JRCPTB

Joint Royal Colleges of Physicians Training Board

Curriculum for Palliative Medicine Training

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

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1. Introduction

The Shape of Training (SoT) review was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission and the Francis report. With an ageing population, patients exhibit co-morbidities and increasing complexity, living with these conditions into older age. Patients with long term conditions and frailty have specific needs and require a palliative approach for the last years of their life. Much of this care is supported at home or in care homes so acute medical and palliative medicine services need a revised approach to training the physician of the future in order to meet these complex needs in both acute and community settings.

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

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

This model will enhance the training of Palliative Medicine physicians, by enabling the management of the acutely unwell patient with an increased focus on chronic disease management, comorbidity and complexity. For Palliative Medicine doctors, there will be a significant focus on identifying reversibility (or lack of) in acutely unwell patients with life-limiting conditions and in promoting safe management in non-acute settings, e.g. community and hospice. Enhanced IM skills will better equip Palliative Medicine physicians to work as members of the wider multidisciplinary teams enabling patients to remain in their usual place of residence or working alongside physicians in the acute hospital to most

effectively manage patients with complex palliative care needs and those approaching the end of their lives wherever this is based.

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

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

2. Purpose

2.1 Purpose of the curriculum

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

The model for Palliative Medicine training will:

- Build on the knowledge, skills and attitudes acquired during stage 1 IM training and ensure that Palliative Medicine doctors develop and demonstrate a range of essential capabilities for managing patients with a range of life-limiting, progressive conditions.
- Ensure trainee physicians can provide safe, high quality, holistic palliative care in all settings (including acute hospital, ambulatory, community, care home and hospice / specialist palliative care unit) during and on completion of their postgraduate training.
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including advanced communication skills.
- Ensure that Palliative Medicine doctors are capable of providing and enabling palliative care for those in harder to reach community settings such as psychiatric units, hostels and prisons.
- Allow flexibility between specialties through GPCs and higher-level learning outcomes.
- Further develop the attributes of professionalism, particularly recognition of the primacy of patient welfare that is required for safe and effective care of those with life-limiting, progressive conditions, and develop physicians who ensure patients' views are central to all decision making, which needs to be robust, individualised and incorporates a thorough understanding of medical ethics.

- Ensure that Palliative Medicine physicians have advanced communication skills to manage complex and challenging situations with patient, carers and colleagues.
- Provide the opportunity to further develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team to enable them to make independent clinical decisions on completion of training.
- Ensure the flexibility to allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities.

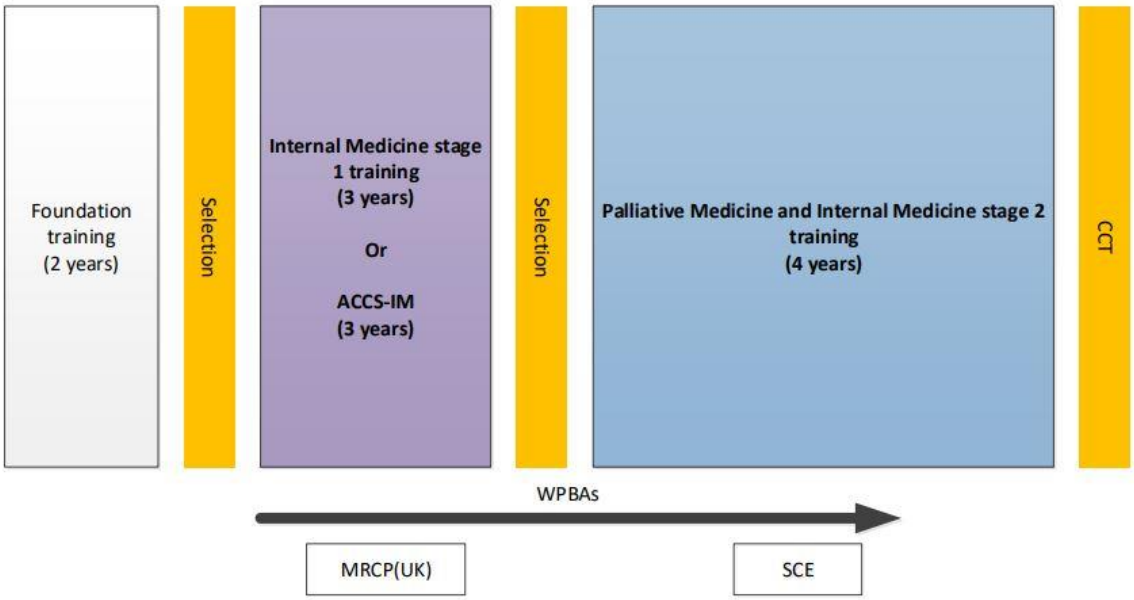
This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

2.2 High level learning outcomes – capabilities in practice (CiPs)

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement 4. Is focussed on patient safety and delivers effective quality improvement in patient care 5. Carrying out research and managing data appropriately 6. Acting as a clinical teacher and clinical supervisor
Clinical CiPs (Internal Medicine)
1. Managing an acute unselected take 2. Managing the acute care of patients within a medical specialty service 3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment 4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions 5. Managing medical problems in patients in other specialties and special cases 6. Managing a multi-disciplinary team including effective discharge planning 7. Delivering effective resuscitation and managing the acutely deteriorating patient 8. Managing end of life and applying palliative care skills
Specialty CiPs
1. Managing patients with life limiting conditions across all care settings 2. Ability to manage complex pain in people with life limiting conditions across all care settings

3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings
4. Ability to demonstrate effective advanced communication skills with patients with life-limiting conditions, those close to them and colleagues across all care settings
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings
6. Manages delivery of holistic psychosocial care in patients with life-limiting conditions and those close to them, including religious, cultural and spiritual care across all care settings
7. Demonstrates the ability to lead a palliative care service in any setting, including those in the third sector

2.3 Training pathway



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

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

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

There are no notable exclusions to the scope of practice.

2.4 Duration of training

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

There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[1].

