,2,4
Reflect on the overlaps and conflicts that may occur with personal, societal and professional moral frameworks	CbD, MCR	1,2,4

5.2 Self Management

To be able to manage themselves, and take care of their own health and wellbeing		
Knowledge	**Assessment Methods**	**GMP**
Know about tools and techniques for managing stress	CbD, MCR	1,2
The role and responsibility of occupational health and other support networks	SCE, MCR	1,2
The limitations of self in professional competence	CbD, MCR	1,2,3
Skills		
Recognise the manifestations of stress on self and others and know where and when to look for support	MSF, MCR	1,3
Balance personal and professional roles and responsibilities. Prioritise tasks, having realistic expectations of what can be completed by self and others	MSF, MCR	1,2,3

Behaviours		
Recognition of personal health as an important issue	MSF, MCR	1, 2
Conscientious, able to manage time and delegate	MSF, MCR	1, 2

5.3 The Doctor-Patient Relationship

To demonstrate the skills and attitudes necessary to deal with difficulties in the doctor-patient relationship

Knowledge	Assessment Methods	GMP
Discuss potential sources of conflict in the doctor-patient relationship including: • Over-involvement • Personal identification • Negative feelings/personality clash • Demands which cannot be met • Coercion and manipulation • Transference and counter-transference	CbD, MSF, MCR	1,2
Describe the concepts of interest – vested, best and proper in all relationships with their attendant duties and freedoms	SCE, CbD, MCR	1,2,4
Know about the nature of coercion vs persuasion and the limits and boundaries of confidentiality and truth telling	SCE, mini-CEX, CbD, MCR	1,2,4
Skills		
How to deal with sources of conflict in the doctor-patient relationship including: • Over-involvement • Personal identification • Negative feelings/personality clash • Demands which cannot be met • Coercion and manipulation • Transference and counter-transference • Unwelcome influences from family or other care-givers	CbD, mini-CEX, MCR	1,3
Behaviours		
Respect diversity of status and values in patients and colleagues	MSF, MCR	1,3
Deal with coercive and bullying behaviour in others	MSF, CbD, MCR	1,2,3,4

5.4 Supporting Professional Colleagues

To demonstrate responsible support of professional colleagues		
Knowledge	**Assessment Methods**	**GMP**
Recognise ways staff support can be offered/coordinated	MSF, SCE, MCR	2,3
Skills		
Identify individuals who are having difficulties and recognise when, and how, to take action if this adversely affects patient care	MSF, MCR	1,3
Assessment of personal and team member safety when conducting visits in the community	CbD, MCR	1,2,3
Identify and prioritise tasks and responsibilities including to delegate and supervise safely	CbD, MCR	1,2,3
Behaviours		
Being a supportive colleague to other members of staff	MSF, MCR	1,3
Willing to supervise the work of less experienced colleagues	MSF, MCR	1,2,3
Willing to engage or confront difficulties with and between colleagues	MSF, MCR	1,3
Willing to take the concerns of others seriously	MSF, MCR	1,3

6. Culture, Language, Religion and Spirituality

6.1 Culture and Ethnicity

To demonstrate an awareness of, and respect for, the social and cultural values and practices of others

To recognise differences in beliefs and personal values. To be able to recognise and deal with conflicts in the beliefs and values in the clinical team

Knowledge	Assessment Methods	GMP
Recognition of cultural influences on the meaning of illness for patient and family	CbD, SCE, MCR	1,2,3
Recognise social and cultural issues and practices such as: • The impact of cultural beliefs and practices on health outcomes • Health determinants that affect patients and communities • The effects of social and cultural issues on access to healthcare, including a recognition of health issues of migrants and refugees	SCE, MCR	1,2
Know the national and international situation regarding the distribution of disease, the factors that determine health and disease, and major population health responses	SCE, MCR	1
Discuss prejudice and preferences within self, others, society and cultures	SCE, MCR	1,2
Know about facilitation and conflict resolution methods	SCE, MCR	1,3
Skills		
Use and support of interpreters	CbD, mini-CEX, MCR	1,2,3
Able to recognise and deal with conflicts of beliefs and values within the team	CbD, MSF, MCR	1,2,3
Apply the theoretical frameworks of autonomy and freedoms where these differ across and within cultures, especially where the interests and autonomies of partnership, families and groups cannot be distinguished easily	CbD, MCR	1,2,4
Show awareness of and sensitivity to the way in which cultural and religious beliefs affect approaches and decisions, and to respond respectfully	CbD, mini-CEX, MCR	1,2,3,4
Respect diversity and recognise the benefits it may bring, as well as associated stigma	CbD, MCR	1,2,3,4
Behaviours		
Acknowledge and accommodate differences in belief and practice to ensure thorough assessment and acceptable care	CbD, mini-CEX, MSF, MCR	1,2,3,4
Recognise personal beliefs and attitudes and the importance of not imposing these on others	CbD, MSF, MCR	1,2,3,4
Respond to people in an ethical, honest, and non-judgmental manner	CbD, mini-CEX, MSF, MCR	1,2,3,4
Adopt assessments and interventions that are inclusive, respectful of diversity and patient-centred	CbD, mini-CEX, MCR	1,2,4

Recognise and show respect for diversity and differences in others	CbD, mini-CEX, MCR	1,4
Use authority sensitively and assertively to resolve conflict and manage disagreement	CbD, mini-CEX, MCR	1,2,3,4

6.2 Religion and Spirituality

To have the knowledge and skills to elicit spiritual concerns, recognise and respond to spiritual distress and demonstrate respect for differing religious beliefs and practice and accommodation of these in patient care

Knowledge	Assessment Methods	GMP
Knowledge of pastoral systems within different religious groups and know how to work with their representatives within the multidisciplinary team	CbD, SCE, MCR	1,2,3
Knowledge of the major cultural and religious practices that relate to medical practice, dying and bereavement	SCE, CbD, MCR	1,2
Knowledge of spirituality issues in relation to life-threatening physical illness and the role of spiritual care	CbD, SCE, MCR	1,2
Skills		
Able to distinguish between an individual's spiritual and religious needs	CbD, MCR	1,3
Able to elicit and respond to spiritual concerns appropriately as part of assessment	CbD, mini-CEX, MCR	1,3
Behaviours		
Recognise the importance of hope and ability to nurture hope in palliative care	CbD, MCR	1,4
Able to acknowledge and respond to spiritual distress, including referral to others	CbD, mini-CEX, MCR	1,2,3
Accept own limitations and seek specialist advice when needed	MSF, CbD, mini-CEX, MCR	1

7. Ethics

7.1 Principles of Medical Ethics and Confidentiality

To know and apply appropriately the principles, guidance and laws regarding medical ethics and confidentiality

Knowledge	Assessment Methods	GMP
Demonstrate knowledge of the principles of medical ethics	CbD, mini-CEX, MCR	1
Outline and follow the guidance given by the GMC on confidentiality	CbD, mini-CEX, MCR	1
Define the provisions of the Data Protection Act and Freedom of Information Act	CbD, mini-CEX, MCR	1
Define the principles of Information Governance	CbD, mini-CEX, MCR	1
Define the role of the Caldicott Guardian and Information Governance lead within an institution, and outline the process of attaining Caldicott approval for audit or research	CbD, mini-CEX, MCR	1,4
Outline situations where patient consent, while desirable, is not required for disclosure e.g. serious communicable diseases, public interest	CbD, mini-CEX, MCR	1,4
Outline the procedures for seeking a patient's consent for disclosure of identifiable information	CbD, mini-CEX, MCR	1
Recall the obligations for confidentiality following a patient's death	CbD, mini-CEX, MCR	1,4
Recognise the problems posed by disclosure in the public interest, without patient's consent	CbD, mini-CEX, MCR	1,4
Recognise the factors influencing ethical decision making: including religion, personal and moral beliefs, cultural practices	CbD, mini-CEX, MCR	1
Do not resuscitate: Define the standards of practice defined by the GMC when deciding to withhold or withdraw life-prolonging treatment	CbD, mini-CEX, MCR	1
Recognise the role and legal standing of advance directives	CbD, mini-CEX, MCR	1
Outline the principles of the Mental Capacity Act	CbD, mini-CEX, MCR	1
Skills		
Use and share information with the highest regard for confidentiality, and encourage such behaviour in other members of the team	CbD, mini-CEX, MSF, MCR	1,2,3
Use and promote strategies to ensure confidentiality is maintained e.g. anonymisation	CbD, MCR	1
Counsel patients on the need for information distribution within members of the immediate healthcare team	CbD, MSF, MCR	1,3
Counsel patients, family, carers and advocates tactfully and effectively when making decisions about resuscitation status, and withholding or withdrawing treatment	CbD, mini-CEX, MCR	1,3
Behaviours		
Encourage informed ethical reflection in others	CbD, MSF, MCR	1
Willing to seek advice of peers, legal bodies, and the GMC in the event of ethical dilemmas over disclosure and confidentiality	CbD, mini-CEX, MSF, MCR	1
Respect patient's requests for information not to be shared, unless	CbD, mini-CEX, MCR	1,4

this puts the patient, or others, at risk of harm		
Willing to share information about their care with patients, unless they have expressed a wish not to receive such information	CbD, mini-CEX, MCR	1,3
Willing to seek the opinion of others when making decisions about resuscitation status, and withholding or withdrawing treatment	CbD, mini-CEX, MSF, MCR	1,3

7.2 Theoretical Ethics and Applied Ethics in Clinical Practice of Palliative Medicine

To demonstrate an understanding of the theoretical basis for applied ethics in clinical practice, and be able to evaluate personal attitudes, beliefs and behaviours

To demonstrate skills in ethical reasoning and decision-making in end-of-life care, at consultant level, both for their own patients and for those that are referred to them in an advisory capacity

To demonstrate the skills and ability to justify their own ethical position in relation to palliative care practice using sound philosophical arguments

Knowledge	Assessment Methods	GMP
Knowledge of professional guidance with particular regard for sources such as the GMC and BMA and an awareness that guidance has evolved to reach its current position	CbD, SCE, MCR	1,2,4
Know about theoretical approaches to medical ethics, including fact/value distinctions, virtue ethics, principlism, deontology, consequentialism, utilitarianism, casuistry, rights-based approaches and the place of narrative-based approaches	CbD, SCE, MCR	1,2,4
Describe at a basic level metaphysical and ethical concepts of terms such as good and bad, truth and lies, goods and harms, means and ends, the nature of intrinsic and instrumental value, intentionality, causes and consequences, acts and omissions, interests and types of rights.	SCE, CbD, MCR	1,2,4
Know about the challenges of language in analysing and communicating complex ethical situations	CbD, MCR	1,2,4
Be aware of society's fluid definitions and views about concepts such as • Suffering • Dignity • Rights	CbD, MCR	1
Knowledge of current debates in ethics related to palliative medicine	CbD, SCE, MCR	1,2,4
Explain and evaluate society's dilemmas over euthanasia and assisted suicide	CbD, MCR	1, 4
Explain the doctrine of double effect and its relevance	CbD, mini-CEX, MCR	1,2,3,4
Explain the challenges of resource allocation and futility in respect of the end of life	CbD, MCR	1, 4
Ensure that all decisions and actions are in the best interests of the patient and the public good	CbD, mini-CEX, MCR	1,2,4
Familiar with the rights of children and vulnerable adults	CbD, SCE, mini-CEX, MCR	1,2,4
Familiar with the rights of disabled people to participate in healthy and rewarding employment	CbD, SCE, MCR	1
Practice in accordance with an appropriate knowledge of	CbD, SCE, mini-CEX,	1,2

contemporary legislation	MCR	
Skills		
Ability to navigate through difficult problems using and justifying the use of moral theory as it applies in specific situations	CbD, MCR	1,2,4
Ability to apply where necessary, the principles of virtue ethics in teamworking	MSF, MCR	1,3,4
Gain valid consent	CbD, mini-CEX, MSF, MCR	1,2,3,4
Give information	CbD, mini-CEX, MSF, MCR	1,2,3,4
Respect confidentiality and its limits	CbD, mini-CEX, MSF, MCR	1,2,3,4
Assess capacity to make particular decisions	CbD, mini-CEX, MSF, MCR	1,2,3,4
Manage non-autonomous people or individuals without capacity	CbD, mini-CEX, MSF, MCR	1,2,3,4
Use and limits of advance decisions to refuse treatment	CbD, mini-CEX, MSF, MCR	1,2,3,4
Use and limits of advance statements	CbD, mini-CEX, MSF, MCR	1,2,3,4
Undertake best interest judgements	CbD, mini-CEX, MSF, MCR	1,2,3,4
Make and communicate DNAR decisions	CbD, mini-CEX, MCR	1,2,3,4
Manage conflicts of interest between patient and their relatives	CbD, mini-CEX, MSF, MCR	1,2,3,4
Balance responsibility for decisions (doctors, patients & teams)	CbD, mini-CEX, MSF, MCR	1,2,3,4
Manage resource allocation (including of oneself)	CbD, mini-CEX, MSF, MCR	1,2,3,4
Explain and justify withholding and withdrawal of treatment (including hydration / non-hydration)	CbD, mini-CEX, MSF, MCR	1,2,3,4
Balance responsibility for decisions (doctors, patients & teams)	CbD, mini-CEX, MSF, MCR	1,2,3,4
Manage patients who request euthanasia	CbD, mini-CEX, MSF, MCR	1,2,3,4
Manage patients who request physician-assisted suicide	CbD, mini-CEX, MSF, MCR	1,2,3,4
Conduct advance care planning with patients	CbD, mini-CEX, MSF, MCR	1,2,3,4
Make and communicate DNAR decisions	CbD, mini-CEX, MSF, MCR	1,2,3,4
Ethical conduct in research / clinical trials	CbD, mini-CEX, MSF, MCR	1,2,3,4
Behaviours		
Dignify patients	MSF, CbD, MCR	1,4
Be just and ensure that all decisions and actions are in the best interests of the patient and the public good	CbD, mini-CEX, MCR	1,2,4

