Palliative Medicine London/KSS Dual Trainee Handbook: 2022 curriculum

Updated: June 2024

Contents

About this handbook

This handbook has been created by London/KSS Palliative Medicine trainees currently completing training under the new 2022 curriculum. The handbook aims to provide helpful tips, as well as summarise formal guidance, for London/KSS Palliative Medicine dual trainees. It has been ratified by the London Training Programme Directors, Internal Medicine lead, lead employer, and Palliative Medicine Trainees Committee. The handbook will be reviewed at least annually.

Key contacts and organisations

Sector leads/co-leads: sector leads should be contacted with queries before escalating to TPDs. Note the IM lead Dr Caulkin is happy to be copied in with queries related to IM or the 2022 curriculum.

NE/NC London:
Dr Lucy Bemand-Qureshi - lucy.bemand-qureshi@nhs.net
Barking, Havering and Redbridge University Hospitals NHS Trust

NW London:
Dr Aruni Wijeratne - Aruniwijeratne@pah.org.uk
Epsom & St Helier University Hospitals NHS Trust and Princess Alice Hospice
and
Dr Sam Lund - slund@royaltrinityhospice.london
Trinity Hospice

SW London: Dr Julia Fleming - julia.fleming2@nhs.net
St Catherine's Hospice

SE London: Dr Armita Jamali - armita.jamali@rmh.nhs.uk
The Royal Marsden NHS Foundation Trust
and
Dr Angela Halley - angela.halley@rmh.nhs.uk
The Royal Marsden NHS Foundation Trust

Training Programme Directors (TPDs):

NE/NC/NW: Dr Nick Gough - Nicholas.gough@nhs.net or Nicholas.gough@gstt.nhs.uk
Guy's and St Thomas' NHS Foundation Trust

SE/SW/KSS: Dr Catherine Gleeson - c.gleeson@nhs.net
St Catherine's Hospice
(Use hospice email for non-training matters cathygleeson@stch.org.uk)

IM Lead Palliative Medicine Specialty Training Committee, London & KSS:

Dr Ruth Caulkin - rcaulkin@nhs.net
Chelsea and Westminster NHS Foundation Trust

London Palliative Medicine Trainees Committee:

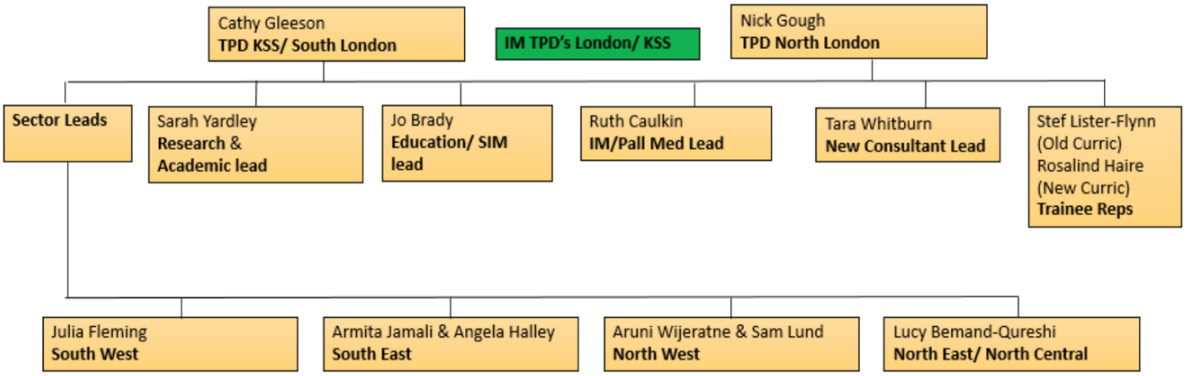
The committee is made up of registrar representatives from the four London/KSS sectors, two education/SIM representatives, a less than full-time training representative and currently two co-chairs. Roles are advertised based on vacancies and all registrars are invited to apply. The committee is mainly involved in the planning and organisation of mandatory and non-mandatory regional training days. It also maintains a bank of useful information for trainees, found on the committee's Googledrive.

Committee Co-Chairs: Dr Rosalind Hare and Dr Stephanie Lister-Flynn.

Contact: pallmedlondon@gmail.com

Specialist Training Committee (STC):

This is the London/KSS overarching committee responsible for specialist training, with representatives from NHS England, the Head of School and the lead employer also present.



Additional Information:

Joint Royal Colleges Physician Training Board (JRCPTB): Responsible for ePortfolio, out of programme experiences or research, flexible training, curriculum and workplace-based assessments. They charge a subscription, and it is compulsory to be a member.

Specialist Advisory Committee (SAC): National committee for specialist training.

Operations Officer for Palliative Medicine, Healthcare Education Team: Responsible for specialist training, Annual Review of Competence Progression (ARCP), penultimate year assessments, and completion of training review. Contact your trainee representative or sector lead if you are having problems with the above, and they can escalate to the palliative medicine contact within NHS England. Alternatively submit an enquiry via the PGMDE Support Portal.

Key resources

The following are useful webpages and documents, giving key information about the dual training requirements, found on the JRCPTB Specialties pages (full URLs given in case embedded hyperlinks used elsewhere don't work):

- Palliative Medicine: https://www.jrcptb.org.uk/specialties/palliative-medicine
  - Palliative Medicine ARCP decision aid 2022 curriculum
  - Palliative Medicine Rough Guide to Training (under Forms and guidance)
  - Palliative Medicine 2022 curriculum
- Internal Medicine: https://www.jrcptb.org.uk/internal-medicine
  - Internal Medicine Stage 2 ARCP decision aid for 2022
  - Internal Medicine (Stage 2) 2022 curriculum

About dual training

The introduction of a new dual curriculum took place in 2022. The aim is to ensure that future consultants have specialty-specific and generic skills to manage patients with acute medical conditions, complex life-limiting disease and multiple health conditions in all palliative care settings. Palliative Medicine higher specialty training will typically be completed in four years (ST4-ST7) of full-time training. Once completed, trainees will qualify in both Internal Medicine (IM) and Palliative Medicine. Prior to the 2022 curriculum, Palliative Medicine trainees did not complete specific IM training. The 2022 and the 2010 palliative medicine curricula are likely to both run in parallel for a number of years whilst trainees on the old curriculum finish training.