2.5 Flexibility and accreditation of transferrable capabilities

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. In addition, the generic CiPs will be shared across all physicianly curricula and the IM clinical CiPs will be shared across all group 1 specialities, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training. The curriculum supports the accreditation of transferrable competencies (using the Academy framework).

[1] A Reference Guide for Postgraduate Specialty Training in the UK

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

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

2.6 Less than full time training

Trainees are entitled to opt for less than full time training programmes. Less than full time 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.

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 in accordance with the Gold Guide.

2.7 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework[2] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

[2] Generic professional capabilities framework

The nine domains of the GMC's Generic Professional Capabilities

Good medical practice (GMP)[3] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

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

The nine domains and subsections of the GPC framework are directly identifiable in the IM curriculum. They are mapped to each of the generic and clinical CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

[3] Good Medical Practice

3 Content of Learning

The curriculum is spiral and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from needing direct supervision to be entrusted to act unsupervised.

3.1 Capabilities in practice

CiPs describe the professional tasks or work within the scope of the specialty and internal medicine. CiPs are based on the concept of entrustable professional activities[4], which use the professional judgement of appropriately trained, expert assessors as a defensible way of forming global judgements of professional performance.

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

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

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standards of professional conduct).

This section of the curriculum details the six generic CiPs, eight clinical CiPs for internal medicine (stage 2) and seven of specialty CiPs for Palliative Medicine. The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are given for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

[4] Nuts and bolts of entrustable professional activities

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	MCR	Multiple consultant report
Mini-CEX	Mini-clinical evaluation exercise	PS	Patient survey
MSF	Multi source feedback	TO	Teaching observation
QIPAT	Quality improvement project assessment tool		

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements • Aware of public health issues including population health, social detriments of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching

	• Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for operational structures within the NHS Aware of the need to use resources wisely
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings

	• Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (eg cognitive impairment, speech and hearing problems, capacity issues) • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations • Shares decision making with children and young people • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF PS End of placement reports ES report
Category 3: Safety and quality	
4. Is focussed on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills

	• practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	
5. Carrying out research and managing data appropriately	
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship

Evidence to inform decision	MCR MSF GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO Relevant training course End of placement reports

3.3 Clinical capabilities in practice

The eight IM clinical CiPs describe the clinical tasks or activities which are essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Clinical CiPs – Internal Medicine	
1. Managing an acute unselected take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences

	• Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Recognises need to liaise with specialty services and refers where appropriate
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
2. Managing the acute care of patients within a medical specialty service	
Descriptors	• Able to manage patients who have been referred acutely to a specialised medical service as opposed to the acute unselected take (eg cardiology and respiratory medicine acute admissions) • Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations

	• Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Demonstrates appropriate continuing management of acute medical illness in a medical specialty setting • Refers patients appropriately to other specialties as required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues

	• Demonstrates appropriate continuing management of acute medical illness inpatients admitted to hospital on an acute unselected take or selected take • Recognises need to liaise with specialty services and refers where appropriate • Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF ACAT Mini-CEX DOPS
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills

	• practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and team-working
Evidence to inform decision	MCR ACAT mini-CEX PS Letters generated at outpatient clinics
5. Managing medical problems in patients in other specialties and special cases	
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties • Demonstrates appropriate and timely liaison with other medical specialty services when required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR ACAT CbD
6. Managing a multi-disciplinary team including effective discharge planning	
Descriptors	• Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover

	• Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan • Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF ACAT Discharge summaries
7. Delivering effective resuscitation and managing the acutely deteriorating patient	
Descriptors	• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious • Demonstrates the professional requirements and legal processes associated with consent for resuscitation • Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families • Demonstrates competence in carrying out resuscitation
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement

	Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR DOPS ACAT MSF ALS certificate Logbook of cases Reflection Simulation training with assessment
8. Managing end of life and applying palliative care skills	
Descriptors	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life • Demonstrates safe and effective use of syringe pumps in the palliative care population • Able to manage non-complex symptom control including pain • Facilitates referrals to specialist palliative care across all settings • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR CbD Mini-CEX MSF Regional teaching Reflection

3.4 Specialty capabilities in practice

The specialty CiPs describe the clinical tasks or activities which are essential to the practice of Palliative Medicine. The CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

KEY

ACAT	Acute care assessment tool	**DOPS**	Direct observation of procedural skills
CbD	Case-based discussion	**SCE**	Specialty Certificate Examination (Knowledge based assessment)
GCP	Good Clinical Practice	**MCR**	Multiple consultant report
Mini-CEX	Mini-clinical evaluation exercise	**PS**	Patient survey
MSF	Multi source feedback	**TO**	Teaching observation
QIPAT	Quality improvement project assessment tool	**LEADER**	Clinical leadership development tool

Specialty CiPs: Palliative Medicine	
1. Managing patients with life limiting conditions across all care settings	

Descriptors	• Demonstrates ability to:
	  ○ Undertake a holistic palliative care assessment; and to formulate, prioritise, communicate and implement an effective palliative care plan
	  ○ Manage a caseload of patients with complex palliative care problems across a range of care settings and promote coordinated care, in and out of hours
	  ○ Understand the impact of multi-morbidity, advanced ageing and frailty in people with life-limiting conditions
	• Effective management of medical emergencies across all palliative care settings, including determining when intervention is inappropriate and how to manage this in the patient's usual residence if appropriate
	• Ability to support patients and those close to them to identify meaning in their lives, enhance well-being and where appropriate, support people to focus towards realistic hope and goals
	• Understanding of and application of the ethical and legal frameworks of decision-making in teenagers and young adults
	• Awareness of the specific needs of those in hard to reach or marginalised groups that traditionally struggle to access palliative care services