Act lawfully and well within the parameters of what the profession considers to be ethical.	CbD, SCE, mini-CEX, MCR	1,2
Behave with probity by demonstrating that all clinical decisions have moral content.	CbD, MCR	1,2,4
Accept that all decisions are made with some evaluative process and that this cannot happen in a moral vacuum.	CbD, MCR	1,2,4
Recognise the threads of ethical reasoning, practice and behaviours that run throughout the curriculum and ensure that they are embraced and applied with integrity	CbD, MSF, MCR	1,2,4
Acknowledge the centrality of ethical/ moral reasoning in all aspects of clinical decision making	CbD, MCR	1,2,4
Appreciate that teamwork is as much an ethical/ moral contract as it is a technical one.	CbD, mini-CEX, MCR	1,2,3,4
Recognise the different emphases that other professions place on certain elements of a moral problem and understand how to identify, engage and resolve or come to consensus as to the way to proceed	CbD, MSF, MCR	2,3,4
Acknowledge the role of leadership skills in resolving conflicts	CbD, MSF, MCR	2,3,4
Respond to people honestly, recognising that it is impossible not to bring judgements to bear but ensuring that these are fair to and respectful of others	CbD, mini-CEX, MCR	1,2,4
Appreciate the importance of truth-telling within the constraints of other duties such as confidentiality, best interest, the freedom to maintain ignorance and the diverse interests of families and social networks	CbD, MSF, MCR	2,3,4
Use appropriate methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved	CbD, mini-CEX, MCR	1,2,4
Act with appropriate professional and ethical conduct in challenging situations	CbD, mini-CEX, MCR	1,2,4
Uphold the rights of children and vulnerable adults	CbD, MCR	1,2,4
Uphold he rights of disabled people to participate in healthy and rewarding employment	CbD, MCR	1,2,4
Accept uncertainty	CbD, mini-CEX, MCR	1

8. Legal Frameworks

8.1 Valid Consent

To recognise the necessity of obtaining valid consent from the patient and how to obtain it

Knowledge	Assessment Methods	GMP
Outline the guidance given by the GMC on consent, in particular:	CbD, DOPS, MSF, MCR	1
Recognise that consent is a process that may culminate in, but is not limited to, the completion of a consent form	CbD, DOPS, MSF, MCR	1
Recognise the particular importance of considering the patient's level of understanding and mental state (and also that of the parents, relatives or carers when appropriate) and how this may impair their capacity for informed consent	CbD, DOPS, MSF, MCR	1
Skills		
Present all information to patients (and carers) in a format they understand, checking understanding and allowing time for reflection on the decision to give consent	CbD, mini-CEX, MCR	1,3
Provide a balanced view of all care options	CbD, mini-CEX, MCR	1,3,4
Behaviours		
Respect a patient's rights of autonomy even in situations where their decision might put them at risk of harm	CbD, mini-CEX, MCR	1
Do not exceed the scope of authority given by a competent patient	CbD, mini-CEX, MCR	1
Do not withhold information relevant to proposed care or treatment in a competent patient	CbD, mini-CEX, MCR	1,3,4
Do not seek to obtain consent for procedures which they are not competent to perform, in accordance with GMC/regulatory bodies	CbD, mini-CEX, MCR	1,3
Willing to seek advance directives	CbD, mini-CEX, MCR	
Willing to obtain a second opinion, senior opinion, and legal advice in difficult situations of consent or capacity	CbD, mini-CEX, MSF, MCR	1,3
Inform a patient and seek alternative care where personal, moral or religious belief prevents a usual professional action	CbD, mini-CEX, MCR	1,3,4

8.2 Legal Framework for Practice

To know the legal framework within which healthcare is provided in the UK and/or devolved administrations in order to ensure that personal clinical practice is always provided in line with this legal framework

Knowledge	Assessment Methods	GMP
All decisions and actions must be in the best interests of the patient	CbD, SCE, mini-CEX, MCR	1,2,4
Know the legislative framework within which healthcare is provided in the UK and/or devolved administrations – in particular mental health legislation (including powers to detain a patient and giving emergency treatment against a patient's will under common law); organ donation and retention; communicable disease notification; medical risk and	CbD, SCE, mini-CEX, MCR	1,2,4

driving		
Identify the differences between health related legislation in the four countries of the UK	CbD, MCR	1
Identify sources of medical legal information	CbD, mini-CEX, MCR	1
Demonstrate a knowledge of disciplinary processes in relation to medical malpractice	CbD, mini-CEX, MSF, MCR	1
Recognise the role of the medical practitioner in relation to personal health and substance misuse, including understanding the procedure to be followed when such abuse is suspected	CbD, mini-CEX, MSF, MCR	1
Skills		
Able to cooperate with other agencies with regard to legal requirements – including reporting to the Coroner's/Procurator Officer, the Police or the proper officer of the local authority in relevant circumstances	CbD, mini-CEX, MCR	1
Able to prepare appropriate medical legal statements for submission to the Coroner's Court, Procurator Fiscal, Fatal Accident Inquiry and other legal proceedings	CbD, MSF, MCR	1
Be prepared to present such material in Court	CbD, mini-CEX, MCR	1
Incorporate legal principles into day to day practice	CbD, mini-CEX, MCR	1
Practice and promote accurate documentation within clinical practice	CbD, mini-CEX, MCR	1,3
Behaviour		
Willing to seek advice from the employer, appropriate legal bodies (including defence societies), and the GMC on medico-legal matters	CbD, mini-CEX, MSF, MCR	1
Promote informed reflection on legal issues by members of the team All decisions and actions must be in the best interests of the patient	CbD, mini-CEX, MSF, MCR	1,3

8.3 Aspects of the Law Particularly Relating to Palliative Medicine Practice

To demonstrate the skills and knowledge to make decisions and practice palliative medicine within a legal/lawful framework and access appropriate legal help and advice when necessary

Knowledge	Assessment Methods	GMP
Knowledge of appropriate guidelines produced by BMA, GMC, Royal Colleges and medical defence bodies	CbD, SCE, mini-CEX, MCR	1,2,3,4
Know the legal aspects related to patients' death: • Certification of death procedures, including definition and procedure for confirming brain death • Cremation regulations • Procedures for relatives following a death • The role of the undertaker • Procedures around post mortems • Law relating to euthanasia and physician assisted suicide	CbD, SCE, MCR	1,2
Describe the legal aspects of therapeutics: • Definitions of treatment • Refusal of treatment by patients • Advance decisions to refuse treatment	CbD, SCE, MCR	1,2

• Advance statements • Responsibilities of prescriber /pharmacist/nurses • Non-medical prescribing • Controlled drugs prescribing, transport and storage • Use of drugs beyond their product licence and unlicensed drugs • Withdrawal/withholding of treatment from competent & incompetent patients • Drugs and situations where the doctrine of double effect is relevant in clinical practice • Obligations to treat/ not to treat • Resuscitation guidelines		
Discuss the law relating to the doctor/patient relationship: • Consent • Autonomous/non–autonomous/ partially autonomous patients • Capacity, including knowledge of the guidance in the Code of Practice for the Mental Capacity Act • Power of attorney • Record taking and patient access to records including the provisions of the Data Protection Act and Freedom of Information Act • The role of the Caldicott Guardian within an institution • Confidentiality and its limits • Assault/battery/manslaughter as applied to medicine • Child protection • Wills	CbD, SCE, MCR	1,2
Know about the law relating to organisations: • Corporate law relating to charities/trusts, responsibilities/liabilities of trustees and employers • Provision of continuing care and community nursing care by local authorities • Laws & regulations relating to care homes • Employment law, including equal opportunities • Discrimination – gender, race, disability, age	SCE, MCR	1,2
Know about charity and company law: • Corporate governance • Trusteeship • Charity acts and charity commissioners • The company limited by guarantee	SCE, MCR	1,2
Skills		
Be able to certify death in accordance with the law, including definition and procedure for confirming brain death	SCE, MCR	1,2
Where appropriate, safely prescribe drugs beyond their product licence, or without a product licence, ensuring correct procedures are followed including gaining appropriate patient consent	CbD, mini-CEX, MCR	1,2,4
Manage appropriate withdrawal/withholding of treatment from competent & incompetent patients	CbD, mini-CEX, MCR	1,2,4

Identify and manage situations where the doctrine of double effect is relevant in clinical practice	CbD, mini-CEX, MCR	1,2,4
Implementation of resuscitation guidelines	CbD, mini-CEX, MCR	
Gain valid patient consent	CbD, mini-CEX, MCR	1,2,4
Record taking and facilitating patient access to records including the provisions of the Data Protection Act and Freedom of Information Act	CbD, MCR	1,2,4
Behaviours		
Act with respect to confidentiality and its limits	CbD, mini-CEX, MSF, MCR	1,2,3,4
Act in a non-discriminatory manner with respect to gender, race, disability, age	mini-CEX, MSF, MCR	1,4

9. Teamwork

9.1 Team Working and Patient Safety

To develop the ability to work well in a variety of different teams and team settings – for example the ward team and the infection control team - and to contribute to discussion on the team's role in patient safety

To develop the leadership skills necessary to lead teams so that they are more effective and better able to deliver safer care

To demonstrate effective membership and leadership of multi-professional specialist palliative care teams, including advisory teams in the acute hospital and community

Knowledge	Assessment Methods	GMP
Outline the components of effective collaboration and team working	CbD, MCR	1
Describe the roles and responsibilities of members of the healthcare team	CbD, MCR	1
Outline factors adversely affecting a doctor's and team's performance and methods to rectify these	CbD, MCR	1
Discuss theories of teamwork, e.g. psychological, psychodynamic, managerial	CbD, SCE, MCR	1,2,3,4
Describe the nature of roles within teams: sometimes overlapping, others professionally distinct, with the boundaries sometimes unclear	CbD, SCE, MCR	1,2,3,4
Discuss skill-mix of a team, particularly in relation to the appointment of new members	CbD, SCE, MCR	1,2,3,4
Know about forms of team support	CbD, SCE, MCR	1,2,3,4
Discuss strategies that facilitate team functioning, and those which do not	CbD, SCE, MCR	1,2,3,4
Acknowledge the inevitability of conflict within a team, and strategies to manage this	CbD, SCE, MCR	1,2,3,4
Discuss team dynamics in different situations and over time	CbD, MCR	3,4
Describe the role of team dynamics in the way a group, team or department functions	CbD, MCR	3,4
Describe team structures and the structure, roles and responsibilities of multidisciplinary teams within the broader health context of palliative medicine, including other agencies	CbD, MCR	3
Skills		
Able to work in a team	MSF, MCR	1,2,3
Practise with attention to the important steps of providing good continuity of care	CbD, mini-CEX, MCR	1,3,4
Accurate, attributable note-keeping including appropriate use of electronic clinical record systems	CbD, mini-CEX, MCR	1,3
Preparation of patient lists with clarification of problems and ongoing care plan	CbD, mini-CEX, MSF, MCR	1
Detailed handover between shifts and areas of care	CbD, mini-CEX, MSF, MCR	1,3
Demonstrate leadership and management in the following areas: • Education and training of junior colleagues and other	CbD, mini-CEX, MCR	1,2,3

members of the healthcare team • Deteriorating performance of colleagues (e.g. stress, fatigue) • High quality care • Effective handover of care between shifts and teams		
Provide appropriate supervision to less experienced colleagues	CbD, MSF, MCR	3
Facilitate the use of skills and contributions of other members of the multi-professional team	MSF, MCR	1,3
Identification of oneself in relation to the differing theoretical models of teamwork	CbD, MCR	1,3
Take on differing and complementary roles within the different communities of practice within which the trainee works	CbD, MSF, MCR	1,3
Support bringing together different professionals, disciplines, and other agencies, to provide high quality healthcare	MSF, MCR	1,3
Facilitate, chair and contribute to meetings	CbD, MSF, MCR	1,3
Encourage staff to develop and exercise their own leadership skills	MSF, MCR	1,3
Identify and prioritise tasks and responsibilities including to delegate and supervise safely	CbD, MSF, MCR	1,2,3
Work collegiately and collaboratively with a wide range of people outside the immediate clinical setting	MSF, MCR	1,2,3
Prepare for meetings – reading agendas, understanding minutes, action points and background research on agenda items	MSF, MCR	1,2,3
Communicate effectively in the resolution of conflicts, providing feedback, and identifying and rectifying team dysfunction	MSF, MCR	1,2,3,4
Behaviours		
Encourage an open environment to foster and explore concerns and issues about the functioning and safety of team working	CbD, MSF, MCR	2, 3
Foster an open and clear ethical climate in team life in which discussion of difficult problems are seen as routine and not exceptional	MSF, CbD, MCR	2,3,4
Recognise limits of own professional competence and only practise within these	CbD, MSF, MCR	2, 3
Recognise and respect the request for a second opinion	CbD, MSF, MCR	3
Recognise the importance of induction for new members of a team	CbD, MSF, MCR	2, 3
Recognise the importance of prompt and accurate information sharing with the primary care team following hospital discharge	CbD, mini-CEX, MSF, MCR	2, 3
Interact effectively with professionals in other disciplines and agencies	CbD, MSF, MCR	1,3
Take full part in multidisciplinary meetings	MSF, MCR	3
Recognise a team approach and be willing to consult and work as part of a team	CbD, MSF, MCR	1,2,3
Respect the skills and contributions of colleagues, including non-medical professionals	CbD, MSF, MCR	1,3
Balance the needs of the different or overlapping teams of which the doctor may be a member at any one time	MSF, MCR	1,3
Value a wide application of teamwork to include all the professionals and organisations involved in the care of a particular patient, including	MSF, MCR	1,3

specialist nurses, statutory and voluntary organisations		
Acknowledge the impact on patients and carers of the number of professionals who may be involved in their care	CbD, mini-CEX, MSF, MCR	1,3
Identification of oneself in relation to differing theoretical models of teamwork	CbD, MCR	1,3