The training will be made up of discrete IM and Palliative Medicine placements, although it is accepted that experience and skills are transferable and relevant to both. In total, trainees will be required to complete nine to 12 months of IM across the four years of training with a requirement for a minimum of three months in the final year (or one immersion month of acute experience, with active involvement in the care of 100 patients in either iteration). The structure of this will depend on the arrangements agreed within a deanery. For London/KSS trainees, it is likely that IM will be completed in four-month blocks but this may vary for those training less than full-time, or other reasons. IM posts will be in a range of specialties including Acute Medicine, Geriatric Medicine, Stroke Medicine and Respiratory Medicine. During an IM block, Palliative Medicine trainees will be part of the medical registrar on-call rota and perform duties including running the acute medical take, leading medical emergency calls and participating in outpatient clinics.

In exceptional circumstances it may be possible to complete training in less than four years. JRCPTB has produced guidance on accelerated CCT and this should be discussed early with your educational supervisor and Training Programme Director (TPD) if you meet the requirements. You would need to demonstrate acquisition of the necessary competences in both IM and Palliative Medicine to be considered for an earlier CCT date.

Supervisors

You will have a Palliative Medicine educational supervisor (ES) and clinical supervisor (CS) every year of training. One consultant may fulfil both roles. For years with IM blocks you should ideally also have an IM ES, but occasionally this may not be possible. You will

always have an IM CS. The Palliative Medicine 2022 Rough Guide states trainees should have an induction meeting with their ES to plan the training year, and this should be formally recorded in the ePortfolio. If there is a separate CS there should also be an induction meeting with them. See Educational Supervisor Report section for requirements for end of year documentation from supervisors.

Placements

IM and Palliative Medicine training will take place across a variety of settings including acute hospital trusts, inpatient specialist palliative care units/hospices and patients' own homes. For London/KSS trainees, it is likely that you will be placed in the same acute hospital for at least two of your three IM placements. For Palliative Medicine, a minimum period of six months (full-time equivalent) is needed in each of: inpatient specialist palliative care unit/hospice, hospital palliative care team, and community palliative care. The six months experience in community specialist palliative medicine can be done as a continuous block or cumulative experience across placements, and includes outpatients, day hospice, domiciliary visits, community and primary care meetings. It is recommended that the Palliative Medicine component of training is done in a hospice in ST4 and ST6, and in a hospital in ST5 and ST7. This is not a hard-and-fast rule, and the main priority is that there is balance across the whole of the training programme.

Ranking placement preferences

For London/KSS trainees a preference form will be emailed every January asking for three placement preferences for the October rotational placements. Placements are prioritised depending on training needs and availability of relevant placements. Factors including personal circumstances will be considered, however training needs are the priority. Trainees will be informed of their next rotational placement 12 weeks prior to the October start date (typically early July).

The four London/KSS training sectors

London/KSS is divided into four sectors, containing the following placement options (an up to date list will be included on that year's preference form):

- **North West**

Palliative Medicine: Meadow House Hospice (Ealing), Rennie Grove Peace Hospice Watford and Herts community, Royal Trinity Hospice, St John's Hospice, St Luke's Hospice and Harrow community, Chelsea and Westminster Hospital, Royal Marsden Hospital (Chelsea), Imperial NHS Trust.

IM: IM units to be confirmed in the future dependent on training needs.

- **North East/North Central**

Palliative Medicine: St Joseph's Hospice (Hackney), St Francis Hospice (Romford), North London Hospice, UCLH and CNWL community, Barts and the London, Marie Curie Hospice and Royal Free Hospital, North Middlesex University Hospital, Barking, Havering and Redbridge University Trust (BHRUT) - Queen's Hospital (Romford).

IM: North Middlesex Hospital, Whipps Cross, Barnet Hospital, Queen's Hospital (Romford).

- **South West**

Palliative Medicine: Princess Alice Hospice (Esher), St Barnabas Hospice (Worthing), St Catherine's Hospice (Crawley), St Raphael's Hospice (Cheam), Phyllis Tuckwell Hospice/ Frimley Park Hospital, Royal Surrey County Hospital (Guildford), Guy's and St Thomas' Hospital and community, St George's Hospital, Royal Marsden Hospital (Sutton), Royal Sussex Hospital (Brighton).

IM: Royal Sussex Hospital (Brighton), Princess Royal Hospital (Haywards Heath), Frimley Health NHS Trust (Farnham).

- **South East**

Palliative Medicine: Pilgrims Hospice (Margate), Pilgrims Hospice (Canterbury), Pilgrims Hospice (Ashford), Royal Marsden Hospital (Sutton), St Christopher's Hospice, King's College Hospital, Guy's and St Thomas' Hospital and community, William Harvey Hospital (Ashford), Croydon University Hospital, Eastbourne District General Hospital.

IM: Eastbourne District Hospital, Croydon University Hospital, Princess Royal University Hospital (Farnborough), East Kent Hospitals NHS Trust (Ashford).

This information is correct for the 2024/2025 training year. As more trainees start on the dual curriculum there will be an increase in units for IM training.