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills Domain 3: Professional knowledge • National legislative requirements • The health service and healthcare systems in the four UK countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement
Evidence to inform decision	SCE CbD mini-CEX DOPS Reflective practice MCR ES report Range of clinical activity reviewed and/or description of range of experience in different settings (e.g. out of hours work; range of hospital, community and palliative care inpatient experience)
2. Ability to manage complex pain in people with life-limiting conditions across all care settings	
Descriptors	• Up-to-date knowledge, understanding and skills to assess and manage complex pain secondary to life-limiting progressive disease, taking into account patient preferences and reversibility • Knowledge of the pathophysiology of pain to inform pain assessment and management • Application of evidence-based knowledge and skill in the effective use of non-pharmacological management, opioid & non-opioid analgesics to manage complex pain, including safe prescribing in patients with organ failure, frailty and low body weight or who are in the last hours or days of life • Knowledge of managing pain whilst minimising longer term adverse effects in those with progressive disease but longer prognoses • Appropriate knowledge of interventional pain techniques to effectively manage complex pain that is not responding to conventional treatments • Ability to refer to and share care with other pain services • Ability to safely manage pain in the context of drug misuse and dependence

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills Domain 3: Professional knowledge Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 9: Capabilities in research and scholarship
Evidence to inform decision	SCE CbD mini-CEX DOPs Reflective practice MCR ES report Review of clinical activity, e.g. community and interventional pain experience
3. Demonstrates the ability to manage complex symptoms secondary to life-limiting conditions across all care settings	
Descriptors	• Advanced skills in the identification and assessment of physical, psychological and psychiatric symptoms in patients with progressive life-limiting illnesses and ability to formulate clear, individualised management plans taking into account patient preferences and reversibility • Advanced understanding of the pathophysiology of symptoms to inform assessment and management • Application of evidence-based knowledge and skill to manage physical symptoms in life-limiting illness across a range of systems, e.g. respiratory, cardiac, gastrointestinal, genitourinary, neurological, psychiatric, musculoskeletal and dermatological • Application of appropriate knowledge and skill in managing mental health/psychiatric issues in patients with life limiting conditions, including awareness of when to refer to specialist mental health services • Ability to effectively use non-pharmacological interventions for symptoms to treat patients with life-limiting progressive disease • Detailed understanding of pharmacology and therapeutics of drugs used for managing physical and psychiatric symptoms, including safe prescribing in patients with organ failure, frailty and low body weight or who are actively dying

	• Appropriate knowledge of the use of drugs outside their product license and the legislation relevant to safe prescribing in NHS and third sector organisations
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills Domain 3: Professional knowledge Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 9: Capabilities in research and scholarship
Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR ES report Review of clinical activity, e.g. community experience
4. Ability to demonstrate effective advanced communication skills with patients with life-limiting conditions, those close to them and colleagues across all care settings	

Descriptors	• Demonstration of advanced communication skills, including ability to consult, negotiate and involve patients and those close to them in their care
	• Demonstrates ability to
	  ○ focus on the positive goals for patients and their families, to make the most of time remaining
	  ○ manage complex and challenging situations with patients, those close to them and colleagues
	  ○ facilitate effective communication of complex issues and information as patients transfer across settings
	  ○ identify obstacles to communication and skills in overcoming these
	• Ability to enhance communication across organisations and care settings, to support the multi-professional team managing people with life-limiting illness, including supporting the development of multi-professional colleagues' skills in effective and sensitive communication through integrated care, expert communication and education

	• Awareness of advantages of using technology to aid clinical assessment and communication in the palliative care population, e.g. telemedicine, virtual clinics and remote consultations, remote teaching and peer support • Awareness of opportunities and limitations for people in creating and managing digital legacies via social media platforms • Ability to advocate for vulnerable patients with life-limiting conditions and those close to them and to navigate ethical and legally challenging situations, such as end of life decision making • Ability to provide an expert opinion for other specialties on complex ethical or legal issues relevant to palliative care, including communicating decisions effectively; managing professional and family meetings; using expert communication as a form of treatment/intervention • Demonstrates an awareness of the skills needed to communicate with teenagers and young adults and to support development of self-determination/emerging autonomy in the context of the family unit when transitioning from paediatric to adult services, within often well-established patterns of communication
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	Mini CEX CbD MSF Reflective practice MCR ES report Simulation training Patient survey Evidence of advanced communication skills training (as agreed by local training programme)
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings	

Descriptors	• Ability to recognise (and support other clinicians to recognise) dying, including an understanding of clinical uncertainty and limited reversibility in people with progressive life-limiting conditions • Safe implementation of anticipatory care for patients who are approaching the last days of life, including prescribing, advance care planning, escalation plans and establishing priorities for care • Ability to proactively support other professionals in developing effective management strategies and plans for caring for dying patients • Ability to coordinate palliative care and support teams caring for those with specific needs such as learning disability or complex mental health needs • Safe and effective use of medication in the dying phase to manage common and complex symptoms • Ability to judge the appropriateness of interventions in dying patients • Awareness of the role environment plays in caring for the dying patient and ability to adapt accordingly e.g. hospital, own home, hospice/inpatient unit, care home or other community setting/place of residence or secure settings such as prison • Ability to identify and manage distress at the end of life in patients (and those close to them) and colleagues • Demonstrates detailed understanding and application of the ethical and legal frameworks and legislation supporting decision making at the end of life, including mental capacity legislation and the national medical examiner scheme (England and Wales) • Development of expert skills in ethical reasoning and decision-making in end-of-life care • Awareness of dying as a social process; appreciates and facilitates the role of a wider social network and non-professional support at this time and understands the positive impacts of health-promotion and community engagement in end of life care
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training

Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR LEADER ES report Review of clinical activity patient log, e.g. community experience
6. Manages delivery of holistic psychosocial care of patients and those close to them, including loss and grief; and religious, cultural and spiritual care across all care settings	
Descriptors	• Ability to identify, assess and manage complex psychosocial issues affecting patients and those close to them and healthcare professionals in the context of life-limiting disease • Ability to utilise the multi-professional team, across care settings and between services, to provide customised patient-centred care for patients with complex psychosocial issues • User of appropriate knowledge and skill to support patients and those close to them in dealing with distress, loss and grief, including support for those at risk of prolonged or abnormal bereavement and the needs of children (including siblings) at different developmental stages, teenagers and young adults • Awareness of the range of psychological interventions that can be used to support patients and those close to them • Awareness of the positive and negative impacts of caring on those close to patients with life-limiting illness, including ability to work, life-style changes and managing concurrent physical and mental illness • Awareness of need for people and those close to them to maintain social participation and support networks; to support informal carers in both the positive and enriching and challenging aspects of care giving; and of the potential for empowered, supportive informal networks to improve outcomes • Knowledge of the responses and needs of children or adults with learning difficulties • Knowledge of and skills in recognising and managing mental illness in patients with life limiting conditions, including the ability to differentiate between appropriate sadness and depression • Ability to recognise and manage agitated, violent and/or suicidal patients and/or those close to them, including liaison with

	psychological/psychiatric services and use of appropriate legal frameworks • Awareness of rehabilitation approaches to maximise physical and social functioning in the context of advanced life-limiting illness • Knowledge of financial and welfare benefits available • Awareness of and ability to work alongside the community and social resources available to support vulnerable people, e.g. those that are homeless, in custody, without recourse to public funds, or those with learning or physical disability • Knowledge and skills to elicit spiritual concerns and to recognise and respond to spiritual distress; and respects differing spiritual beliefs and practices • Understanding of the impact of culture, ethnicity and sexuality in response to life-limiting conditions and at the end of life, including an awareness that this may affect equity of access to services
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	SCE CbD mini-CEX MSF Reflective practice MCR ES report Summary of clinical activity, e.g. community experience
7. Demonstrates the ability to lead a palliative care service in any setting, including the third sector	
Descriptors	• Demonstrates ability to synthesise complex clinical and psychosocial information leading to patient-centred decision-making in all settings • Ability to provide an expert opinion in situations where there is clinical uncertainty or conflict with patients and/or those close to them

	• Ability to coordinate care across settings in collaboration with hospital and community providers to optimise patient centred care and use of resources • Ability to collate information from all members of the multidisciplinary team and, if necessary, appropriately challenge other senior healthcare professionals in multi-professional discussions to support decision making across all care settings • Demonstrates ability to support, educate, influence and develop members of the wider multi-professional team to deliver high quality palliative care across all care settings • Engagement with palliative care research, audit and quality improvement to inform service development and evaluation across settings • Awareness of understanding population needs, including remote or rural communities, when developing and delivering palliative care services • Understanding of the principles of financial management of palliative care services in the NHS and third sector • Understanding of the management of pharmacy budgets and regulatory aspects of controlled drugs, particularly in third sector organisations • Effective leadership, negotiation and management skills, including involvement in strategy and management of palliative care services across care settings in the NHS and third sector, including engagement with commissioners, multi-protection care networks and the broader health economy • Understanding of the structures that support effective leadership and management in NHS and third sector organisations, including the role of volunteers, fundraising teams and trustees • Awareness of the range of strategies that could be utilised to deliver sustainable healthcare services across all settings, including third sector
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge • National legislative requirements • The health service and healthcare systems in the four countries

	Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working
Evidence to inform decision	SCE CbD mini-CEX MSF Reflective practice MCR ES report Management course LEADER Quality improvement project/research experience Review of clinical activity patient log, e.g. community or out of hours experience Reflections on incidents and complaints

3.5 Presentations and conditions

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

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

In developing appropriate management plans, trainees must develop skills to help identify what is most important to patients and their families and to recommend interventions (both

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

The table below outlines the range of presentations and clinical issues managed by Palliative Medicine doctors. Knowledge of these conditions is essential to the practice of Palliative Medicine. The presentations outlined in the table provide the clinical context in which trainees should be able to demonstrate the CiPs and GPCs. In this spiral curriculum, trainees will expand and develop their knowledge, skills and attitudes around managing the range of patients with life-limiting conditions across all care settings. The patient should always be at the centre of knowledge, learning and care and have access to palliative care expertise in all settings. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Range of presentations/disease processes/clinical issues	**Examples of areas to be explored**
Cancer	• Understanding of the presentation and current management of all major malignancies • Clinical management of common complications of cancer (including paraneoplastic syndromes) and cancer treatments • Management of the symptoms caused by complications of cancer (including paraneoplastic syndromes) and oncological treatments • Management of cancer emergencies • Interface with acute oncology and supportive care • Range of patient presentation and palliative care need in all settings, including cancer centre and cancer unit
Organ failure	Palliative management of people with cardiac failure, renal failure, liver failure, chronic respiratory disease; including the interface between primary, secondary and tertiary care and importance of advance care planning
Progressive neurological conditions	Including stroke, MND, Parkinson's disease, multiple sclerosis
Dementia	Including interface with care of the elderly, old age psychiatry and primary care

Range of presentations/disease processes/clinical issues	Examples of areas to be explored
Frailty and multi-morbidity	Including cross-specialty working and management of complexity across all care settings • Relationship between frailty and ageing • Recognition of frailty to inform care planning • Interface with multi-morbidity • Impact of frailty on function, care provision and prognostication • Awareness of multidisciplinary approaches to care and management
Other potentially life-limiting conditions	Including HIV, progressive auto-immune and inflammatory conditions
Life-limiting illnesses in Teenagers and Young Adults (TYA)[5]	• Awareness of the range of life-limiting illnesses in teenagers and young adults, such as Duchenne Muscular Dystrophy, Cystic Fibrosis, malignancies affecting the teenage and young adult population, neuro-disability; including the needs of young people moving from paediatric to adult palliative care services • Awareness of services offered and models of care delivered by paediatric palliative care services across all settings • Awareness of specific needs of TYA group and ability to access specialist help and support • Awareness of the complexity of prognostication in these patients • Awareness of ethical and legal frameworks for decision-making in this population, supporting the navigation of patients and those close to them through the spectrum of childhood, Gillick competence and the application of mental capacity legislation in adults, taking into account the family unit and often well-established patterns of communication and behaviour