10. Learning and Teaching

10.1 Learning and Self-Development

To demonstrate the attitudes and skills to maintain a safe, contemporary and competent practice and an understanding of how to maximise their own learning through postgraduate education and supervision

Knowledge	Assessment Methods	GMP
Principles of adult and life-long learning, personal learning styles and reflective practice. Knowledge of own learning style	SCE, MCR	1,2
Concept of continuing professional development	SCE, MCR	1,2
Roles and responsibilities of trainee and trainer	SCE, MCR	1,2,3
Role of supervision, mentoring, learning contracts, critical appraisal and feedback, experiential learning in regard to own and others' development	SCE, MCR	1,2
Local processes for dealing with and learning from clinical errors	CbD, SCE, MCR	1,2,4
Skills		
Plan learning aims, objectives, methods and outcomes	CbD, MCR	1,3
Maintain and routinely practice critical self awareness, including ability to discuss strengths and weaknesses with supervisor, recognising external influences and change behaviour accordingly	CbD, MCR	1,2
Use a reflective approach to practice with an ability to learn from previous experience	CbD, MCR	1,2
Use assessment, appraisal, complaints and other feedback to discuss and develop an understanding of own development needs	CbD, MCR	1,2
Behaviours		
Demonstrate use of adult and life-long learning, and reflective practice	CbD, MCR	1,2
Effectively use supervision, mentoring, learning contracts, critical appraisal and feedback, experiential learning	CbD, MSF, MCR	1,2,4
Show commitment to continuing professional development which involves seeking training and self development opportunities, learning from colleagues and accepting constructive criticism	MSF, MCR	1,2
Respond constructively to the outcome of performance reviews, assessments or appraisals	MSF, MCR	1,2

10.2 Teaching and Training

To develop the ability to teach to a variety of different audiences in a variety of different ways
To assess the quality of the teaching
To train a variety of different trainees in a variety of different ways
To plan and deliver a training programme with appropriate assessments

Knowledge	Assessment Methods	GMP
Describe relevant educational theories and principles, including adult learning principles relevant to medical education	CbD, MCR	1
Demonstrate knowledge of literature relevant to developments and challenges in medical education and other sectors	CbD , MCR	1
Define the roles of the various bodies involved in medical education and other sectors, including the role of the Postgraduate Deanery, Royal Colleges of Physicians and GMC in postgraduate education	SCE CbD, MCR	1
Identify learning methods and effective learning objectives and outcomes, and describe the difference between objectives and outcomes	CbD, MCR	1
Outline the structure of an effective appraisal interview	CbD, MCR	1
Differentiate between appraisal and assessment versus performance review and recognise the need for both	CbD , MCR	1
Differentiate between formative and summative assessment and define their role in medical education	CbD, MCR	1
Outline the role of workplace-based assessments, the assessment tools in use, their relationship to course learning outcomes, the factors that influence their selection and the need for monitoring evaluation	CbD, MCR	1
Outline the appropriate local course of action to assist a trainee experiencing difficulty in making progress within his/her training programme	CbD , MCR	1
Skills		
Able to critically evaluate relevant educational literature	CbD, MCR	1
Vary teaching format and stimulus, appropriate to situation and subject	CbD, TO, MCR	1
Provide effective feedback as appropriate after teaching, and promote learner reflection	CbD, MSF, MCR	1
Conduct developmental conversations as appropriate: appraisal, supervision, mentoring	CbD, MSF, MCR	1
Demonstrate effective lecture, presentation, small group and bed side teaching sessions	CbD, MSF, TO, MCR	1,3
Provide appropriate career support, or refer trainee to an alternative effective source of career information	CbD, MSF, MCR	1,3
Participate in strategies aimed at improving patient education e.g. talking at support group meetings	CbD, MSF, TO, MCR	1
Able to lead departmental teaching programmes including journal clubs	CbD, TO, MCR	1
Recognise the trainee in difficulty and take appropriate action	CbD, MCR	1

including where relevant referral to other services		
Able to identify and plan learning activities in the workplace	CbD, MCR	1
Contribute to educational research or projects through the development of research ideas or data/information gathering. Able to manage personal time and resources effectively to the benefit of the educational faculty and the need of the learners	CbD, TO, MCR	1
Behaviour		
In discharging educational duties, act to maintain the dignity and safety of patients at all times	CbD, MSF, MCR	1,4
Recognise the importance of the role of the physician as an educator within the multi-professional healthcare team and use medical education to enhance the care of patients	CbD, MSF, TO, MCR	1
Balance the needs of service delivery with education	CbD, MSF, MCR	1
Willing to teach trainees and other health and social care workers in a variety of settings to maximise effective communication and practical skills and to improve patient care	CbD, MSF, MCR	1
Demonstrate consideration for learners including their emotional, physical and psychological well being with their development needs. Act to ensure equality of opportunity for students, trainees, staff and professional colleagues	CbD, MSF, MCR	1, 3
Encourage discussions with colleagues in clinical settings to share knowledge and understanding	CbD, MSF, MCR	1,3
Maintain honesty and objectivity during appraisal and assessment	CbD, MSF, MCR	1
Willing to participate in workplace-based assessments and demonstrates a clear understanding of their purpose	CbD, MSF, MCR	1
Willing to take up formal training as a trainer and respond to feedback obtained after teaching sessions	CbD, MSF, MCR	1,3
Willing to become involved in the wider medical education activities and fosters an enthusiasm for medical education activity in others	CbD, MSF, MCR	1
Recognise the importance of personal development as a role model to guide trainees in aspects of good professional behaviour	CbD, MSF, MCR	1
Willing to advance own educational capability through continuous learning	CbD, MSF, MCR	1
Act to enhance and improve educational provision through evaluation of own practice	CbD, MSF, MCR	1
Contribute to educational policy and development at local or national levels	CbD, MSF, MCR	1

11. Research

11.1 Evidence and Guidelines

To develop the ability to make the optimal use of current best evidence in making decisions about the care of patients

To develop the ability to construct evidence based guidelines and protocols in relation to medical practice

Knowledge	Assessment Methods	GMP
Demonstrate knowledge of the application of statistics in scientific medical practice	CbD, MCR	1
Recognise the advantages and disadvantages of different study methodologies (randomised control trials, case controlled cohort etc)	CbD, MCR	1
Identify research methods and how to evaluate scientific publications including the use and limitations of different methodologies for collecting data	CbD, SCE, MCR	
Recognise the principles of critical appraisal	CbD, MCR	1
Distinguish levels of evidence and quality of evidence	CbD, SCE, MCR	1
Recognise the role and limitations of evidence in the development of clinical guidelines and protocols	CbD, MCR	1
Recognise the advantages and disadvantages of guidelines and protocols	CbD, MCR	1,2
Identify the processes that result in nationally applicable guidelines (eg NICE and SIGN)	CbD , MCR	1,2
Recognise the relative strengths and limitations of both quantitative and qualitative studies, and the different types of each	CbD, SCE, MCR	1
Be aware of and maintain an up to date knowledge of research evidence regarding the most important determinants of health	SCE, MCR	1
Skills		
Ability to search the medical literature including use of Pub Med, Medline, Cochrane reviews and the internet	CbD, MCR	1
Appraise retrieved evidence to address a clinical question	CbD, MCR	1
Apply conclusions from critical appraisal into clinical care	CbD, MCR	1
Identify the limitations of research	CbD, MCR	1
Contribute to the construction, review and updating of local (and national) guidelines of good practice using the principles of evidence based medicine	CbD, MCR	1
Behaviours		
Keep up to date with national reviews and guidelines of practice (NICE and SIGN)	CbD, MCR	1
Aim for best clinical practice (clinical effectiveness) at all times, responding to evidence based medicine	CbD, mini-CEX, MCR	1
Recognise the occasional need to practise outside clinical guidelines	CbD, mini-CEX, MCR	1
Encourage discussion amongst colleagues on evidence-based practice	CbD, mini-CEX, MSF, MCR	1

11.2 Ethical Research

To demonstrate an understanding of the scope of healthcare research in general, and palliative care research in particular

To demonstrate the ability to evaluate published research and understand implications for current practice

To demonstrate an understanding of the processes necessary to initiate, plan, carry out and report a project based on sound investigative principles, such as a research study, systematic review, audit project or guideline

Knowledge	Assessment Methods	GMP
Recognise the scientific basis of medicine and its limitations applied in the field of palliative care	CbD, SCE, MCR	1
Outline the differences between audit, research and service evaluation	AA, CbD, mini-CEX, SCE , MCR	1
Describe how clinical guidelines are produced	CbD, MCR	1
Demonstrate a knowledge of research principles	CbD, mini-CEX, MCR	1
Outline the principles of formulating a research question and designing a project	CbD, mini-CEX, MCR	1
Describe the difference between phase 1, 2, 3 and 4 clinical trials	SCE, CbD, MCR	1
Know about research topics and trends in palliative care and allied disciplines e.g. oncology, pain management, rehabilitation	CbD, SCE, MCR	1
Know about research ethics, design and methods in the specific context relevant to palliative care	CbD, SCE, MCR	1
Comprehend principal qualitative, quantitative, bio-statistical and epidemiological research methods	CbD, MCR	1
Know about legal and ethical dimensions of research, including standards such as the GMC Guide to Good Medical Practice (1998), Declaration of Helsinki, European Union Clinical Trials Directive, International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), Good Clinical Practice (GCP)	SCE, MCR	1,2
Know about the process for drug development, and the role of the European Medicines Agency (EMEA), Commission on Human Medicines (CHM), Medicines and Healthcare products Regulatory Agency (MHRA),	SCE, MCR	1,2
Outline sources of research funding	CbD, MCR	1
Recognise the difference between population-based assessment and unit-based studies and be able to evaluate outcomes for epidemiological work	CbD, MCR	1
Knowledge of the research process and governance: • How to formulate original research questions • The appropriateness of various study designs in palliative care e.g. randomised controlled trials, single centre or multi-centre studies, n of 1 trials, qualitative techniques • The appropriate use and limitations of pilot studies • The place of statistical input to a sample size calculation	CbD, SCE, MCR	1,2

- Statistical analysis appropriate to the research question
- The structure and content of research protocols
- Guidance on writing patient information sheets and consent forms
- The principles of informed consent
- The principles of ensuring patient safety and researchers' responsibilities if adverse events occur
- Sources of funding and the structure and content of grant applications
- How to make a research ethics committee application
- The Integrated Research Application System (IRAS)

Skills		
Develop critical appraisal skills and apply these when reading literature	CbD, MCR	1
Demonstrate the ability to write a scientific paper	CbD, MCR	1
Apply for appropriate ethical research approval	CbD, MCR	1
Demonstrate the use of literature databases	CbD, MCR	1
Demonstrate good verbal and written presentation skills	CbD, DOPS, TO, MCR	1
Develop an original project idea	CbD, MCR	1
Perform a comprehensive literature search	CbD, MCR	1
Synthesise the literature to produce a research protocol, audit proforma or clinical guideline	AA, CbD, MCR	1
Choose the appropriate outcome measures in patients with palliative care needs	CbD, MCR	1
Analyse data or cooperate with a statistician in analysing audit or research data	AA, CbD, MCR	1,3
Present a research or audit report or a clinical guideline and discuss how these are best disseminated	AA, MCR	1
Behaviours		
Follow guidelines on ethical conduct in research and consent for research	CbD, MCR	1
Willing to promote research	CbD, MCR	1
Able to work within collaborative research/audit/guideline development teams	MSF, MCR	1,3
Demonstrate the ability to initiate and see through a project to completion	CbD, MCR	1

12. Management

12.1 Human Resources

To provide the trainee with the skills and knowledge to manage the human resources in a specialist palliative care inpatient unit and palliative care team