Transferring between sectors

For London/KSS trainees, if you wish to transfer between sectors for training or significant personal reasons, there is an opportunity to request to change your sector at the time of submitting your preference form. The outcome will depend on availability of placements within the desired sector and agreed transfers will generally only happen at the yearly October rotation date.

The curriculum

The main change between the 2010 and the 2022 curricula is that by the end of ST7, a Palliative Medicine trainee will receive a dual CCT in Palliative Medicine and IM. The IM curriculum is Internal Medicine Stage 2 (IMS2) and this curriculum is shared with all other Group 1 dual-training specialties. The new Palliative Medicine specialty curriculum has a smaller number of capabilities in practice (CiPs) with the aim of the new training moving away from a 'tick-box' approach. The hope is that trainees continue to build on the skills and knowledge acquired during Internal Medicine Stage 1 (IMS1) training (the IMT1-3 years).

Universal requirements of all medical specialties are described in the generic CiPs. The Internal Medicine clinical CiPs describe the capabilities required for Internal Medicine for dual-training specialties. The specialty CiPs describe the capabilities required for Palliative Medicine.

The curricula can be accessed from the JRCPTB website or Key resources above.

Capabilities in Practice (CiPs)

Expected outcomes

The following ratings for the Internal Medicine and Specialty CiPs are expected to have been achieved by the following points in training. A reminder of these for each ST year can be found within the Summary of Progress pages in the ePortfolio under the Progression tab. Please note that the emphasis is to maintain capabilities gained in IM Stage 1, gaining more experience so that you are functioning at Level 4 by the end of the final year of training. Effective resuscitation is the only CiP that requires level 4 throughout training. The Generic CiPs are rated differently to the Internal Medicine and Speciality CiPs: they are rated by the trainee and the educational supervisor (ES) as Below/Meets/Above expectations, not Level 1-4. This information is taken from the respective ARCP decision aids. Note evidence to support acquisition of many of the CiPs can come from IM or Palliative Medicine placements.

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

	ST4	ST5	ST6	ST7
Internal Medicine CiPs:				
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, including management of comorbidities and cognitive impairment	3	3	3	4
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of 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 a multi-disciplinary team including effective discharge planning	3	3	3	4
7. Delivering effective resuscitation and managing the acutely deteriorating patient	4	4	4	4
8. Managing end of life and applying palliative care skills	3	3	3	4
Palliative Medicine CiPs:				
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 with life-limiting conditions, 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 of patients and those close to them, including loss and grief; and religious, cultural and spiritual care across all care settings	2	3	3	4
7. Demonstrates the ability to lead a palliative care service in any setting, including the third sector	2	2	3	4

CiP descriptors

Information on each CiP can be found in the ePortfolio by clicking the "i" next to each CiP on the Curriculum page. The full descriptors are included below for ease of reference and because some of the descriptors contain important curriculum areas which can be hard to cover without planning, such as communicating with teenagers and young adults.

CiPs	Descriptors
Generic Capabilities in Practice (CiPs):	
1. Able to function successfully within NHS organisational and management systems	• 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 commissioning. • Aware of the need to use resources wisely.
2. Able to deal with ethical and legal issues related to clinical practice	• 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.
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	• 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 (e.g. 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.
4. Is focussed on patient safety and delivers effective quality improvement in patient care	• 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.
5. Carrying out research and managing data appropriately	• 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.
6. Acting as a clinical teacher and clinical supervisor	● 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 as clinical supervisor to doctors in earlier stages of training.
Internal Medicine Clinical Capabilities in Practice (CiPs):	
1. Managing an acute unselected take	● 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.
2. Managing the acute care of patients within a medical specialty service	● 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.
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	● Demonstrates professional behaviour with regard to patients, carers, colleagues and others. ● Delivers patient centered 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.
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions)	● Demonstrates professional behaviour with regard to patients, carers, colleagues and others. ● Delivers patient centered 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.
5. Managing medical problems in patients in other specialities and special cases	● 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.
6. Managing a multi-disciplinary team including effective discharge planning	● 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 centered 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.
7. Delivering effective resuscitation and managing the acutely deteriorating patient	● 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.
8. Managing end of life and applying palliative care skills	● 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.

Palliative Medicine Capabilities in Practice (CiPs):	
1. Managing patients with life limiting conditions across all care settings	● 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.
2. Ability to manage complex pain in people with life limiting conditions across all care settings	● 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.
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings	● 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.
4. Ability to demonstrate effective advanced communication skills with patients with life-limiting conditions,	● 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.

those close to them and colleagues across all care settings	○ 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.
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings	● 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.
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	● 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.
7. Demonstrates the ability to lead a palliative care service in any setting, including the third sector	● 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.

ARCP

The exact date of a trainee's annual review of competence progression (ARCP) will depend on the deanery and the trainee's start date. All doctors in training need an annual ARCP, even if they are out of programme (OOP) or working less than full-time (LTFT). This is required for revalidation. For London/KSS trainees, ARCP events are usually held three times a year (February, July and December) to accommodate different start dates. The majority take place in July (for October starters).

In a year with both IM and Palliative Medicine placements, you will likely have one ARCP meeting for both IM and Palliative Medicine, though two separate ARCP outcomes, one for IM and one for Palliative Medicine, will be recorded. The amount of evidence required for your ARCP will be proportionate to the amount of time you have spent in the specialty in that year. If there is a year without an IM placement, you may still have gathered evidence of IM competency from IM maintaining capability days and any corresponding work-place based assessments (WPBA) and patient log, plus any courses. It is important to remember that you will gain experience relevant to IM during your Palliative Medicine placement, so this can also be linked to your IM portfolio. In a year without an IM post, you do not need an IM Educational Supervisor Report. The ARCP panel will include an IM TPD/representative who will review the IM capabilities, and the Palliative Medicine TPDs will review the Palliative Medicine capabilities.