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

Range of presentations/disease processes/clinical issues	Examples of areas to be explored
Survivorship and Supportive Care	Understand the principles of supportive care and the interface between oncology, rehabilitation and other supportive care services Awareness of the evolving need for palliative care over the course of life-limiting illness, including • Integration with active treatment • Significance of transition points • Interface with rehabilitation • Ability to manage patients at all stages of a disease trajectory (from curative treatment to end of life care) • Ability to work with primary care and other specialists
Management of the dying patient	• Development of advanced skills in the identification and management of patients that are dying and their families – both to manage complex dying and to support primary and secondary care teams in the management of non-complex dying • Awareness of societal expectations and perceptions in progressive and advanced disease and death, including an awareness of what constitutes quality of life and a "good death" • Ability to support patients, those close to them and colleagues in normalising death as an outcome, to recognise the possibility of death and plan proactively • Awareness of context in which palliative medicine is practiced, including impact of demographic changes in society; role of community networks in supporting patients and those close to them; opportunities for health promotion; awareness of societal views and law relating to physician assisted suicide and euthanasia

Range of presentations/disease processes/clinical issues	Examples of areas to be explored
Management of concurrent clinical problems in people with life-limiting conditions	• Management of multi-morbidity and acute exacerbations of long-term conditions • Safe management of specific conditions at the end of life, e.g. diabetes, epilepsy/seizures, cognitive impairment, gastro-intestinal failure • Management of psychiatric conditions • Management of psychological and spiritual distress
Management of the complex, acutely unwell, unstable patient across all palliative care settings, including hospice and community and including anticipatory planning for emergency situations	• Identification and management of acute oncology emergencies, e.g. MSCC, SVCO, neutropenic sepsis, tracheal obstruction, bowel obstruction and hypercalcaemia • Identification and management of non-oncological emergencies, e.g. anaphylaxis, severe sepsis, pulmonary embolism, acute pulmonary oedema, seizures, ACS, stroke, hyperglycaemia, hypoglycaemia, hyponatraemia, major haemorrhage and cardiac tamponade • Ability to assess the complex, unstable, acutely unwell patient to determine reversibility, patient preferences and feasibility of appropriate individualised treatment escalation plans, to enable people to be managed in the most appropriate setting, including community and usual place of care • Ability to work across the acute/community interface (e.g. ED, AMU, ambulatory units, community liaison, care homes) to support the management of palliative care patients in the most appropriate setting and support admission avoidance where appropriate • Ability to deliver integrated care for people across all care settings • Ability to share appropriate information across services, including use of electronic record systems, electronic care coordination systems and practice registers

Range of presentations/disease processes/clinical issues	Examples of areas to be explored
Advance care planning in people with life-limiting illness	• Demonstrates ability to identify patient preferences at the end of life, in conjunction with those close to them, to support achievement of realistic goals • Demonstrates ability to sensitively discuss issues around preferred place of care and death, including ability to facilitate a rapid discharge/transfer to a person's preferred place of care • Demonstrates ability to liaise with primary care, social services, palliative care, third sector and NHS-funded care providers when facilitating complex discharges for patients at the end of life • Support people to develop flexible, person-centred advance care plans, based on the needs of individual patients and their care setting
Loss, grief and bereavement	• Awareness of bereavement theories including the process of grieving, adjustment to loss and the social model of grief in adults and children • Ability to support and empower individuals facing loss and to support the acutely grieving person and/or those close to them, including the ability to anticipate and/or recognise abnormal grief and access specialist help • Awareness of factors associated with prolonged or abnormal grief e.g. multiple losses, those in disenfranchised positions or complex family structures • Awareness of interface with religion, spiritual care and cultural influences on loss and grief • Awareness of the range of services and social support available to support the bereaved and the role of communities in resolving grief • Awareness of the opportunities for positive outcomes from bereavement through community engagement
Public health and health promotion in end of life care	• Understanding of the context in which Palliative Medicine is practiced, recognising the benefits of the biomedical approach of harm reduction

Range of presentations/disease processes/clinical issues	Examples of areas to be explored
	and the opportunities of health and well-being promotion, e.g. making every contact count • Understanding of the concepts of health and well-being promotion at the end of life to improve access and experience of outcomes, including the positive aspects of caring and support at the end of life • Awareness of the role of community engagement and development of new models and systems to improve health and well-being for patients with life-limiting conditions and those close to them • Awareness of the range of community engagement initiatives nationally, including compassionate communities and how these interface with formal services • Awareness of the role of palliative care services in promoting and supporting community engagement, including: (i) working in partnership with communities; (ii) understanding local needs and resources and (iii) meeting these needs through a combination of professional and community support • Awareness of the specific needs of those with life-limiting illness in hard to reach groups, e.g. the homeless, prisoners, traveller communities, people with learning disabilities and mental health issues, teenagers and young adults
Self-care and resilience	• Demonstrates the ability to work with supportive networks of care as an essential component of palliative and end of life care • Recognises signs of stress and burnout in self and others and takes action to seek or offer support where appropriate • Develops effective strategies to support resilience and sustain career

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

As clinical leaders of the future, trainees also need to develop an awareness of the potential for broader community engagement, development and health promotion in end of life care, in which palliative care services have an important facilitatory role. There is evidence that community engagement initiatives improve a range of health and social care outcomes at the end of life. These include improving the relevance of services; development of knowledge, skills and capacity in communities; support for self-management and resilience in the face of death, dying and loss; reduced social isolation and its negative health consequences; reduced admissions to secondary care; improved outcomes for informal carers; and support for developing healthier attitudes to death, dying and loss[6] [7] [8]. Community initiatives such as compassionate communities and integrated care networks will be important in delivering sustainable services in the future and in addressing current inequalities in access to specialist palliative care services, which will become more marked as the potential need for palliative, supportive and end of life care increases in line with the predicted population changes.

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

3.6 Practical procedures

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

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

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

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

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

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

- Consultant-led hospice / palliative care inpatient units
- Palliative medicine outpatient clinics
- Palliative care day centres
- Within a patient's home when supported by community palliative care teams
- Hospital palliative care team

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

There are a number of procedural skills in which a trainee must become proficient.