Knowledge	Assessment Methods	GMP
Know the principles of recruitment and appointment procedures	SCE, MCR	1
Know about the duties, rights and responsibilities of an employer, and of a co-worker (e.g. looking after occupational safety of fellow staff)	SCE, MCR	1,2
Recognise that people can be denied employment opportunities unnecessarily through myths, stigma, dogma and insufficient advocacy and support; appreciate the role of doctors and other services in combating this inequality	CbD, MCR	1
Recognise the role that individuals (including patients and carers as well as healthcare professionals) and services can play in combating inequality and discrimination and contribute appropriately to this work	CbD, MCR	1
Know about local Human Resource policies	CbD, MCR	1
Know about individual performance review purpose, techniques and processes, including difference between appraisal, assessment and revalidation	CbD, SCE, MCR	1
Describe when and how to institute disciplinary procedures	CbD, SCE, MCR	1,2
Skills		
Ability to participate in selection and recruitment of staff: • Writing a job description and person specification • Short-listing and interviewing skills • Writing a reference • Contract negotiation	CbD, MCR	1,2,3
Contribute to staff development and training, including mentoring, supervision and appraisal	CbD, MCR	1,2,3
Recognise, analyse and know how to deal with unprofessional behaviours in clinical practice, taking into account local and national regulations	CbD, MCR	1,2,3
Prepare rotas; delegate; organise and lead teams	MSF, MCR	1,2,3
Behaviours		
Ensure appropriate personal language and behaviour	MSF, MCR	1,3,4

12.2 Leadership Skills

To demonstrate the skills needed to lead a clinical team effectively

Knowledge	Assessment Methods	GMP
Recognise different management styles and the similarities and differences in good leadership and management	CbD, SCE, MCR	1,2,3,4

Know about short and long term strategic planning	CbD, MCR	1
Know about a wide range of leadership styles and approaches and the applicability to different situations and people	CbD, SCE, MCR	1,3
Know about methods of obtaining feedback from others	CbD, MCR	1,2,3,4
Skills		
Create an environment in which people want to work, succeed and excel	MSF, MCR	1,2,3,4
Ability to create open and non-discriminatory professional working relationships with colleagues and recognition of the need to prevent bullying and harassment	MSF, MCR	1,2,3,4
Demonstrates leadership skills in: • Goal setting • Short and long term strategic planning • Negotiating skills • Strategic implementation of audit • Directing and delegating	CbD, MSF, MCR	1,3
Behaviours		
Motivate and lead a team	MSF, MCR	1,3,4
Commitment to good communication whilst also inspiring confidence and trust	MSF, MCR	1,3,4
The ability to understand issues and potential solutions before acting	MSF, MCR	1, 2

12.3 Time Management and Decision Making

To demonstrate increasingly the ability to prioritise and organise clinical and clerical duties in order to optimise patient care

To demonstrate improving ability to make appropriate clinical and clerical decisions in order to optimise the effectiveness of the clinical team resource

Knowledge	Assessment Methods	GMP
Recognise that effective organisation is key to time management	CbD, MCR	1
Recognise that some tasks are more urgent and/or more important than others	CbD, MCR	1
Recognise the need to prioritise work according to urgency and importance	CbD, MCR	1
Maintain focus on individual patient needs whilst balancing multiple competing pressures	CbD, MCR	1
Recognise that some tasks may have to wait or be delegated to others	CbD, MCR	1
Recognise the roles, competencies and capabilities of other professionals and support workers	CbD, MCR	1
Outline techniques for improving time management	CbD, MCR	1
Recognise the importance of prompt investigation, diagnosis and treatment in disease and illness management	CbD, mini-CEX, MCR	1,2
Skills		

Identify clinical and clerical tasks requiring attention or predicted to arise	CbD, mini-CEX, MCR	1,2
Estimate the time likely to be required for essential tasks and plan accordingly	CbD, mini-CEX, MCR	1
Group together tasks when this will be the most effective way of working	CbD, mini-CEX, MCR	1
Recognise the most urgent/important tasks and ensure that they managed expediently	CbD, mini-CEX, MCR	1
Organise and manage workload effectively and flexibly	CbD, mini-CEX, MCR	1
Regularly review and re-prioritise personal and team workload	CbD, mini-CEX, MCR	1
Make appropriate use of other professionals and support workers, including secretarial and administrative staff	CbD, mini-CEX, MCR	1
Behaviours		
Ability to work flexibly and deal with tasks in an effective and efficient fashion	CbD, MSF, MCR	3
Recognise when you or others are falling behind and take steps to rectify the situation	CbD, MSF, MCR	3
Communicate changes in priority to others	MSF, MCR	1
Remain calm in stressful or high pressure situations and adopt a timely, rational approach	MSF, MCR	1
Recognise and handle uncertainty appropriately within the consultation	MSF, MCR	1

12.4 Information Management

To demonstrate knowledge and skills in using information systems

Knowledge	Assessment Methods	GMP
Demonstrate a knowledge of the content and relevance of: • The Data Protection Act, including rights of access for patients to information held on them • Computer security and backup systems • NHS net and communication systems	CbD, SCE, MCR	1,2,3,4
Know how to access and use local health data	AA, CbD, MCR	1
Know about methods of quality assurance of data and their relevance in practice	AA, CbD, MCR	1,2
Know how to access resources for community action and advocacy (resources, legislation, policy documents)	CbD, MCR	1
Skills		
Able to collect and retrieve patient data collection including the NCPC minimum data set	AA, CbD, MCR	1,3
Conduct an assessment of community health needs, and where appropriate apply these in practice	AA, CbD, MCR	1,3
Able to access and make use of appropriate population, demographic, socio-economic and health data	AA, CbD, MCR	1,3

Behaviours		
Respect patient confidentiality	CbD, MSF, MCR	1,4
Recognise that, in addition to patient specific clinical records, clinical staff also have responsibilities for other records (e.g. research)	CbD, MSF, MCR	1,4

12.5 Structures

To know the structure of the NHS and the management of local healthcare systems, including hospices, in order to be able to participate fully in managing healthcare provision

Knowledge	Assessment Methods	GMP
Know the guidance given on management and doctors by the GMC	CbD, MCR	1
Know the local structure of NHS systems in your locality recognising the potential differences between the four countries of the UK	CbD, MCR	1
Know the structure and function of healthcare systems as they apply to your specialty	CbD , MCR	1
Know the responsibilities of the various Executive Board members and Clinical Directors or leaders	CbD, MCR	1
Know the management structures of hospices	CbD, SCE, MCR	1
Know the function and responsibilities of national bodies such as DH, Care Quality Commission, NICE, NPSA, NCAS; Royal Colleges and Faculties, specialty specific bodies, representative bodies; regulatory bodies; educational and training organisations	CbD, SCE, MCR	1
Know the structures, roles, financing and operation of organisations relevant in his/her training area, such as: • PCTs • Practice-based commissioners • NHS provider units • Strategic Health Authorities • NHS Executive and NHS frameworks • Major organisations and charities involved in palliative care, such as the NCPC, APM, EAPC, HtH, HIS • Deputising services and co-operatives	CbD, MCR	1
Appreciate the consistent debates and changes that occur in the NHS including the political, social, technical, economic, organisational and professional aspects that can impact on provision of service	CbD, MCR	1
Recognise the importance of local demographic, socio-economic and health data and their use to improve system performance	CbD, MCR	1
Know the principles of: • Clinical coding • European Working Time Regulations including rest provisions • National Service Frameworks • Health regulatory agencies (e.g. NICE, Scottish Government) • NHS finance and budgeting • Consultant contract and the contracting process • Resource allocation • The role of the Independent sector as providers of healthcare	CbD, mini-CEX, MCR	1

• Patient and public involvement processes and role		
Aware of issues that might affect health inequalities that are currently under debate regarding changes in the NHS, including the public policy process	CbD, MCR	1
Recognise how health systems can discriminate against patients from diverse backgrounds, and how to work to minimise this discrimination, for example in respect of age, gender, race, culture, disability, spirituality, religion, and sexuality	CbD, MCR	1
Skills		
Participate in managerial meetings	CbD, MCR	1
Take an active role in promoting the best use of healthcare resources	CbD, mini-CEX, MCR	1
Work with stakeholders to create and sustain a patient-centred service	CbD, mini-CEX, MCR	1
Employ new technologies appropriately, including information technology	CbD, mini-CEX, MCR	1
Conduct an assessment of the community needs for specific health improvement measures	CbD, mini-CEX, MCR	1
Identify and communicate effectively with influential decision-makers/ facilitators of change	CbD, MCR	1,3
Discuss the local, national and UK health priorities and how they impact on the delivery of healthcare relevant to palliative medicine	CbD, MCR	1,3
Identify trends, future options and strategy relevant to palliative medicine and delivering patient services	CbD, MCR	1,3
Behaviours		
Recognise the importance of equitable allocation of healthcare resources and of commissioning	CbD, MCR	1,2
Recognise the role of doctors as active participants in healthcare systems	CbD, mini-CEX, MCR	1,2
Respond appropriately to health service objectives and targets and take part in the development of services	CbD, mini-CEX, MCR	1,2
Recognise the role of patients and carers as active participants in healthcare systems and service planning	CbD, mini-CEX, MCR	1,2,3
Willing to improve managerial skills (e.g. management courses) and engage in management of the service	CbD, MSF, MCR	1

12.6 Managing a Palliative Care Service

To demonstrate knowledge and skills necessary to run a palliative care service, including encouraging innovation, facilitating transformation from a management perspective, and evaluating impact

Knowledge	Assessment Methods	GMP
Know about ethical and equality aspects relating to management and leadership e.g. approaches to use of resources/ rationing; approaches to involving the public and patients in decision making	CbD, MCR	1,2
Discuss the requirements of running a department, unit or practice relevant to palliative medicine	CbD, MCR	1,2

Outline efficient use of clinical resources in order to provide care	CbD, MCR	1,2
Describe commissioning, funding and contracting arrangements relevant to palliative medicine	SCE, CbD, MCR	1,2
Outline how financial pressures experienced by specialty dept are managed	CbD, MCR	1,2
Know about organisational performance management techniques and processes	CbD, MCR	1,2
Describe a variety of methodologies for developing creative solutions to improving services	SCE, MCR	1,2
Know about project management methodology	SCE, MCR	1
Describe how to plan, implement and evaluate change	CbD, MCR	1,2
Discuss the implications of change on systems and people	CbD, MCR	1,3
Skills		
Manage time and resources effectively in terms of delivering services to patients	MSF, MCR	1,2,3
Use and adhere to clinical guidelines and protocols, morbidity and mortality reporting systems	CbD, MCR	1,2
Question existing practice in order to improve services	CbD, MCR	1,2
Apply creative thinking approaches (or methodologies or techniques) in order to propose solutions to service users	CbD, MSF, MCR	1
Develop protocols and guidelines and implementation of these	AA, MCR	1,2,3
Analyse feedback and comments and integrate them into plans for the service	AA, MCR	1,2,3
Plan, implement and evaluate change	AA, MCR	1,2,3
Provide medical expertise in situations beyond those involving patient care	CbD, MCR	1,3
Recognise the wider impact of implementing change in healthcare provision and the potential for opportunity costs	CbD, MCR	1,3
Behaviours		
Recognise equity in healthcare access and delivery	CbD, MCR	1
Recognise the needs and priorities of non-clinical staff	MSF, MCR	1,3
Act as an advocate for the service	MSF, MCR	1,3
Open minded to new ideas	MSF, MCR	1
Positive towards improvement and change	MSF, MCR	1
Strive for continuing improvement in delivering patient care services		
A proactive approach to new technologies and treatments	CbD, MCR	1
Support colleagues to voice ideas	MSF, MCR	1,3
Willing to articulate strategic ideas and use effective influencing skills	MSF, MCR	1,3
Appreciate the importance of involving the public and communities in developing health services	CbD, MCR	1,3
Willing to participate in decision making processes beyond the immediate clinical care setting	CbD, MCR	1,3
Commitment to implementing proven improvements in clinical practice and services	CbD, MCR	1,2

Obtain the evidence base before declaring effectiveness of changes	CbD, MCR	1,2
Attitudes and behaviours that assist dissemination of good practice	MSF, MCR	1,2,3

12.7 Running a Palliative Care Unit

To demonstrate knowledge and skills necessary to run a palliative care unit

Knowledge	Assessment Methods	GMP
Know about the supply of drugs to hospices / palliative care units, stock lists, financing and regulations for controlled drugs	CbD, SCE, MCR	1,2
Know about storage and retrieval of case notes	SCE, MCR	1,2
Know about health and safety legislation	SCE, MCR	1,2
Know how to ensure equipment safety and maintenance	SCE, MCR	1,2
Know about nursing and residential home registration	SCE, MCR	1,2
Discuss hospice security	SCE, MCR	1,2
Discuss the role of volunteers	CbD, MCR	1,2
Know about disposal of bodies	SCE, MCR	1
Describe organisational performance management techniques and processes	CbD, MCR	1,2
Skills		
Management of volunteers	MSF, MCR	1,2,3
Storage and retrieval of case notes	CbD, MCR	1,2
Manage time and resources effectively in terms of delivering services to patients	MSF, MCR	
Behaviours		
Show a commitment to taking action when resources are not used efficiently or effectively	CbD, MCR	1

12.8 Financial Management

To demonstrate an understanding of the principles of financial management in relation to organisations and budgets and will act with probity

Knowledge	Assessment Methods	GMP
Describe public and charitable health funding structure	SCE, MCR	1
Know about different types of accounting systems	SCE, MCR	1
Describe the process of budget setting and management	SCE, MCR	1
Describe business management principles: priority setting and basic knowledge of how to produce a business plan	CbD, MCR	1,2
Skills		
Able to read and interpret accounts	CbD, MCR	1
Formulate business plans	CbD, MCR	1,3
Behaviours		
Interacting with fundraisers to facilitate effective fundraising within	MSF, MCR	1,3

professional codes of practice		
Commitment to the proper use of public money. Show a commitment to taking action when resources are not used efficiently or effectively	MSF, MCR	1,4