The deadline for completion of your ePortfolio is two weeks prior to your ARCP date to allow time for the ARCP panel to review evidence submitted ahead of your ARCP date. However, the ePortfolio does not become locked to editing prior to ARCP. Any evidence submitted after an ESR is written will obviously not be reflected within it.

Most ARCPs are conducted 'in absentia' which means that you do not need to be present. However, you may be asked to attend in your first year and penultimate year. If you are invited to attend your ARCP online then you will be given the date in advance and an approximate time to attend. A virtual ARCP typically takes around twenty minutes and you will need to be able to attend with audio and camera on. It may be that the timings of your ARCP change during the day, so it is worth giving advance notice to your colleagues in case you need to be flexible. You will be informed of the ARCP outcome on the day.

If you have questions or concerns about preparing for your ARCP, you are encouraged to discuss this with your educational supervisor (ES) in the first instance, or to contact your sector lead, IM lead or TPD.

Educational Supervisor Report

In a training year with both IM and Palliative Medicine, it is recommended that you have educational supervisors for both IM and Palliative Medicine. An Educational Supervisor Report (ESR) will be required from the IM ES and a separate ES report from the Palliative Medicine ES. These are key documents which the ARCP panel will consider.

If you have a CS who is not also an ES: the Palliative Medicine Rough Guide states, "At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP." We suggest the CS thus completes an End of Attachment Appraisal. Trainee and trainer are expected to meet regularly during

the placement for personalised, professional development discussions, depending on local arrangements.

If you have no IM ES in a year with an IM block: occasionally it may not be possible to allocate an IM ES, but you will always have an IM clinical supervisor. In this situation, the Palliative Medicine ES completes an IM ESR based on feedback from Multiple Consultant Reports (including from your IM CS), an End of Attachment Appraisal by your IM CS, and other evidence. Note the Palliative Medicine ES will also need to rate your generic CiPs, IM clinical CiPs, and IM practical procedures in this situation, based on evidence in your portfolio and discussion with the trainee and potentially also with the IM CS if needed.

ARCP and ePortfolio library

You should consider creating a folder for each training year in the Personal Library section of your ePortfolio with a clear title e.g. “ARCP ST4”. This will ensure that it is easy for the panel to review information required at each ARCP. Within this folder, sub-folders can be created for each domain e.g. QIP, Teaching Attended and Teaching Delivered. Within these folders, consider including presentations, feedback and certificates. It is important to ensure that your ALS certificate is present in the current ARCP folder along with Form R.

Note you cannot edit or move any of your IM Stage 1 folders once you start Palliative Medicine training. If you are able to make changes before your IMS1 folders become locked, consider grouping them together into a big IMS1 folder to clearly distinguish them from your Palliative Medicine specialty training items.

ARCP checklist for trainees

Prior to your ARCP, ensure that you have completed the following:

1. Form R (part A and B):
    a. This is found in TIS self- service.
    b. Make sure you download the completed Part A and B forms, save as PDFs and upload into your ePorfolio personal library.
2. Self-rate all the CiPs - generic, IM and specialty:
    a. Write a comment by each CiP identifying the evidence to support this rating.
3. Self-rate all the practical procedures for both IM and Palliative Medicine:
    a. Write a comment by each practical procedure identifying supporting evidence for the rating.
4. Ensure that your IM ES has rated your generic CiPs, IM clinical CiPs, and IM practical procedures.
    a. If you do not have an IM ES, make sure you Palliative Medicine ES has done this, on the basis of your End of Attachment Appraisal by your IM CS, your MCRs, DOPS and other WPBA. Your supervisors may find it beneficial to speak to one another if there is difficulty completing the ratings.
5. Ensure that your Palliative Medicine ES has rated your generic CiPs, specialty CiPs, and Palliative Medicine practical procedures.
6. Ensure that you have signed off your Personal Development Plans (PDPs) as “achieved” (there is a question in the ES report asking if they have been achieved).

7. Ensure that you have completed an 'MSF Self and ensure that your ES has released your Summary MSF:
    a. Note that the Summary MSF cannot be released unless the MSF Self has been completed by the trainee.
    b. For your ES to release the Summary MSF, they should click Assessment, MSF, Create form, Summary MSF.
8. Complete the Summary of Clinical Activity and Teaching Attendance (HST) under the Assessment tab:
    a. Note, once you have submitted this as non-draft, it cannot be edited again.
    b. This proforma splits out your teaching in a different way from the logbook requirements below, so make sure you record which teaching is internal/external/e-learning as you go along as well.
9. As recommended by the TPDs, create both IM and Palliative Medicine logbooks (e.g. in Excel) to include evidence for the following information, and upload these into your ePortfolio library. This is to help make it easy to evidence your competence to assessors at ARCP. Consider making a different tab for each year of training so the ARCP panel can appreciate progression.
    a. For IM placements:
        - Number of patients seen on the acute medical take (total of 750 required by CCT. Note as per presentations given by the TPDs, this doesn't refer only to patients you have fully clerked yourself but includes all acute take patients you have been responsible for and whose care you've been involved in, including in an advisory or reviewing capacity, and ward reviews of acutely unwell patients. Specific clinical details of all 750 patients don't need to be recorded but consider recording complex or interesting cases to provide evidence of breadth of experience. Total numbers must be recorded).
        - Number of outpatient clinics and the clinic supervisor (total of 20 IM clinics required by CCT). Aim for a range of outpatient clinics if possible. Note that you need to have provided care of patients yourself in the clinic in order for it to contribute to these numbers – clinics where you just observe another clinician aren't counted. This can include clinics done on Maintaining Capability (MC) days.
        - Number of hours of IM teaching (total of 75 hours required by CCT, including 20 hours in the final year of IMS2).
        - Number of hours of IM simulation (total of 12 hours required by CCT, including four hours in final year of IMS2).
        - Maintaining Capability (MC) days and supervisors and a brief description of what you did.
    b. For Palliative Medicine placements:
        - List of on-calls completed (including weekends, nights, bank holidays). Consider recording any particularly interesting/challenging cases during the shift.
        - Evidence of community experience (if included in rotation). Record whether it was whole day or half day, and a brief description of your main activities and any particularly interesting/challenging cases.
        - Palliative Medicine teaching attended.
        - Simulation sessions attended.
        - Maintaining Capability (MC) days and supervisors and a brief description of what you did.
    c. For both IM and Palliative Medicine:

- Teaching delivered.
- Management evidence (e.g. meetings attended, rota management).