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

simple tube / tracheostomy change			
Indwelling pleural/peritoneal catheter: identification of appropriate patients; day to day management and troubleshooting of complications, e.g. displacement, infection, blockage	Yes	Yes	1 x DOPS

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting help when appropriate. For all practical procedures, the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. The table below sets out the minimum competency level expected for each of the practical procedures.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Procedure	**ST4**	**ST5**	**ST6**	**ST7**
Syringe Pump set up	Direct supervision	Limited supervision	Limited supervision	Competent to set up independently
NIV management	Direct supervision			Competent in skills lab
Spinal line management	Direct supervision			Competent in skills lab
Tracheostomy care	Direct supervision			Competent in skills lab
Indwelling catheter (pleural/ascitic) management	Direct supervision	Limited supervision	Limited supervision	Competent to manage complications and advise patients re: management

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director (TPD) will be responsible for coordinating the specialty training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the Annual Review of Competency Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the ARCP decision aid (available on the JRCPTB website).

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 curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

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

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person. It will be best practice for trainees to have an educational supervisor who practises internal medicine for periods of IM stage 2 training. Educational supervisors of IM trainees who do not themselves practise IM must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' IM performance and include this in their educational reports.

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

- Training in a sequence of posts which provides experience of palliative medicine for patients with any diagnosis, in a full range of settings, including: patients' own homes, care homes (nursing and residential), day hospice, inpatient specialist palliative care units/hospice, and in acute and/or specialist hospitals. In order to develop the breadth of experience required to achieve the curriculum capabilities, it is recommended that a minimum indicative period of six months is spent in each of inpatient specialist palliative care unit/hospice, hospital and community, with local flexibility to how this is delivered
- Trainees must undertake the specialist palliative care training components of the curriculum through placements in services across a range of settings (inpatient, community and hospital), working with a full multi-professional specialist palliative care team as defined in the NICE Guidance on Supportive and Palliative Care (2004)

- The majority of trainees will benefit from starting their training in an inpatient unit to develop their core palliative medicine knowledge and skills, which are then transferrable when working in an advisory capacity in hospital or community settings
- The minimum indicative training times allow for significant flexibility within training to allow individuals to meet training requirements; training programme directors and ARCP panels will provide oversight to ensure that training is balanced across the programme

Inpatient specialist palliative care (IPU)

- A specialist palliative care unit is defined as a unit that is consultant-led, working with a multidisciplinary team that has the skills and training in specialist palliative care to manage and support the complex symptom, psychological and social needs of patients and families that cannot be managed in other settings.
- Blocks of training in an IPU are strongly recommended, however a flexible approach is needed, recognising that some placements will include concurrent experience in hospital or community
- Training in more than one IPU is recommended, to ensure experience across the training years and with a range of patient groups and service models
- Trainees will develop increasing capability to manage inpatients independently, both in and out of hours and over a consistent period as a senior trainee. They should be capable to manage certain acute and longstanding medical co-morbidities within the specialist inpatient setting but recognise when escalation to the acute sector may be necessary and appropriate
- Trainees will develop expert skills in patient-centred care, advance care planning, complex decision making and discharge planning, and the support of patients and families in crisis.
- Trainees will become aware of the pivotal role of the specialist in-patient unit as a point of access to expertise for primary and secondary care, delivering joined up and co-ordinated care for its local population
- Many IPU teams have a range of junior medical staff providing opportunities to support and supervise junior medical colleagues and physician associates, and work with specialty doctors, nursing colleagues, professions allied to medicine and therapists.
- Trainees will gain an understanding of IPU/hospice management, including the contribution of the third sector to NHS care; budget management and commissioning services; working with volunteers (including Trustees); involvement in governance and medicines management; and have the opportunity to be involved in service improvement.

Hospital Palliative Care

- Experience working with an advisory/liaison hospital specialist palliative care team in an acute and/or specialist hospital (this can include work within a specialist hospital inpatient unit, but not exclusively), ideally with experience of managing patients in and out of hours
- By completion of training, trainees will be expected to be confident to triage, prioritise and assess new referrals; give telephone advice to colleagues; provide continuity of care to patients on a team's caseload; support other members of the multiprofessional team in managing their caseloads through application of expert medical knowledge and skill;

liaise and negotiate safe and effective care plans with parent teams; and ensure the safe discharge of patients from hospital, including effective handover to community services

- Trainees need to be confident in a range of areas relating to hospital palliative medicine practice, including:
    - safely managing complex palliative care issues in hospital inpatients under the care of a parent team and in recognising the opportunities and limits of interventions in the acute setting
    - identification of those patients with more complex needs that would benefit from transfer to a specialist palliative care IPU
    - supporting parent clinical teams in recognising clinical uncertainty, including escalation and de-escalation of treatment/ interventions
    - supporting parent clinical teams in complex decision-making towards the end of life, including in intensive care, where there is conflict and where expert application of ethical and legal frameworks for people at the end of life is needed
    - managing patients in a consultative capacity in a hospital setting independently by the end of training

Community palliative care

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

Cancer and oncology training

- Exposure to a range of oncology experience during training. This may include:
    - Awareness of and ability to recognise the range of acute oncology presentations in all care settings
    - Ability to assess patients presenting with new metastatic cancer, including cancer of unknown primary, and to support clinical teams in investigation and management, based on patient preferences and performance status
    - Knowledge of the use of systemic anticancer therapies (including likely benefits and toxicities); participating in cancer site specialist multidisciplinary teams; working alongside acute oncology services
    - Knowledge of indications for radiotherapy, likely toxicity and outcome of palliative treatments
    - Awareness of the complications of radical treatments in order to support oncology teams in managing severe symptoms
- Experience of working in a cancer centre is highly recommended, as it is recognised that the complexity of patients managed in a tertiary setting will be different to those managed in other settings

Non-cancer training

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

Out of hours' palliative care

- Experience of working in all palliative care setting out of hours. By the end of training trainees need to:
    - Demonstrate the ability to undertake face to face assessments of new patient and those with new problems;
    - Formulate effective and safe management plans
    - Manage problems independently (as clinically appropriate) over the course of the on-call period. This should include safe mechanisms for handover and handback of patients, especially where trainees are covering several palliative care services on call.
    - Demonstrate the ability to provide telephone advice to healthcare professionals out of hours across hospital, specialist inpatient and community settings; Demonstrate ability to prioritise and effectively manage workload when working across multiple settings on call;
    - By the end of training be able to manage a caseload independently out of hours Experience of working alongside primary care and with other specialist clinicians, delivering shared care and undertaking joint assessments across all settings