13. Clinical Governance

13.1 Complaints and Medical Error

To recognise the causes of error and to learn from them, to realise the importance of honesty and effective apology and to take a leadership role in the handling of complaints

Knowledge	Assessment Methods	GMP
Basic consultation techniques and skills described for Foundation programme and to include: • Describe the local complaints procedure • Recognise factors likely to lead to complaints (poor communication, dishonesty, clinical errors, adverse clinical outcomes etc) • Adopt behaviour likely to prevent causes for complaints • Dealing appropriately with concerned or dissatisfied patients or relatives • Recognise when something has gone wrong and identify appropriate staff to communicate this with • Act with honesty and sensitivity in a non-confrontational manner	CbD, MSF, MCR	1
Outline the principles of an effective apology	CbD, MSF, MCR	1
Identify sources of help and support for patients and yourself when a complaint is made about yourself or a colleague	CbD, MSF, MCR	1
Skills		
Contribute to processes whereby complaints are reviewed and learned from	CbD, MSF, MCR	1
Explain comprehensibly to the patient the events leading up to a medical error or serious untoward incident, and sources of support for patients and their relatives	CbD, MSF, MCR	1,3
Deliver an appropriate apology and explanation (either of the error or of the process for investigation of potential error and reporting of the same)	CbD, MSF, MCR	1,3,4
Distinguish between system and individual errors (personal and organisational)	CbD, MSF, MCR	1
Show an ability to learn from previous error	CbD, MSF, MCR	1
Behaviours		
Take leadership over complaint issues	CbD, MSF, MCR	1
Recognise the impact of complaints and medical error on staff, patients, and the National Health Service	CbD, MSF, MCR	1,3
Contribute to a fair and transparent culture around complaints and errors	CbD, MSF, MCR	1
Recognise the rights of patients, family members and carers to make a complaint	CbD, MSF, MCR	1,4
Recognise the impact of a complaint upon self and seek appropriate help and support	CbD, MSF, MCR	1, 3, 4

13.2 Prioritisation of Patient Safety in Clinical Practice

To recognise that patient safety depends on the effective and efficient organisation of care, and health care staff working well together

To recognise that patient safety depends on safe systems not just individual competency and safe practice

To never compromise patient safety

To recognise the risks of treatments and to discuss these honestly and openly with patients so that patients are able to make decisions about risks and treatment options

To ensure that all staff recognise risk and work together to minimise risk

Knowledge	Assessment Methods	GMP
Outline the features of a safe working environment	CbD, mini-CEX, MCR	1, 2
Outline the hazards of medical equipment in common use	CbD, MCR	1, 2
Recall side effects and contraindications of medications prescribed	CbD, mini-CEX, MCR	1, 2
Recall principles of risk assessment and management	CbD, MCR	1, 2
Recall the components of safe working practice in the personal, clinical and organisational settings	CbD, MCR	1, 2
Outline local procedures and protocols for optimal practice e.g. GI bleed protocol, safe prescribing	CbD, mini-CEX, MCR	1, 2
Describe the investigation of significant events, serious untoward incidents and near misses	CbD, mini-CEX, MCR	1, 2
Skills		
Recognise limits of own professional competence and only practise within these	CbD, mini-CEX, MCR	1, 2
Recognise when a patient is not responding to treatment, reassess the situation, and encourage others to do so	CbD, mini-CEX, MCR	1
Ensure the correct and safe use of medical equipment, ensuring faulty equipment is reported appropriately	CbD, mini-CEX, MCR	1, 2
Improve patients' and colleagues' understanding of the side effects and contraindications of therapeutic intervention	CbD, mini-CEX, MCR	1,3
Sensitively counsel a colleague following a significant untoward event, or near incident, to encourage improvement in practice of individual and unit	CbD, MCR	3
Recognise and respond to the manifestations of a patient's deterioration or lack of improvement (symptoms, signs, observations, and laboratory results) and support other members of the team to act similarly	CbD, mini-CEX, MSF, MCR	1
Behaviours		
Continue to maintain a high level of safety awareness and consciousness at all times	CbD, mini-CEX, MCR	2
Encourage feedback from all members of the team on safety issues	CbD, mini-CEX, MSF, MCR	3
Report serious untoward incidents and near misses and co-operate with the investigation of the same	CbD, mini-CEX, MSF, MCR	3
Willing to take action when concerns are raised about performance of members of the healthcare team, and act appropriately when these concerns are voiced to you by others	CbD, mini-CEX, MSF, MCR	3

Continue to recognise one's own limitations, and operate within them competently	CbD, mini-CEX, MCR	1

13.3 Principles of Quality and Safety Improvement

To recognise the desirability of monitoring performance, learning from mistakes and adopting no blame culture in order to ensure high standards of care and optimise patient safety

Knowledge	Assessment Methods	GMP
Know the elements of clinical governance	CbD, MSF, MCR	1
Describe responsibilities of doctors; professional and organisational goals	CbD, MCR	1,2
Recognise that governance safeguards high standards of care and facilitates the development of improved clinical services	CbD, MSF, MCR	1,2
Define local and national significant event reporting systems relevant to specialty	CbD, mini-CEX, MCR	1
Recognise importance of evidence-based practice in relation to clinical effectiveness	CbD, MCR	1
Outline local health and safety protocols (fire, manual handling etc)	CbD, MCR	1
Recognise risk associated with the trainee's specialty work including biohazards and mechanisms to reduce risk, including risk management tools, techniques and protocols	CbD, MCR	1
Outline the use of patient early warning systems to detect clinical deterioration where relevant to the trainee's clinical specialty	CbD, mini-CEX, MCR	1
Keep abreast of national patient safety initiatives including National Patient Safety Agency, NCEPOD reports, NICE guidelines, clinical standards board for Scotland	CbD, mini-CEX, MCR	1
Describe quality improvement methodologies including a range of methods of obtaining feedback from patients, the public, and staff	SCE, MCR	1
Describe the principles and processes of evaluation, audit, research and development, clinical guidelines and standard setting in improving quality	AA, SCE, MCR	1,2
Know about service review and accreditation of palliative care services	SCE, MCR	1,2
Describe patient outcome reporting systems within the specialty and the organisation, including qualitative methods to gather patient feedback, and how these relate to national programmes	AA, SCE, MCR	1,2
Describe how healthcare governance influences patient care, research and educational activities at a local, regional and national level	SCE, MCR	1,2
Skills		
Adopt strategies to reduce risk	CbD, MCR	1,2
Contribute to quality improvement processes, e.g.: • Audit of personal and departmental/directorate/practice performance • Errors / discrepancy meetings • Critical incident and near miss reporting • Unit morbidity and mortality meetings	AA, CbD, MCR	2

Local and national databases		
Maintain a portfolio of information and evidence, drawn from your medical practice	CbD, MCR	2
Reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation	AA, MCR	1,2,3,4
Analyse feedback and comments and integrate them into plans for the service	AA, MCR	1,2
Use a broad range of scientific and policy publications relating to delivering healthcare services	SCE, MCR	1,2
Use of complaints management systems	CbD, MCR	1,2
Improve services following evaluation / performance management	AA, MCR	1,2,3
Assess and analyse situations, services and facilities in order to minimise risk to patients and the public	AA, MCR	1,2
Monitor the quality of equipment and safety of environment relevant to the specialty	CbD, MCR	1,2
Compare and benchmark healthcare services	AA, MCR	1,2
Behaviours		
Willing to participate in safety improvement strategies such as critical incident reporting	CbD, MSF, MCR	3
Develop reflection in order to achieve insight into own professional practice	CbD, MSF, MCR	3
Demonstrate personal commitment to improve own performance in the light of feedback and assessment	CbD, MSF, MCR	3
Engage with an open no blame culture	CbD, MSF, MCR	3
Respond positively to outcomes of audit and quality improvement	CbD, MSF, MCR	1,3
Co-operate with changes necessary to improve service quality and safety	CbD, MSF, MCR	1,2
Actively seek advice / assistance whenever concerned about patient safety	CbD, MSF, MCR	1,2,3,4
Willing to take responsibility for clinical governance activities, risk management and audit in order to improve the quality of the service	MSF, MCR	1,2,3,4
Listen to and reflect on the views of patients and carers, and deal with complaints in a sensitive and co-operative manner	MSF, MCR	2,3,4

13.4 Audit

To develop the ability to perform an audit of clinical practice and to apply the findings appropriately and complete the audit cycle		
Knowledge	**Assessment Methods**	**GMP**
Describe clinical, organisational and multi-professional audit	SCE, AA, MCR	1, 2
Know the different methods of obtaining data for audit including patient feedback questionnaires, hospital sources and national reference data, applied to palliative care	AA, CbD, MCR	1
Recognise the role of audit (improving patient care and services, risk management etc)	AA, CbD , MCR	1
Know the steps involved in completing the audit cycle, including setting standards in relation to palliative care	AA, CbD, MCR	1
Know the working and uses of national and local databases used for audit such as specialty data collection systems such as NCPC or SIGN data sets, cancer registries etc	AA, CbD, MCR	1
Describe the working and uses of local and national systems available for reporting and learning from clinical incidents and near misses in the UK	CbD, SCE, MCR	
Recognise the impact of mapping service change	AA, MCR	1,2
Recognise barriers to change	AA, MCR	1
Skills		
Design, implement and complete audit cycles	AA, CbD, MCR	1,2
Contribute to local and national audit projects as appropriate (e.g. National Confidential Enquiry into Perioperative Deaths (NCEPOD), Scottish Audit of Surgical Mortality (SASM))	AA, CbD, MCR	1,2
Use clinical audit with the purpose of highlighting resources required	AA, MCR	1,2,3
Support audit by junior medical trainees and within the multi-disciplinary team	AA, MSF, MCR	1,2,3
Behaviours		
Compliance with national guidelines that influence healthcare provision	CbD, mini-CEX, MCR	1,2
Recognise the need for audit in clinical practice to promote standard setting and quality assurance	AA, MCR	1,2

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the statutory responsibility of the General Medical Council (GMC) which devolves responsibility for the local organisation and delivery of training to the deaneries. Each deanery oversees a "School of Medicine" which is comprised of the regional Specialty Training Committees (STCs) in each medical specialty. Responsibility for the organisation and delivery of specialty training in Palliative Medicine in each deanery is, therefore, the remit of the regional Palliative Medicine STC. Each STC has a Training Programme Director who coordinates the training programme in the specialty.

For those following the general practice route, this will be general practice training years 1-3 followed by specialty training for 4 years as defined in this curriculum (years 4 - 7). For those following an anaesthetic or surgical route, this will be anaesthetic or surgical training up to intermediate level. Those doctors training via these routes (GP anaesthetics or surgery) who have not had adequate experience of adult general medicine, as defined above, should undertake fixed term specialty training in medicine before embarking on specialty training in palliative medicine (years 4-7). Training via these routes may therefore take anything between 7 and 8+ years depending on the nature of the posts completed.

Following selection into specialist training in palliative medicine, the curriculum will be delivered through a sequence of posts in a training rotation. These will deliver all aspects of the curriculum and be managed by the specialty training committee within a Deanery. All individual posts and the whole rotational programme will be assessed by the SAC in palliative medicine for educational content, training opportunities and balance, before making a recommendation to GMC. Educational approval for each post and for the whole rotational programme will be granted at the discretion of GMC.

Through the rotational programmes, all trainees will occupy posts which provide experience of palliative medicine in a full range of settings (patients' own homes, day hospice, hospices and other inpatient specialist palliative care units, outpatients and general hospitals). Programmes will provide flexibility to meet trainees' needs and attachments to oncology, chronic pain services, primary care and other related specialties will be available in order to meet the competencies as stated in the section on content of learning. Doctors wishing to train less than full time will undergo the same training pro-rata. Times are stated as whole time equivalents and will be worked pro-rata for those working less than full time.

Trainees who wish to acquire extensive research competencies, in addition to those specified in the curriculum, may undertake a research project as an ideal way of obtaining those competencies. All options can be considered including taking time out of programme to complete a specified project or research degree. Time out of programme needs prospective approval from the SAC and the support of the Postgraduate Dean. Funding will need to be identified for the duration of the research period. A maximum period of 3 years out of programme is allowed. Up to 12 months of this may count towards a CCT if prospective approval is obtained from GMC.

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the entire curriculum is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided.

However, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

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

- Four years training in a sequence of posts which provides experience of palliative medicine for patients with any diagnosis, in a full range of settings; patients' own homes, day hospice, inpatient specialist palliative care units, and general hospitals including a regional hospital and a cancer centre/unit
- A minimum of 2 years must be spent in specialist palliative care, working with a full multi-professional specialist palliative care team as defined in the NICE Guidance on Supportive and Palliative Care (2004).
- At least 1 year of this will be in an inpatient specialist palliative care unit with a minimum of 10 beds,
- At least 6 months will be in a hospital specialist team and
- At least 6 months cumulative experience is expected in community specialist palliative care. Training in community palliative medicine may or may not be done as a continuous block and includes outpatients, day hospice, home visits and working with a community specialist palliative care team.
- Experience of palliative medicine outpatients both new and follow-ups.
- Experience of working within the NHS and hospices within the four year training programme
- Attachments to oncology, chronic pain services (including observation of nerve blocking techniques and experience of the management of epidural and/or intrathecal catheters for cancer pain), and other related medical specialties to meet the competencies set out in the curriculum
- Experience of working closely with cancer - site specialist MDTs, liaison psychiatry/psycho-oncology services, social services, chaplaincy services, pharmacy, rehabilitation services, discharge teams and bereavement services. Access to paediatric palliative care to understand transition from paediatric to adult services should be provided.
- Experience in managing the palliative care of patients with a variety of non-malignant conditions.