10. For years with both IM and Palliative Medicine blocks, you will need two ES reports (ESRs) – one from your IM ES and one from your Palliative Medicine ES. If you don't have an IM ES, your Palliative Medicine ES will need to complete an IM ESR based on evidence and feedback given during your IM post, as described above.
    a. Note that your ES must be logged in as an educational supervisor, not a clinical supervisor, to create the ESR.
    b. To create the report your ES should click: Progression, Supervisor's report, Educational Supervisor's Report (specified for IM or Palliative Medicine).
    c. There is a useful flowchart explaining completing ES reports.

Combined ARCP decision aid

The below table has been made by combining the information from the two decision aids as available in March 2024 plus clarification from the TPDs/IM lead. The decision aids can be found online here:

- Palliative Medicine
- Internal Medicine Stage 2

There are now Summary of Progress pages for Palliative Medicine and Internal Medicine Stage 2 in the ePortfolio under the Progression tab. This functionality outlines the requirements for each training year with an auto-populated summary of the relevant ePortfolio evidence to help measure progress towards satisfactory completion as you approach an ARCP.

Combined ARCP decision aid Palliative Medicine/Internal Medicine June 2024

Assumed training full-time in London/KSS with IM placement in ST4, ST5 & ST7

Assessment:	Palliative medicine or IM requirement:	Comment:	ST4	ST5	ST6	ST7
CbD/Mini CEX/OPCAT	**PM**		4	4	4	2
	IM	*In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini CEXs) to be carried out by consultants supervising in IM.*	3	3	**0***	3
ACAT	**PM**	*Each ACAT must cover 5 cases. Performance on take/presenting on ward round/MDT.*	0	0	2	0
	IM		4	4	**0***	4
MCR	**PM**	*The ES should not complete an MCR for their own trainee.*	2	2	2	2
	IM	*2 in any year with an IM block, 3 if final year of training.*	2	2	**0***	3
MSF	**PM**	*During a year with IM training at least 4 raters should have worked with the trainee in an IM context. An indicative minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical).*	1	1	1	1
	IM					
ES Report	**PM**		1	1	1	1
	IM		1	1	**0***	1
QIPAT	**PM**		1 project to be assessed with QIPAT		1 project completed as supervisor with QIPAT	
	IM		At least 1 QI project to be completed in IMS2 and assessed with quality improvement project tool (QIPAT) or equivalent			
Teaching	**PM**	*Evidence of a range of teaching, including audience, topic and type of teaching; role in organising teaching; evidence of formal training in teaching and learning. Summary of attendance at and involvement in teaching to be recorded in ePortfolio.*	Participation in and evaluation of teaching medical students, junior doctors, nurses and AHPs	Participation in and evaluation of teaching medical students, junior doctors, nurses and AHPs	Participation in and evaluation of a range of teaching activities. Evidence of basic understanding of principles of adult education and learning	Ongoing participation in teaching across a range of settings. Evidence of training in an implementation of principles of adult education and learning
Teaching observation	**PM**		1	1	1	1
	IM		At least 1 Teaching Observation to be completed by end of IMS2			
ALS	**PM**		Valid ALS certificate			
	IM					
Patient survey	**PM**		Completion of 1 satisfactory patient survey by end of training, with indicative minimum 15 respondents (including patients seen during IM training).			
	IM					

Palliative Medicine specific requirements						
Assessment:	**Palliative medicine or IM requirement:**	**Comment:**	**ST4**	**ST5**	**ST6**	**ST7**
Clinical management	**PM**		Evidence of participation in and awareness of some aspects of management – e.g. responsibility for organising on call rotas, organising and managing own workload effectively; supervision of more junior doctors	Evidence of participation in and awareness of some aspects of management, e.g. designing rotas; organising and leading teams; organising teaching sessions or journal clubs	Evidence of awareness of NHS and third sector management structures and how local services link to these. Attendance at relevant local management meetings and evidence of participation in management-related activities.	Evidence of understanding of management structures within NHS and third sector services and awareness of a range of clinical management activities, e.g. understanding budgets; liaison with commissioners and senior management; business planning
LEADER	**PM**	*Trainees should complete two LEADER assessments by the end of training*		1		1
RRP	**PM**		2	2	2	2
SCE	**PM**				Attempted SCE	Passed SCE
Communication skills	**PM**		Evidence of completion of locally approved advanced communication skills training by the end of training			
Internal Medicine specific requirements						
Outpatient clinics	**IM**		Indicative minimum of 20 clinics in specialties other than the trainee's specialty by the end of IMS2.			
Acute unselected take patients	**IM**		Active involvement in the care of 750 patients presenting with acute medical problems by the end of IMS2, with 100 patients in the final year of training.			
Continuing ward care	**IM**		12 months of experience and training in continuing ward care of patients admitted with acute medical problems by end of IMS2, including 3 months in final year of IMS2 training.			
Simulation training	**IM**		At least 12 hours of simulation training to include recognition of human factor in interactions during IMS2, including at least 4 hours in the final year of IMS2 training.			
Study leave	**IM**		75 hours of recognised IM study leave (CPD points and/or Deanery organised) by end of IMS2, including 20 hours in final year of IMS2 training.			

ePortfolio assessments

Prior to starting training, you will need to register and pay for an ePortfolio that is required for both the IM and Palliative Medicine curriculum. Please note that this payment can be included as part of your professional subscriptions tax reclaim to HMRC. The content from IMS1 will remain in your ePortfolio.