Communication Skills

- Training in advanced communication skills (attendance at a locally-approved course, in addition to demonstration of expert communication via CiPs and workplace-based assessments, particularly MSF and the patient survey)

Other Requirements

- Training in teaching to enable trainees to develop their skills to independently enhance, facilitate and educate the wider multi-professional team in the delivery of palliative and end of life care across settings
- Training in management and leadership, including the core knowledge and skills required to lead palliative care services in the third sector
- Experience of joint working with chronic pain services (including observation of nerve blocking techniques and of the management of epidural and/or intrathecal catheters for cancer pain)
- Experience of working closely with other specialist services, including: care of the elderly; liaison psychiatry/psychology services; social services; chaplaincy services; pharmacy; rehabilitation services; primary care; discharge teams and bereavement services. This list is not exhaustive and it is recommended that specialist experience is integrated into palliative care placements.
- Exposure to paediatric palliative care and TYA services to support the care of patients transitioning from paediatric to adult services
- Experience of working with NHS and third sector providers within the training programme
- Awareness of the development of genomics and personalised medicine and potential impact on patients' care and treatment
- Development of strategies to support self-awareness/self-management, via reflection, feedback and the use of supervision, to enable trainees to develop the coping skills and resilience to sustain a career in the speciality
- Training in health-promotion and community engagement in end of life care to increase awareness of the possibilities to be realised through working in partnership with local communities

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus 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.

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

Reviewing patients with consultants
It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (which may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD). This may be accomplished when working alongside

a consultant in the hospital, specialist inpatient unit or community setting, or following out of hours work supervised by a consultant.

Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments
Every patient seen, on the ward, outpatients or community, provides a learning opportunity, which will be enhanced by following the patient 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 as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

Ward rounds by more senior doctors
Every time a trainee observes another doctor reviewing a patient, there is an opportunity for learning. Ward rounds should be led by a more senior doctor and include feedback on clinical and decision-making skills.

Multi-disciplinary team meetings
There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

Community and outpatient settings
Palliative Medicine trainees will undertake part of their training in the community. For the purposes of the curriculum, this includes outpatient clinics (see below); patient's own home; care homes; ambulatory units; primary care and day hospice. Trainees may undertake joint consultations with another doctor or nurse specialist but are also expected to become proficient in independent assessment. By the end of training, trainees will have developed the skills to assess and manage patients both with colleagues and independently and have gained a comprehensive understanding of the range of community services available.

Outpatient clinics (Palliative Medicine or other specialty clinics conducted either face to face or remotely via telephone or video consultation)
The educational objectives of attending clinics are:

- To understand the management of chronic diseases and/or assess patient's palliative care needs in an outpatient setting.
- Be able to assess a patient in a defined time-frame.
- To interpret and act on the referral to clinic/service.
- To propose an investigation (as appropriate) and management plan in a setting different from the acute medical situation.
- To review and amend existing plans.
- To write an acceptable letter back to the referrer and patient.
- To communicate effectively with the patient and those close to them and other health care professionals.

These objectives can be achieved in a variety of settings including hospitals, day care/ambulatory facilities and the community. The clinic might be primarily run by a specialist nurse (or other qualified health care professionals) rather than a consultant physician. After initial induction, trainees will review patients under direct supervision. The

degree of responsibility taken by the trainee will increase as competency increases. Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Trainees have supervised responsibility for the care of inpatients or community patients if they hold a caseload. 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 competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

Formal postgraduate teaching
The content of these sessions is 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 (face to face or via remote platforms) to cohorts of trainees (e.g. a weekly training hour for IM teaching within a training site)
- case presentations
- research, audit and quality improvement projects
- lectures and small group teaching
- Grand Rounds
- clinical skills demonstrations and teaching
- critical appraisal and 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.

Learning with peers - There are many opportunities for trainees to learn with their peers across the multi-disciplinary team as well as other specialties. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions.

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 such as e-Learning for Healthcare (e-LfH)

- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals
- 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 and leadership courses and communication courses, which are particularly relevant to patient safety and experience.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the local deanery for further guidance.

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months “acting-up” as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of “acting up” and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:

- assess trainees' actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand 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
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme
- inform the 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 changes of career direction.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. A range of assessments are needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (e.g. through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgement in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees continually to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. 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.

Reflection and feedback should be an integral component to all SLEs and WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

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

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

Global assessment anchor statements

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

Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the eportfolio with signposting to the evidence to support their rating.

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

For **generic CiPs**, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for

the stage of training as a minimum to be judged satisfactory to progress to the next training year.

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

Level descriptors for clinical and specialty CiPs

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

The ARCP will be informed by the ES report and the evidence presented in the eportfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

5.4 Critical progression points

There will be a key progression point on completion of specialty training. Trainees will be required to be entrusted at level 4 in all CiPs in order to achieve an ARCP outcome 6 and be recommended for a CCT.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grids below set out the expected level of supervision and entrustment for the IM clinical CiPs and the specialty CiPs and include the critical progression points across the whole training programme.