Acting up as a consultant (AUC)

"Acting up" provides doctors in training coming towards the end of their training with the experience of navigating the transition from junior doctor to consultant while maintaining an element of supervision.

Although acting up often fulfills a genuine service requirement, it is not the same as being a locum consultant. Doctors in training acting up will be carrying out a consultant's tasks but with the understanding that they will have a named supervisor at the hosting hospital and that the designated supervisor will always be available for support, including out of hours or during on-call work. Doctors in training will need to follow the rules laid down by the Deanery / LETB within which they work and also follow the JRCPTB rules which can be found on the JRCPTB website.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences. Trainees will learn from practice, clinical skills appropriate to their level of training and to their attachment within the department.

Trainees will achieve the competencies described in the curriculum through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

Learning Experiences
The curriculum will be delivered by tutored clinical experience in all settings (hospice/specialist palliative care inpatient unit, day hospice, hospital, outpatients and community), including multidisciplinary team meetings, ward rounds and clinical governance meetings. This is not a modular curriculum and it will be delivered via rotational training posts building on experience and training at each stage. The doctor will be given increasing responsibilities for patient management during the course of the curriculum.

A variety of learning methods will be employed, allowing a richness of experience to suit individual learners' styles.

The majority of the curriculum will be delivered through work-based experiential learning with protected time for independent learning and appropriate tutored study leave. This will amount to a total of up to 30 days per year, the nature and organisation of which can be determined by local Deaneries and specialty training committees. Study leave will be granted to enable trainees to achieve their educational objectives as set out at the beginning of each training post, and through regular appraisal, by agreement between trainees and their educational supervisors in accordance with the curriculum and in agreement with the postgraduate dean. Trainees will have several clinical and educational supervisors during the course of their training. The educational supervisor will oversee the learning in each post on the rotation and specific teaching will be delivered both by the consultant clinical supervisor and other members of the multi-professional team.

Adults learn by

- reflecting and building upon their own experiences
- identifying what they need to learn
- being involved in planning their education and training
- evaluating the effectiveness of their learning experiences

For trainees to maximise their experiential learning opportunities it is important that they work in a 'good learning environment'. This includes encouragement for self-directed learning as well as recognising the learning potential in aspects of day to day work and generally adopting a positive attitude to training.

Learning with Peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.

Active involvement in group discussion is an important way for doctors to share their knowledge and experiences. Lectures and formal educational sessions make up only a small part of the postgraduate training in palliative medicine. The bulk of learning occurs as a result of clinical experience (experiential learning) and self-directed study

informed by appraisal and personal development plans to cover the curriculum. The degree of self-directed learning will increase as trainees become more experienced.

A supportive, open atmosphere should be cultivated and questions welcomed. The list of learning opportunities below offers guidance only - there are other opportunities for learning that are not listed here. Trainees will learn in different ways according to their level of experience.

Work-based Experiential Learning - The content of work-based experiential learning is decided by the local faculty for education but includes active participation in:

- Medical clinics including specialty clinics. After initial induction, trainees will review patients in outpatient clinics, under direct supervision. The degree of responsibility taken by the trainee will increase as competence increases. As experience and clinical competence increase, trainees will assess 'new' and 'review' patients, discuss each case and present their findings to their clinical supervisor. This will allow feedback on diagnostic skills and facilitate training in planning appropriate investigations and developing management plans.
- Specialty-specific out-of-hours admissions and/or referrals. This will include out-of-hours telephone advice to non-specialist colleagues. Trainees should have the opportunity to discuss their on-call clinical activity and receive feedback from their clinical supervisor
- Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments. Every patient seen, on the ward or in out-patients, provides a learning opportunity, which will be enhanced by following patients through the course of their illness: the experience of the evolution of patients' problems over time is a critical part both of the diagnostic process and the clinical management. Patients seen should provide the basis for critical reading and reflection on clinical problems. Ward-based learning includes ward rounds and multi-professional team meetings. These should be led by a consultant, or the trainee may lead the ward round and be observed by a consultant, and include feedback on clinical and decision making skills.
- Consultant-led ward rounds. Every time a trainee observes another doctor, consultant or fellow trainee, seeing a patient or a relative there is an opportunity for learning. Ward rounds, including those where out-of-hours admissions are reviewed, should be led by a consultant and include feedback to the trainee on clinical and decision-making skills. Alternatively, the trainee may lead the ward round and be observed by a consultant. The trainee should receive feedback on his/her clinical and decision making skills.
- Multi-disciplinary palliative care team meetings - these should either be led by a consultant, or the trainee may lead and be observed by a consultant. They should include feed-back on clinical and decision-making skills.
- There are many situations where clinical problems are discussed with clinicians in other disciplines such as radiology, oncology, pain specialists or pathology. This may be during formal multidisciplinary meetings in other specialties, or informally as the need arises. These provide excellent opportunities for observation of clinical reasoning.
- Trainees need to learn to make increasingly independent decisions on diagnosis, investigations and treatment consistent with their level of experience and competence and with maintaining patient safety. These decisions should be reviewed with their consultant clinical supervisor.

Within the hospice/inpatient specialist palliative care unit environment, doctors will learn to deliver specialist palliative care to patients with the most complex problems

in addition to managing concurrent general medical problems in inpatients in the context of advanced disease. This will include developing and applying admission and discharge criteria to such units and liaison with hospital teams and primary care. Trainees have supervised responsibility for the care of in-patients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competence increases. There should be appropriate levels of clinical supervision throughout training with increasing clinical independence and responsibility as learning outcomes are achieved (see Section 5: Feedback and Supervision). The management of emergencies in palliative care will be covered, both during the working day and out of hours. Doctors will be involved with complex discharge planning arrangements and be exposed to a variety of models for bereavement care.

Within day hospice, doctors will experience the differences/tensions between medical and social models of care and will deliver specialist palliative care within a multi-professional team in this environment with close liaison with primary care and hospital teams.

Within hospital, doctors will work with clinical nurse specialists in palliative care and others within the multi-professional team in an advisory role. This will develop skills in decision-making and working with a variety of hospital-based specialist teams to enhance the palliative care of hospital inpatients with specialist palliative care needs. Doctors will be involved with complex discharge planning arrangements from the hospital setting.

Within outpatients, doctors will manage specialist palliative care problems in conjunction with primary care colleagues and will enhance their skills in symptom management and advance care planning.

In the community, doctors will work with clinical nurse specialists and other members of the multi-professional team to advise primary care teams in the specialist aspects of palliative care for patients in their own homes and in care homes. This will involve accessing drugs and equipment in community settings, advance care planning and the use of pathways of care.

Practical procedures will be learnt in any of the above settings as appropriate. Doctors will learn to manage emergencies in palliative care through working on call for a minimum of 20 full weekends (Saturday - Monday) during the delivery of this curriculum, for units and teams who accept out-of-hours admissions and/or referrals. They will also provide out of hours advice to non-specialist colleagues.
Having gained experience in the delivery of specialist palliative care in all these settings, the trainee will be able to understand the strengths and limitations of palliative care delivery in different environments, weigh up the merits of care in different settings with individual patients, be in a position to redesign or develop services for populations of patients and work with colleagues in primary, secondary and tertiary care to deliver the best possible palliative care to patients and families and carers.

Formal Postgraduate Teaching – The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the Royal Colleges of Physicians.

Suggested activities include:

- A programme of formal bleep-free regular teaching sessions to cohorts of trainees (e.g. a weekly core training hour of teaching within a Trust/hospice)
- Case presentations
- Journal clubs - increasing exposure to journal club presentations allows development of critical thinking and in-depth study of particular areas.
- Research and audit projects and presentations
- Lectures
- Grand Rounds
- Small group teaching
    - Case presentations and small group discussion, particularly of difficult cases, including presentations at clinical and academic meetings. This should include critical incident analysis.
    - Small group bedside teaching, particularly covering problem areas identified by trainees.
    - Small group sessions of data interpretation, particularly covering problem areas identified by trainees.
    - Video consultation with subsequent small group discussion.
- One-to-one teaching
    - Review of out-patients, ward referrals or in-patients with supervising consultant.
    - Review case presentations with educational supervisor including selected notes, letters and summaries.
    - Critical incident analysis.
    - Discussion between trainee and trainer of knowledge of local guidelines.
    - Video consultation with subsequent individual discussion with trainer.
    - Feedback following mini-CEX, DOPS, CbD assessments.
    - Teaching evaluation feedback
    - Audit evaluation and feedback
    - Feedback following the completion of a Record of Reflective Practice providing an opportunity to reflect in detail on a patient's case or other scenario.
- Clinical skills demonstrations and teaching, including - local resuscitation skills review by a resuscitation training officer including simulation with manikins. This may be gained by attending an BLS and/or ALS course
- Critical appraisal of evidence based medicine and journal clubs
- Joint specialty meetings
- Attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.
- Teaching others
    - Increasing exposure to teaching undergraduate medical students, students and practitioners from allied health professions and postgraduate doctors provides excellent learning opportunities for the teacher.
    - Presenting cases at grand rounds or similar clinical meetings provides the opportunity to review the literature relating to the clinical case. This provides the opportunity for in-depth study of one clinical problem as well as learning important critical thinking skills.

Independent Self-Directed Learning -Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- Reading, including web-based material
- Personal study including computer-based learning

- Maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- Audit participation. Trainees should be directly involved and expect to undertake a minimum of one in-depth audit and supervise a second audit during the four year training programme
- Research projects. The trainee experiences and understands the processes necessary to initiate, plan, carry out and report a project based on sound investigative principles, such as a research study, systematic review, audit project or clinical guidelines.
- Reading journals and critical appraisal
- Practise examination questions and subsequent reading.
- Writing reviews and other teaching material
- Achieving personal learning goals beyond the essential core curriculum

Formal Study Courses - Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses.

For palliative medicine the following course is essential:

- Completion of an approved* communication skills course

* Until nationally approved courses are readily available, courses approved by the STC will be accepted

The following courses are recommended:

- Ethical issues in end-of-life care
- Management training, to include both the NHS and charitable sector
- Teaching/presentation skills course
- Research in palliative care
- Study days organised by the Association for Palliative Medicine.

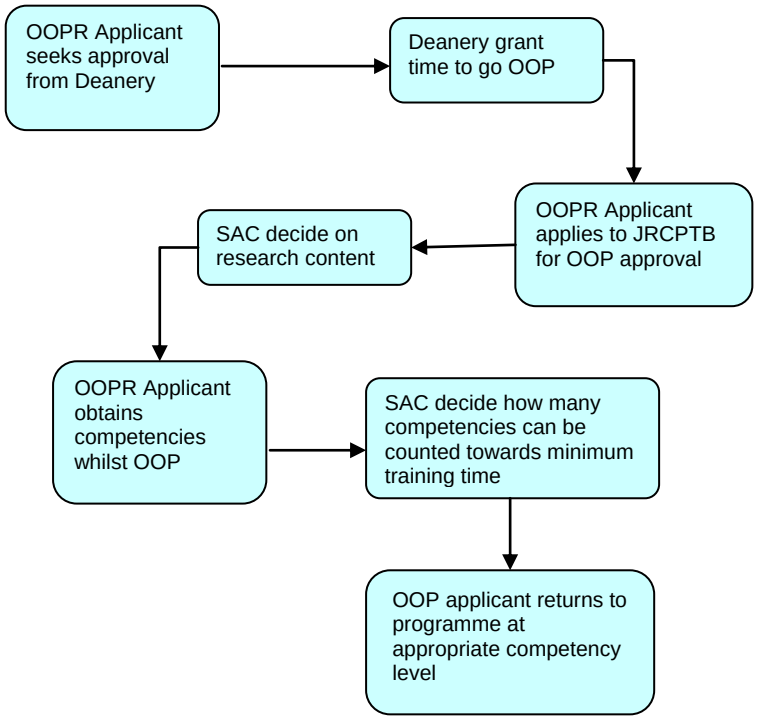
4.3 Research

Trainees who wish to acquire research competencies, in addition to those specified in their specialty curriculum, may undertake a research project as an ideal way of obtaining those competencies. For those in specialty training, one option to be considered is that of taking time out of programme to complete a specified project or research degree. Applications to research bodies, the deanery (via an OOPR form) and the JRCPTB (via a Research Application Form) are necessary steps, which are the responsibility of the trainee. The JRCPTB Research Application Form can be accessed via the JRCPTB website. It requires an estimate of the competencies that will be achieved and, once completed, it should be returned to JRCPTB together with a job description and an up to date CV. The JRCPTB will submit applications to the relevant SACs for review of the research content including an indicative assessment of the amount of clinical credit (competence acquisition) which might be achieved. This is likely to be influenced by the nature of the research (eg entirely laboratory-based or strong clinical commitment), as well as duration (eg 12 month Masters, 2-year MD, 3-Year PhD). On approval by the SAC, the JRCPTB will advise the trainee and the deanery of the decision. The deanery will make an application to the GMC for approval of the out of programme research. All applications for out of programme research must be prospectively approved.