There are a number of work-place based assessments (WPBA) in the Palliative Medicine curriculum that you will not have encountered in IMS1. They are described below. Descriptions of the assessments can be found in the Palliative Medicine and IM curricula documents and also the Palliative Medicine Rough Guide under Forms and Guidance.

LEADER

This is a new assessment in the 2022 curriculum. The LEADER assessment is a tool to assess a trainee's clinical leadership skills. The domains assessed are leadership in a team; effective services; acting in a team; direction setting and reflection. Often Palliative Medicine consultants are expected to take on clinical leadership roles (e.g. chairing multidisciplinary and non-clinical meetings) early in their careers, and leadership is mentioned in both generic and specialty CiPs. It is hoped that these assessments can capture and promote trainees' leadership skills. Trainees need to complete two LEADER assessments by the end of their training.

Record of Reflective Practice (RRP)

This is a formal reflection with a consultant or supervisor. An RRP should be centred around a case with one or two dilemmas that are to be discussed during the RRP. The hope is that the discussion will help the trainee formulate ways to address these dilemmas if faced again with a similar case. A trainee must complete two RRPs each training year during their Palliative Medicine rotation.

Patient survey

The patient survey is the second new mandatory assessment in the 2022 curriculum. The survey aims to assess things such as interpersonal skills, professionalism and communication skills from the patient's perspective. Patient surveys can be challenging in Palliative Medicine due to patients being very unwell, therefore responses from those close to the patient (including relatives and informal carers) will be accepted. One patient survey is required during training. A minimum number of 15 responses will be required but it is recommended to aim for 30. These responses don't all have to be from within one post but should be from within one training year. The survey is sent electronically directly to the patient/relative/carer's email address (the ticket is found under the Assessments tab of the ePortfolio). If electronic surveys are not possible, it is suggested that the 2021 JRCPTB proformas be printed and given to patients/relatives/carers to complete and return anonymously to a third party, and the feedback scanned or transcribed onto the ePortfolio. These forms can be found here. Please note that as per the Palliative Medicine ARCP decision aid, this survey can include patients seen in IM, and one survey will meet the requirements of both the Palliative Medicine and IM curricula (despite it being listed in both decision aids).

MSF

Trainees will be familiar with the MSF from IMS1. One MSF is required each training year. In a year with IM, at least four raters should have worked with the trainee in the IM setting. An MSF needs a minimum of 12 raters and a minimum of three consultants (as per the Palliative Medicine ARCP decision aid). The MSF is a method of assessing generic skills including communication, leadership, reliability and team working, which are in keeping with the domains of GMC's *Good Medical Practice*.

Note, similarly to IMS1, if a trainee has done different training blocks over a training year, the MSF respondents will be linked to the Post which the trainee selected when generating the ticket in ePortfolio. It is not possible to create one summary report for MSF responses linked to multiple posts without asking the JRCPTB ePortfolio team to manually move responses. Do this via the Help tab in ePortfolio, then click Support to submit your request.

ACAT

The concept of an ACAT is the same as in IMS1 training. There should be a minimum of five cases for an ACAT assessment. The focus should be on multi-tasking, prioritisation and organisational skills - it is not for comment on the management of individual cases. IM ACATS should be completed by consultants supervising acute unselected take/a post-take setting.
New guidance on Palliative Medicine ACAT requirements was circulated via email in March 2024 following an SAC meeting:

- In a year when a trainee is doing **only** Palliative Medicine training placements they need to do a minimum of **two** Palliative Medicine ACATs.
- In a year when a trainee is doing Palliative medicine **and** Internal Medicine placements they need to do a minimum of **four** ACATs in IM and it is **encouraged** that they do **two** Palliative Medicine ACATs (but not mandated) to demonstrate on-call/ward round learning.

Teaching observation

A trainee is required to complete one teaching observation in Palliative Medicine each training year and must complete one teaching observation in IM by the end of training. The teaching observation form can be based on any formal teaching completed by the trainee where they have been observed by the assessor. The trainee should identify appropriate teaching sessions and assessors.

Outpatient clinics

Aim to keep an up-to-date record of IM clinics during each training year. A minimum number of 20 clinics in specialties other than Palliative Medicine need to be completed by the end of training. These can include community experience, virtual clinics and ambulatory care. An Out Patient Care Assessment Tool (OPCAT) in an optional assessment designed to assess outpatient capability in a single clinic (Palliative Medicine or IM) where a minimum of three patients have been seen. Any Palliative Medicine OPCATs count toward the annual Palliative Medicine SLE requirement as per the Palliative Medicine ARCP decision aid.

Clinical management and leadership

Aim to keep a record during training of evidence of leadership and management experience, as this is both a generic and specialty CiP and is specifically listed in the Palliative Medicine ARCP decision aid. Evidence could include chairing MDTs and meetings, managing Palliative Medicine or IM rotas or teaching programmes, junior doctor supervision, and attending relevant courses and management meetings. A LEADER form could be completed for evidence of leadership skills demonstrated in a Palliative Medicine context, as described above. Palliative Medicine trainees are eligible to apply to Chief Registrar programmes based at acute hospital trusts.