Table 1: Outline grid of levels expected for Internal Medicine clinical capabilities in practice (CiPs)

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

	Internal Medicine stage 2 + specialty training				CCT
Specialty CiP	**ST4**	**ST5**	**ST6**	**ST7**	**CRITICAL PROGRESSION POINT**
1. Managing an acute unselected take	**3**	**3**	**3**	**4**	
2. Managing the acute care of patients within a medical specialty service	**2**	**3**	**3**	**4**	
3. Providing continuity of care to medical inpatients	**3**	**3**	**3**	**4**	
4. Managing outpatients with long term conditions	**3**	**3**	**3**	**4**	
5. Managing medical problems in patients in other specialties and special cases	**3**	**3**	**3**	**4**	
6. Managing an MDT including discharge planning	**3**	**3**	**3**	**4**	
7. Delivering effective resuscitation and managing the deteriorating patient	**4**	**4**	**4**	**4**	
8. Managing end of life and applying palliative care skills	**3**	**3**	**3**	**4**	

Table 2: Outline grid of levels expected for Palliative Medicine specialty capabilities in practice (CiPs)

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

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

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

5.5 Evidence of progress

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

Summative assessment

Examinations and certificates

- Palliative Medicine Specialty Certificate Examination (SCE)

The Specialty Certificate Examination has been developed by the Federation of Royal Colleges of Physicians in conjunction with the specialist society. The examination tests the extra knowledge base that trainees have acquired since taking the MRCP(UK) diploma. The knowledge base itself must be associated with adequate use of such knowledge and passing this examination must be combined with satisfactory progress in workplace based assessments for the trainee to successfully reach the end of training and be awarded the CCT in add specialty. Information is available on the MRCPUK website.

Workplace-based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Clinical Leadership Development (LEADER)

WPBA

- Direct Observation of Procedural Skills (DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the eportfolio and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's eportfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Acute Care Assessment Tool (ACAT)
The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. It is primarily for assessment of their ability to prioritise, to work efficiently, to work with and lead a team, and to interact effectively with nursing and other colleagues. It can also be used for assessment and feedback in relation to care of individual patients. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT.

Case-based Discussion (CbD)
The CbD assesses the performance of a trainee in their 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 focus on a written record (such as written case notes, out-patient letter, and discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

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 evaluate 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. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source 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 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, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Clinical Leadership Development (LEADER)
The LEADER is an assessment that has been in use by the Royal College of Paediatrics, to

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

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

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

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

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical and specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training. The requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's eportfolio.

There should be review of the trainee's progress to identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes for completion training approximately 12-18 months before CCT. This should include an external assessor from outside the training programme.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid, which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

Poor performance should be managed in line with the Gold Guide.

5.7 Assessment blueprint

The tables below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY

ACAT	Acute care assessment tool	**CbD**	Case-based discussion

DOPS	Direct observation of procedural skills	**Mini-CEX**	Mini-clinical evaluation exercise
MCR	Multiple consultant report	**MSF**	Multi source feedback
PS	Patient survey	**QIPAT**	Quality improvement project assessment tool
TO	Teaching observation	**LEADER**	Clinical leadership development

Blueprint for WPBAs mapped to CiPs

Learning outcomes	**ACAT**	**CbD**	**DOPS**	**MCR**	**Mini -CEX**	**MSF**	**PS**	**QIPAT**	**TO**	**LEADER**
Generic CiPs										
Able to function successfully within NHS organisational and management systems				√		√				
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√				
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement				√		√	√			
Is focussed on patient safety and delivers effective quality improvement in patient care				√		√		√		
Carrying out research and managing data appropriately				√		√				
Acting as a clinical teacher and clinical supervisor				√		√			√	
Clinical CiPs										
Managing an acute unselected take	√	√		√		√				
Managing an acute specialty-related take	√	√		√		√				
Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	√		√	√	√	√				
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions	√			√	√		√			
Managing medical problems in patients in other specialties and special cases	√	√		√						
Managing a multi-disciplinary team including effective discharge planning	√			√		√				
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√				
Managing end of life and applying palliative care skills		√		√	√	√				
Practical procedural skills			√							

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	LEADER
Palliative Medicine Specialty CiPs										
Managing patients with life limiting conditions across all care settings	√	√	√	√	√		√			√
Ability to manage complex pain in people with life limiting conditions across all care settings		√			√					
Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings		√			√					
Ability to demonstrate effective advanced communication skills with patients, those close to them and colleagues across all care settings		√		√		√	√			
Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings		√		√	√		√			√
Manages delivery of holistic psychosocial care including religious, cultural and spiritual care across all care settings		√			√		√			
Demonstrates the ability to lead a palliative care service in any setting, including those in the third sector								√		√

Blueprint for knowledge based assessment (SCE)

Learning outcomes	SCE/KBA/ Diploma
Specialty CiPs	
1. Managing patients with life limiting conditions across all care settings o Concurrent clinical problems o Management of emergencies o Rehabilitation and public health/health promotion o Cancer and supportive care o Range of non-cancer life-limiting conditions o Ethics and law	SCE
2. Ability to manage complex pain in people with life limiting conditions across all care settings	SCE
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings o Clinical problems/symptom related to life limiting disease o Pharmacology and therapeutics	SCE

Learning outcomes	SCE/KBA/ Diploma
4. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings	SCE
5. Manages delivery of holistic psychosocial care including religious, cultural and spiritual care across all care settings	SCE
6. Demonstrates the ability to lead a palliative care service in any setting, including those in the third sector	SCE

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[9].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

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 discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in

[9] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[10].

Educational supervisor
The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements. Trainees on a dual training program may have a single educational supervisor responsible for their internal medicine and specialty training, or they may have two educational supervisors, one responsible for internal medicine and one for specialty.

Clinical supervisor
Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). 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.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[11]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

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.

[10] Promoting excellence: standards for medical education and training
[11] Recognition and approval of trainers

Trainees
Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

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.

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 not mandatory (particularly 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. If there are significant concerns following the end of attachment appraisal then the programme director should be informed. Supervisors should also identify areas where a trainee has performed about the level expected and highlight successes.

7 Quality Management

The organisation of training programs is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into the specialty
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace-based assessment may be delivered by deaneries or by the colleges, or both.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB and the SAC. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The JRCPTB has a role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. The SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its specialties and subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, examination outcomes, new consultant survey, external advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. 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 an eportfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the eportfolio

On enrolling with JRCPTB trainees will be given access to the eportfolio. 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 trainee's 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 supervisor's 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.

Deaneries, training programme directors, college tutors and ARCP panels may use the eportfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous eportfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the eportfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the eportfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other eportfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-

assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

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.

Deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

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
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years
- Deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every three years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries 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. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- monitoring of College Examinations

- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.

JRCPTB

Joint Royal Colleges of Physicians Training Board

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