Upon completion of the research period the competencies achieved will be agreed by the OOP Supervisor, Educational Supervisor and communicated to the SAC, accessing the facilities available on the JRCPTB eportfolio. The competencies achieved will determine the trainee's position on return to programme; for example if an ST3 trainee obtains all ST4 competencies then 12 months will be recognised

towards the minimum training time and the trainee will return to the programme at ST5. This would be corroborated by the subsequent ARCP.

This process is shown in the diagram below:



Funding will need to be identified for the duration of the research period. Trainees need not count research experience or its clinical component towards a CCT programme but must decide whether or not they wish it to be counted on application to the deanery and the JRCPTB.

A maximum period of 3 years out of programme is allowed and the SACs will recognise up to 12 months towards the minimum training times.

4.4 Academic Training

Other than gaining academic experience through OOPE, there are a small number of academic training programmes available in Palliative Medicine. Academic Clinical Fellowships (ACFs) provide part-funding for the basic salary to allow the trainee to set aside 25% of their time to develop academic skills and to prepare and compete for a training fellowship to undertake a higher degree. Funding for ACFs is usually for two or three years. Clinical competencies, including all necessary assessments, need to be gained within the 75% of the trainee's time allocated to clinical work. At the end of an ACF the trainee will regain a non-academic training programme to complete their training and gain their CCT.

Academic integrated pathways to CCT are a) considered fulltime CCTs as the default position and b) are run through in nature. The academic programmes are CCT programmes and the indicative time academic trainees to achieve the CCT is the same as the time set for non-academic trainees. If a trainee fails to achieve all the required competencies within the notional time period for the programme, this would be considered at the ARCP, and recommendations to allow completion of clinical training would be made (assuming other progress to be satisfactory). An academic trainee working in an entirely laboratory-based project would be likely to require

additional clinical training, whereas a trainee whose project is strongly clinically oriented may complete within the “normal” time (see the guidelines for monitoring training and progress) http://www.academicmedicine.ac.uk/careersacademicmedicine.aspx. Extension of a CCT date will be in proportion depending upon the nature of the research and will ensure full capture of the specialty outcomes set down by the Royal College and approved by GMC.

All applications for research must be prospectively approved by the SAC and the regulator, see www.jrcptb.org.uk for details of the process.

5 Assessment

5.1 The assessment system

The purpose of the assessment system is to:

- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, measure their own performance and identify areas for development;
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience;
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- ensure trainees are acquiring competencies within the domains of Good Medical Practice*;*
- assess trainees’ actual performance in the workplace;
- ensure that trainees possess the essential underlying knowledge required for their specialty;
- inform the Annual Review of Competence Progression (ARCP), identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider change of career direction.

The integrated assessment system comprises workplace-based assessments and knowledge assessments. Individual assessment methods are described in more detail below.

Workplace-based assessments will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide trainees with formative feedback. They are not individually summative but overall outcomes from a number of such assessments provide evidence for summative decision making. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

5.2 Assessment Blueprint

In the syllabus (3.3) the “Assessment Methods” shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used.

5.3 Assessment methods

The following assessment methods are used in the integrated assessment system:

Examinations and certificates

- The Specialty Certificate Examination in Palliative Medicine (SCE)
- Basic Life Support Certificate

The Federation of Royal Colleges of Physicians of the UK, in conjunction with the Association for Palliative Medicine, has developed a Specialty Certificate Examination. The aim of this national assessment is to assess a trainee's knowledge and understanding of the clinical sciences relevant to specialist medical practice and of common or important disorders to a level appropriate for a newly appointed consultant.

The aim of this national assessment is to assess a trainee's knowledge and understanding of the clinical sciences relevant to specialist medical practice and of common or important disorders to a level appropriate for a newly appointed consultant. The Specialty Certificate Examination is a prerequisite for attainment of the CCT.

Information about the SCE, including guidance for candidates, is available on the MRCP(UK) website www.mrcpuk.org

Workplace-based assessments WPBAs

- Multi-Source Feedback (MSF)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Direct Observation of Procedural Skills (DOPS)
- Case-Based Discussion (CbD)
- Audit Assessment (AA)
- Teaching Observation (TO)
- A minimum of 2 multiple consultant report (MCR) per year of training.

Supportive Evidence Assessment

- Record of Reflective Practice

These methods are described briefly below. More information about these methods including guidance for trainees and assessors is available in the eportfolio and on the JRCPTB website www.jrcptb.org.uk. Workplace-based assessments should be recorded in the trainee's eportfolio. The workplace-based assessment methods include feedback opportunities as an integral part of the assessment process. This is explained in the guidance notes provided for the techniques.

Multisource feedback (MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides objective systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administration staff, and other allied professionals. The trainee will not see the individual responses by raters; feedback is given to the trainee by the Educational Supervisor.

mini-Clinical Evaluation Exercise (mini-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid

learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Direct Observation of Procedural Skills (DOPS)
A DOPS is an assessment tool designed to assess the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

Case based Discussion (CbD)
The CbD assesses the performance of a trainee in his/her management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should include discussion about a written record (such as written case notes, out-patient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

Audit Assessment Tool (AA)
The Audit Assessment Tool is designed to assess a trainee's competence in completing an audit. The Audit Assessment can be based on review of audit documentation OR on a presentation of the audit at a meeting. If possible the trainee should be assessed on the same audit by more than one assessor.

Teaching Observation (TO)
The Teaching Observation form is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation 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).

Record of Reflective Practice (RRP)
The Record of Reflective Practice (RRP) comprises clinical case studies, incidents, managerial issues or other workplace scenarios, and is designed to test a range of competencies derived from the curriculum using a structured record and feedback grid.

It will enable formative feedback on trainees' progress and contribute to the evidence that the curriculum has been covered. This will help both the trainee and educational supervisor to set learning goals and monitor progress.

The trainee will create a file over his/her training period by selecting two scenarios each year that highlight the skills needed to meet the relevant curriculum competencies. Topics may be selected at an early appraisal meeting when setting learning priorities for his/her clinical attachment, and may be reviewed throughout the attachment as appropriate.

The reflective record contains a series of questions to guide completion and to encourage breadth and depth of reflection. The suggested questions provide a framework to both facilitate and enhance the thought processes in decision-making, and provide a structure for feedback and further discussion. Feedback will be provided by at least 2 different supervisors.

Multiple Consulant Report (MCR)
The Multiple Consultant Report (MCR) captures the views of consultant supervisors on a trainee's clinical performance. The MCR year summary sheet summarises the

feedback received, outcomes for clinical areas and comments which will give valuable insight to how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and included in the educational supervisor's report.

Assessors
Where the clinical or educational supervisor deems it appropriate, workplace-based assessments may be delegated to a colleague. This may be a doctor in training of greater seniority than the trainee, or a non-medical colleague who possesses knowledge and skills which enable him/her to assess the trainee in a particular skill or behaviour. All assessors will understand the requirements of the specialty curriculum, be trained in the assessment method in question and be an expert in the area being assessed.

5.4 Decisions on progress (ARCP)

The Annual Review of Competence Progression (ARCP) is the formal method by which a trainee's progression through her/his training programme is monitored and recorded. ARCP is not an assessment – it is the review of evidence of training and assessment. The ARCP process is described in A Reference Guide for Postgraduate Specialty Training in the UK (the "Gold Guide" – available from www.mmc.nhs.uk). Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's eportfolio.

The ARCP Decision Aid is included in section 5.5, giving details of the evidence required of trainees for submission to the ARCP panels.

5.5 ARCP Decision Aid

Palliative Medicine Specialty Training
The guidance below documents the targets that have to be achieved for a satisfactory ARCP outcome at the end of each training year. Please refer to the JRCPTB website for the most current version of the ARCP decision aids.

Assessment		**ARCP year 3 (End of ST3)**	**ARCP year 4 (End of ST4)**	**ARCP year 5 (End of ST5 = PYA)**	**ARCP year 6 (End of ST6 = CCT)**
Expected competence		ES to confirm trainee has gained experience in the initial assessment and management of patients presenting with common palliative care problems and common palliative care emergencies Evidence of engagement in at least 50% of 1-7 of the top 10 topics for mini-CEX* Evidence of engagement in 4 of 1-11 top topics for CbD*	ES to confirm trainee is competent in the assessment and management of patients presenting with any of the common palliative care problems and common palliative care emergencies Evidence of engagement in all of 1-7 of the top 10 topics for mini-CEX* Evidence of engagement in 8 of 1-11 top topics for CbD*	ES to confirm trainee is autonomously competent in the assessment and management of patients presenting with all common palliative care problems/emergencies Evidence of engagement with at least 80% of the top 10 topics for mini-CEX* Evidence of engagement in 12 of top 20 topics for CbD*	ES to confirm trainee is autonomously competent in the assessment and management of patients presenting with all palliative care problems/emergencies Evidence of engagement with 100% of the top 10 topics for mini-CEX* Evidence of engagement in 16 of top 20 topics for CbD*
SCE				Attempted SCE	Passed SCE to obtain CCT
SLEs	**mini-CEX***	6	6	4	2
	CbD*	4	4	4	4
	ACAT	Optional – can be used to receive feedback and improve learning on acute medical take or ward round. It is recommended that at least five cases have been managed during ward round or session			
Supervised learning events (SLEs) should be performed proportionately throughout each training year by a number of different assessors across the breadth of the curriculum with structured feedback and action plans to aid the trainee's personal development					

Assessment	ARCP year 3 (End of ST3)	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5 = PYA)	ARCP year 6 (End of ST6 = CCT)
MSF	1 satisfactory	1 satisfactory	1 satisfactory	1 satisfactory
DOPS*	Minimum 2	Minimum 2	Minimum 2	Minimum 2
BLS	Must have valid BLS	Must have valid BLS	Must have valid BLS	Must have valid BLS
Audit Assessment (AA)	Evidence of participation in an audit	Evidence of completion of an audit with major involvement in design, implementation, analysis and presentation of results and recommendations 1 audit assessment	Evidence of participation in supervision of a second audit with major involvement in supervising a clinician in the design, implementation, analysis and presentation of results and recommendations	Evidence of satisfactory completion of portfolio/record of audit involvement, 1 audit assessment
Teaching Observation (TO)	Evidence of participation in teaching of medical students, junior doctors and other AHPs 1 teaching observation	Evidence of participation in teaching of medical students, junior doctors and other AHPs 1 teaching observation	Evidence of participation in teaching with results of students' evaluation of teaching. Evidence of understanding of the principles of adult education 1 teaching observation	Portfolio evidence of ongoing evaluated participation in teaching. Evidence of implementation of the principles of adult education 1 teaching observation
Research	Evidence of critical thinking around relevant clinical questions	Evidence of satisfactory preparation for a project based on sound research principles	Evidence of developing research awareness and competence. Evidence might include participation in research studies, critical reviews, presentation at relevant research meetings or participation in (assessed) courses	Satisfactory academic portfolio / record with evidence of research awareness and competence. Evidence might include a completed research study / guideline / protocol with presentations/publication. Research project educational supervisor report satisfactorily completed

Assessment	ARCP year 3 (End of ST3)	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5 = PYA)	ARCP year 6 (End of ST6 = CCT)
Management	Evidence of participation in and awareness of some aspect of management – e.g. responsibility for organising on call rotas, organise and manage own workload effectively and flexibly, supervision of junior medical staff	Evidence of participation in and awareness of some aspect of management – examples might include preparing rotas; delegating; organising and leading teams. Organising teaching sessions or journal clubs Evidence of leading MDT meetings.	Evidence of awareness of managerial structures and functions within the NHS. Such evidence might include attendance at relevant courses, participation in relevant local management meetings with defined responsibilities. Evidence of leading MDT, involvement in induction of junior doctors	Evidence of understanding of managerial structures e.g. by reflective portfolio entries around relevant NHS and voluntary sector management activities. Evidence of contribution to senior management meetings, recruitment process, handling of critical incidents
Record of Reflective Practice (RRP)	2 satisfactorily completed RRPs	2 satisfactorily completed RRPs	2 satisfactorily completed RRPs	2 satisfactorily completed RRPs
Educational supervisor's report	Satisfactory – to include summary of MCR and any actions resulting	Satisfactory – to include summary of MCR and any actions resulting	Satisfactory – to include summary of MCR and any actions resulting	Satisfactory – to include summary of MCR and any actions resulting
Multiple Consultant Report	2	2	2	2
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				

Please refer to supplementary guidance below

Supplementary guidance on WPBAs for Palliative Medicine

Top 10 topics for mini-CEX [with references to curriculum topics]:

1. Communication with patients and families [3.1, 3.2, 3.3, 3.4]
2. Clinical evaluation/examination for symptom management [2.2, 2.3, 2.4, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13]
3. Clinical evaluation of concurrent clinical problems [2.5]
4. Clinical evaluation of emergencies [2.14]
5. Managing family conflict in relation to unrealistic goals [2.20]
6. Assessing the dying patient [2.22]
7. Clinical evaluation and ongoing care of the dying patient [2.22]
8. Prescribing in organ failure [2.18]
9. Evaluation of psychological response of patient & relatives and to illness [4.1, 4.2, 4.3]
10. Evaluating spiritual and religious needs [6.2]

Top 20 topics for CbD [with references to curriculum topics]:

1. Communication with colleagues and between services [1.3, 1.4]
2. Recognition, assessment and management of critical change in patient pathway [2.4]
3. Shared care in different settings [2.4]
4. Management of concurrent clinical problems [2.5]
5. Management of symptoms/clinical problems (including intractable symptoms) [2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13]
6. Symptoms as sensory, psychological and social experience for patients and impact on carers [2.6]
7. Therapeutic options & appropriate choice of treatment/non-treatment [2.6]
8. Opioid use (including opioid switching) [2.7]
9. Other interventions in pain management [2.7]

10. Management of emergencies [2.14]
11. Pharmacology/therapeutics [2.17, 2.18]
12. Psychosocial care [2.22, 4.1]
13. Psychological responses of patients and carers to life-threatening illness and loss [4.2]
14. Self-awareness and insight [5.1]
15. Grief and bereavement [4.5]
16. Patient and family finances [4.6]
17. Culture, ethnicity, religion, spirituality [6.1, 6.2]
18. Ethics [7.1, 7.2]
19. Doctor/patient relationship [7.2, 8.1, 8.2, 8.3]
20. Teamwork & leadership [9.1, 12.2, 12.6]

DOPS requirement

Amendments made to the 2010 curriculum in 2013 include changes to the requirement for DOPS (please see appendix 1 for a summary of DOPS requirements for each curriculum). The principles behind the introduction of the new DOPS are that trainees should be able to manage patients with a tracheostomy, central line or NIV in a specialist palliative care setting. The guidelines in each area will be different and the trainees should be assessed according to the local guidelines and governance in place in their area. There are no specific forms for these DOPS and the generic forms on eportfolio can be used.