DOPS

There are two sets of mandatory practical procedures, one for IM and one for Palliative Medicine. The standards expected by each training year are listed in the table below, as specified in the respective ARCP decision aids. Note for Internal Medicine it is assumed that the trainee achieved competence in all the procedures in IMS1, and this competence should be maintained during IMS2 by continued practice or skills lab training. Further Direct Observation of Procedural Skills (DOPS) are not required to evidence this unless requested by an ES or the trainee feels it would be beneficial.

Note, for Palliative Medicine DOPS only two procedures need to be undertaken in a clinical setting: syringe pump set up and management of an indwelling pleural/peritoneal catheter. Three syringe pump set up DOPS must be completed throughout training, in a range of clinical settings and with different assessors. The other three Palliative Medicine DOPS can be assessed in a simulated setting. Note a total of seven Palliative Medicine DOPS is required to complete training with a minimum of one DOPS in each year of training. You must have a summative DOPS in each of the five Palliative Medicine procedures by the end of training.

Note DOPS can be assessed by anyone competent in that skill and in providing feedback; unlike many of the other ARCP requirements, they don't only have to be completed by consultants.

Procedure	Comment	ST4	ST5	ST6	ST7
Internal Medicine:					
Advanced Cardiopulmonary Resuscitation (CPR)		Leadership of CPR team			
Ascitic tap		Competent to perform unsupervised			
Direct Current (DC) Cardioversion		Competent to perform unsupervised			
Lumbar puncture		Competent to perform unsupervised			
Nasogastric (NG) tube		Competent to perform unsupervised			
Pleural aspiration of fluid (diagnostic)	Assumed that a trainee that is capable of performing pleural aspiration of fluid is capable of introducing a needle to decompress a large symptomatic pneumothorax	Competent to perform unsupervised			
Abdominal paracentesis		Skills lab or satisfactory supervised practice			
Access to circulation for resuscitation (femoral vein or interosseous)	Requirement is for one of these two mechanisms for obtaining access	Skills lab or satisfactory supervised practice			
Central Venous Cannulation (internal jugular or subclavian)		Skills lab or satisfactory supervised practice			
Intercostal drain for effusion	Pleural procedures should be in line with BTS guidance and US guidance should be provided by pleural-training US practitioner	Skills lab or satisfactory supervised practice			
Intercostal drain for pneumothorax	Pleural procedures should be in line with BTS guidance and US guidance should be provided by pleural-training US practitioner	Skills lab or satisfactory supervised practice			
Temporary cardiac pacing using an external device		Skills lab or satisfactory supervised practice			

Procedure	Comment	ST4	ST5	ST6	ST7
Palliative Medicine:					
Total requirement:	*Evidence of completion of mandatory DOPS by ST7 (minimum total 7 by end of training)*	*Minimum 1 DOPS per training year (covering any of the procedural skills)*	*Minimum 1*	*Minimum 1*	*Minimum 1*
Syringe pump set up		Limited supervision (formative). 3 syringe pump DOPS are required throughout training, in a range of clinical settings and with different assessors			Competent to set up independently (summative)
NIV set up and troubleshooting	E.g. checking the machine is set up according to the initiating team's advice, correct mask fit and comfort, assess for common problems/emergencies and know who to contact for advice	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative)
Spinal lines	Principles, indications and likely complications	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative)
Tracheostomy care	Management of common complications e.g. secretions and a simple tube/tracheostomy change	Skills lab or satisfactory supervised practice (formative)			Competent in simulated setting (summative)
Indwelling pleural/peritoneal catheter	Identification of appropriate patients; day-to-day management and troubleshooting of complications (e.g. displacement, infection, blockage)	Skills lab or satisfactory supervised practice/limited supervision (formative)			Competent to manage complications and advise patients re management (summative)

Maintaining Capability (MC) days

Maintaining Capability (MC) days (previously called 'keeping in touch'/KIT days in 2022/2023, now a term reserved only for trainees on new parent leave), aim to help dual trainees maintain competence in both Palliative and Internal Medicine whilst dual training. These days should be clinical and patient-facing.

The document "Guidance for implementation of Internal Medicine Training during higher specialty training in new Group 1 specialties" requires that trainees in Group 1 specialities achieve the following:

- Are involved in the acute unselected take for at least three years
- The frequency of involvement is not specified but it is suggested that involvement is at least once a month.

The TPDs (via emails and presentations to trainees) have thus advised that for every one month a dual trainee has in a Palliative Medicine post they should have one IM MC day, and for every one month completed in an IM post, they should have one Palliative Medicine MC day. Note the Palliative Medicine training structure is markedly different to other Group 1 medical specialties e.g. Respiratory Medicine, which do not have discrete IM and Respiratory Medicine blocks, and are on the general medicine registrar rota throughout training, therefore removing the need for MC days in those specialties.

A trainee can arrange MC days in a way that allows them to stay feeling competent in the sister specialty. e.g. specialty clinics, join community teams, running the acute unselected take. It is not appropriate to use these days for mandatory training or courses because they are intended for direct clinical care that maintains clinical ability. These days can be spread throughout a post or grouped together (the latter is often more useful, though a degree of balance is important too, especially with larger numbers of days to be allocated). MC days should be arranged by the trainee with the ESs and rota coordinators in both specialties. When doing Palliative Medicine MC days during an IM block these days should be spent with that hospital's Palliative Medicine department, which you may never have worked in before. Early organisation is thus key.

On MC days the trainee should work whatever their core hours are for that block, as outlined in their work schedule. e.g. if in a Palliative Medicine block where they are rostered to work 0900-1700, they should only work on e.g. the unselected take for these hours and not be expected to do a full long day of a medical registrar shift. There is no separate work schedule for MC days and the trainee will only be paid for their regular rostered hours. It is not specified how MC days are logged/recorded so trainees should seek advice from their ES. Suggestions include keeping an Excel record with a brief summary of what you did on an MC day, and uploading it to an ARCP folder in the ePortfolio, and perhaps doing a reflection or SLE.