- **Management of a tracheostomy**: The rationale behind this is that a trainee would be able to look after a patient with a tracheostomy in situ in a specialist palliative care setting. Trainees should therefore be able to manage common complications e.g. secretions and a simple tracheostomy change.

- **Care of peripherally inserted central catheters and Hickman lines:** The trainee in palliative medicine should be able to manage patients with a PICC or Hickman line in situ in a specialist palliative care setting. Trainees should be able to maintain the patency of these lines and to use the lines appropriately as required and in accordance with local policies.

- **Management of non-invasive ventilation:** The palliative medicine trainee would be expected to manage a patient who required non invasive ventilation in a specialist palliative care setting. Trainees should be able to set up and check non-invasive ventilation on a patient who has already been established on NIV and work with local guidelines within the local governance framework covering these devices.

DOPS are separated into two categories of *routine* and *potentially life-threatening* procedures, with a clear differentiation of formative and summative sign off. Formative DOPS for routine and potentially life threatening procedures should be undertaken before doing a summative DOPS and can be undertake as many times as the trainee and their supervisor feel is necessary.

The following procedures are categorised as *routine* and require summative sign off on one occasion with one assessor to confirm clinical independence. The relevant syllabus section is given in brackets for reference:

- **TENS application** [2.7]
- **Management of spinal lines** [2.7]
- **Passing the nasogastric tube**[2.8]
- **Management of tracheostomy**[2.9]
- **Management of non-invasive ventilation**[2.9]
- **Syringe driver set up** [2.13]
- **Care of peripherally inserted central catheters and Hickman lines** [2.13]

The following procedure is potentially life threatening and therefore requires DOPS summative sign off on two occasions with two different assessors (one assessor per occasion):

- **Paracentesis** [2.8]

5.6 Penultimate Year Assessment (PYA)

The penultimate ARCP prior to the anticipated CCT date will include an external assessor from outside the training programme. JRCPTB and the deanery will coordinate the appointment of this assessor. This is known as “PYA”. Whilst the ARCP will be a review of evidence, the PYA will include a face to face component.

5.7 Complaints and Appeals

The MRCP(UK) office has complaints procedures and appeals regulations documented in its website which apply to all examinations run by the Royal Colleges of Physicians.

All WPBA method outcomes must be used to provide feedback to the trainee on the effectiveness of the education and training where consent from all interested parties has been given. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it.

Appeals against decisions concerning in-year assessments will be handled at deanery level and deaneries are responsible for setting up and reviewing suitable processes. If a formal complaint about assessment is to be pursued this should be referred in the first instance to the chair of the Specialty Training Committee who is accountable to the regional deanery. Continuing concerns should be referred to the Associate Dean.

6 Supervision and feedback

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to personally discuss all cases if required. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Each specialist training programme in palliative medicine will have a Programme Director and named consultant trainers who will undertake educational supervision of individual trainees.

Trainees will at all times have a named Educational Supervisor and Clinical Supervisor, responsible for overseeing their education. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor. Each educational supervisor should have a maximum of 2 trainees at any time (pro rata for part time supervisors). This allows adequate time to be given to the role.

Training under the supervision of several trainers and in two or more different centres with a broad range of learning opportunities is strongly encouraged. All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. This supervision must routinely include the opportunity to personally discuss all cases if required.

The responsibilities of supervisors have been defined by GMC in the document "Operational Guide for the PMETB Quality Framework". These definitions have been agreed with the National Association of Clinical Tutors, the Academy of Medical Royal Colleges and the Gold Guide team at MMC, and are reproduced below:

Educational supervisor
A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's Educational Agreement.

Clinical supervisor
A trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged.

The Educational Supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The Educational Supervisor should be part of the clinical specialty team. Thus if the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the Educational Supervisor. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Training and experience of Supervisors/assessors

All trainers will comply with the GMC Standards for Trainers, January 2008.

All clinical and educational supervisors will be consultants in palliative medicine, on the Specialist Register. It is expected that as a minimum, new educational supervisors will have an experienced colleague overseeing their role for at least the first year, providing mentorship. Where possible, joint supervision with an experienced colleague will be provided for at least 12 months.

Training will include the following as a minimum:

Clinical Supervisors
- Teaching skills course, to include workplace-based teaching
- Workplace-based assessment
- Giving feedback
- Use of specialty portfolio/e-portfolio
- The role of the clinical supervisor
- Equality and diversity

Educational Supervisors
- Teaching skills course, to include workplace-based teaching

- Workplace-based assessment
- Giving feedback
- Use of specialty portfolio/e-portfolio
- The role of the clinical and educational supervisor
- Appraisal
- Managing trainees in difficulty
- Career guidance
- Equality and diversity
- Recruitment and selection, including employment law

The 'Grandfather clause'

It is recognised that some clinicians will have many years experience as a trainer and some may have previously undertaken training which may go some way towards meeting these requirements. These individuals, if they so wish, should have the opportunity to submit a portfolio of evidence to ascertain if they meet the new standards and what, if any, top up training they require.

All clinical and educational supervisors will be expected to demonstrate that they continue to meet the standards outlined through annual appraisal. It is anticipated that this will form part of the 5 yearly revalidation process.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the eportfolio
It is the responsibility of the trainee to keep his/her training record and e-portfolio up to date with clear documentation of all generic and specific training experience, all assessments undertaken, reports from clinical supervisors and other required information. During any research period or other out of programme module, the training record will include an account of work undertaken.

As part of the training record, trainees in palliative medicine will complete a Record of Reflective Practice. A minimum of two cases per year should be submitted to their educational supervisor for structured feedback on his/her learning. The cases may relate directly to patient management or to other aspects of the curriculum, depending on their learning needs and stage of training.

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review

This meeting between trainee and educational supervisor is mandatory (except when an attachment is shorter than 6 months), but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP. At this meeting trainees

should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded and passed on to the educational supervisor for the next post. If there are significant concerns following the end of attachment appraisal then the Programme Director should be informed

7 Managing curriculum implementation

7.1 Training provided on the specialty curriculum

The JRCPTB has provided training for representatives of all Deaneries on the implementation of the curriculum and assessment methods in palliative medicine (2008). Representatives are required to cascade this training to all supervisors in their Deaneries and feedback any issues to the SAC. Further specialty-specific training will be offered if Heads of Specialty Training/programme directors deem it necessary. The training includes giving feedback as part of workplace-based assessments.

The Association for Palliative Medicine (APM) has set up a system to support the supervision of research, with every deanery having a nominated lead for research supervision. Training days on research support for educational supervisors and trainees are run regularly, covering curriculum competencies.

The system of feedback from trainees ensures that they lead the process of curriculum implementation (appendix 2). This is supported by the system of external SAC review at PYA which ensures curriculum coverage over the 4 years. An annual report from Heads of Specialty Training will provide information on strengths and weaknesses of each rotation along with an action plan to remedy any deficits. The SAC will assist local training providers to find solutions and to share good practice. Further information will be gained from the specialty questions in the GMC trainee survey.

7.2 Intended use of curriculum by trainers and trainees

This curriculum and eportfolio are web-based documents which are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) website www.jrcptb.org.uk.

The educational supervisors and trainers can access the up-to-date curriculum from the JRCPTB website and will be expected to use this as the basis of their discussion with trainees. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining a portfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

The SAC in Palliative Medicine provides a checklist for deaneries to enable them to review the posts in their rotations and the balance of training opportunities provided.

All training posts in rotations are approved by the SAC, on the basis of structured information provided by the deaneries on the content of training and experience in each post, and the nature of the supervision. This includes information on the training capacity in each post, both in terms of workload and supervision. Where this information is deemed unsatisfactory or incomplete, it is returned to the deanery with recommended modifications. When approved by the SAC, it is passed to GMC with a recommendation to approve the post. This ensures a balance of training opportunities in deaneries.

The Training Programme Director/Head of Specialty Training in each deanery, through the Specialty Training Committee, is responsible for ensuring that each trainee has a balanced training through an appropriate sequence of posts. This is reviewed annually at the ARCP. In addition, the SAC provides external review at PYA when trainees present their experience of training to date, and recommendations are made for their final year. This ensures that any gaps in training are identified and covered. The mandatory and recommended training requirements set down at the PYA, along with the evidence provided for their completion, are reviewed by the Programme Director/Head of Specialty Training, the Dean and by an officer of the SAC before the trainee is recommended for a CCT.

Specialty specific questions have been included in the GMC trainee survey, to ensure that areas of curriculum delivery that have been known to cause difficulties in the past are reviewed. All STCs include trainee representatives and these feed in to the trainees who sit on the SAC (appendix 2).

GMC undertakes visits to deaneries to quality assure training. The SAC provides an annual report to GMC from the specialty.

7.3 Recording progress

On enrolling with JRCPTB trainees will be given access to the eportfolio for Palliative Medicine. The eportfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainees' main responsibilities are to ensure the eportfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisors' main responsibilities are to use eportfolio evidence, such as outcomes of assessments, reflections and personal development plans, to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

8 Curriculum review and updating

This curriculum has been developed with extensive input from within the specialty, from related specialties from employers and lay members (appendix 1). The SAC encourages feedback from trainees, trainers and other interested parties and

maintains information on suggested updates or additions. These are considered by the SAC on an annual basis, with a major review planned for every 3 years.

The SAC meets three times per year and undertakes to evaluate and monitor the curriculum. It includes representation from all deaneries, a lay member, members from related specialties, an academic representative, trainees and the specialty society (APM). In addition, the chair of the SAC sits on the Joint Specialty Committee in Palliative Medicine within the Royal College of Physicians of London, which includes lay members and also sits ex-officio on the Executive Committee of the APM, providing reports three times per year and being available to discuss items that arise.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates. Accordingly, it warmly welcomes contributors and applicants from as diverse a population as possible, and actively seeks to recruit people to all its activities regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.

LETB quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes;
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post;
- LETBs must ensure that educational supervisors have had equality and diversity training (for example, an e learning module) every 3 years
- LETBs must ensure that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e module) every 3 years.
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. LETBs and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. LETBs must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
- monitoring of College Examinations;
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly disadvantage trainees because of gender, ethnicity, sexual orientation or disability (other than that which would make it impossible to practise safely as a physician). All efforts shall be made to ensure the participation of people with a disability in training.

10 Appendices

Appendix 1

List of contributors

Specialty Advisory Committee members

Dr Fiona Hicks FRCP (chair) Consultant in Palliative Medicine, Leeds
Dr Stephanie Gomm MD FRCP (secretary) Consultant in Palliative Medicine, Manchester
Dr Martine Meyer FRCP (curriculum secretary) Consultant in Palliative Medicine, London
Dr Alison Coakley, Head of Specialty Training, Mersey
Dr Mary Comisky FRCP, Head of Specialty Training, North East
Mrs B A Cooper, Lay member
Dr Julie Doyle FRCP, Head of Specialty Training, Northern Ireland
Professor Karen Forbes FRCP, Academic representative
Dr Joan Hester FRCA, Representative of the Royal College of Anaesthetists
Dr Aruna Hodgson, Head of Specialty Training, North West
Dr Melanie Jefferson FRCP, Head of Specialty Training, Wales
Dr Bernadette Lee FRCP, Head of Specialty Training, London
Dr Kathleen Sherry FRCP, Head of Specialty Training, Scotland
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Dr Milind Arolker MRCP, Trainee representative
Dr Felicity Morgan MRCP, Trainee representative
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Association for Palliative Medicine

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Appendix 2

Scheme for feedback for trainees with individual and/or general concerns about Palliative Medicine curriculum delivery, assessment and content