Study leave

Study leave allocation

Trainees are entitled to 30 days of study leave each year, as per the 2016 junior doctor contract terms and conditions. This is pro rata if the trainee works less than full-time. This entitlement covers Palliative Medicine education opportunities and IM opportunities. The mandatory London/KSS Palliative Medicine training days organised by the trainee committee also come out of this allocation. Trainees are encouraged to attend 75% of these mandatory training days.

Any unused study leave days cannot be rolled over into the next year of training. Note some units will have regular teaching provided; how to use the allocation may need negotiating locally. A plan for how to use your study leave should be made during induction meetings with your ESs and should be spread across any rotations.

The IM Stage 2 ARCP decision aid requires "75 hours of recognised IM study leave (CPD points and/or Deanery organised) by end of IMS2, including 20 hours in final year of IMS2 training". (Note the requirement to thus record study leave and CPD by *hour*, not just days.) There is no similar requirement for Palliative Medicine study leave. See 'Suggested courses' below for IM CPD suggestions.

There is no formal requirement for when trainees take IM versus Palliative Medicine study leave, but there may be local preferences to take IM study leave during IM blocks. In a year when a trainee is doing both an IM and a Palliative Medicine block, study leave should ideally be taken pro rata during those blocks. Note study opportunities, e.g. courses, should not be taken as an MC day. IM study leave can be taken in training years with no IM blocks and used as evidence of ongoing IM competency.

Recording study leave

There is no requirement from the lead employer to record your study leave with them, though the NHS Electronic Staff Record app or website can be used for this. IM and Palliative Medicine ESs should advise how to request and record study leave locally. The only information given on the decision aids about recording study leave is as follows:

- For IM: "Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)"
- For Palliative Medicine: "Study leave: list of courses attended, use of CPD diary."

The ePortfolio has a form called Summary of Clinical Activity and Teaching Attendance (HST) under the Assessment tab (QI/Audit, Teaching & Clinical Activities). This has sections for recording numbers of:

- Internal hospital teaching hours
- External GIM teaching hours
- External specialty teaching hours
- Simulation training hours
- e-learning hours
- Cumulative total for training year hours
- Cumulative total for GIM teaching hours.

The ePortfolio states that, "This summary form should be used to keep a record of clinical activity and attendance at teaching session. Please see the relevant ARCP decision aid for any specific requirements." This form should thus be completed before each ARCP, but in addition to this summary form, a detailed spreadsheet should be kept by each trainee to the show the exact amount and types of teaching they have attended (see the logbook descriptions above).

Trainees could also consider signing up for the RCP trainee CPD diary as a way of recording their teaching. This is free for trainees enrolled with JRCPTB who have a confirmed CCT date. See the RCP website for more information.

Study budget/approval

There is no longer a specific annual study budget per trainee, but instead, as was the case in IMS1, a list of mandatory and optional courses eligible for reimbursement is published by NHS England. Note courses which don't appear on this list may be given discretionary approval via the ES, TPD and Head of School who will provide a discretionary reference number if successful. Discretionary funding is capped at £1000 per course, up to 50% of the total costs of an international course (again maximum £1000), and trainees may only seek reimbursement for one international course during training. Details of discretionary funding procedure are found in the study leave section of the PGMDE Support Portal – see the Process for Discretional Courses 2024 document and Study Leave Process Flowchart 2024.

Finding a course code

The list of preapproved mandatory and optional courses is entitled the Medicine Course List and is found in the PGMDE Support Portal (in the Excel sheet there are some relevant codes at the beginning under All Programmes, and Internal Medicine Training, and then more if you scroll down to Palliative Medicine). Trainees will need to note the course code to write on the expense claim form.

How to reclaim study leave expenses

Repayment of study leave expenses for mandatory or optional courses is managed by NHS England using a word document proforma which is uploaded via the PGMDE Support Portal website ticketing system. It is detailed in this FAQ entitled "I am a Palliative Medicine trainee, how should I apply for study leave and funding?".

Note that all study leave claims should be submitted within **three months** of attending the event (or 60 days for trainees based at the Royal Free as per the study leave flowchart 2024). Longer than this would require TPD approval to be processed, as per this time limit FAQ.

The process for reclaiming study leave expenses is as follows:

1. Download the NHS England "Palliative Medicine Study Leave Expense Form". from the Forms section of the study leave page of the PGMDE Support Portal.
2. Complete the form which will need your assignment/payroll number from your payslip, course code or discretionary reference number, whether the course was mandatory/optional/aspirational, details of the expenses, and a signature from either of your ESs.

3. To submit your form along with your receipts, you have to submit a ticket to NHS England via a Study Leave Query Form in the PGMDE Support Portal – link found on the expense form itself, or here. Note the link to attach the expense form and your receipts is at the very end of the ticket form ("Attachment").
4. You will receive email confirmation of your submitted ticket from NHS England, and another email saying your ticket has been closed once the claim has been processed.
5. The repayment will show up in your payslip as 'Course expenses' in the following month's payroll run.
6. If there are problems with this process you can reply to the email from NHS England generated by your ticket submission. Alternatively you can log in to the PGMDE Support Portal and submit a new ticket. You can see a list of tickets you have submitted by logging into the portal.

Suggested courses

Special thanks to the London Palliative Medicine Trainees Committee and Dr Jo Brady for flagging many of the following courses and opportunities.

General resources

- **Palliative Medicine regional training days:** a programme of study days organised by the London Palliative Medicine Trainees Committee is emailed around for the year. They are a mixture of in-person and online days, mandatory and non-mandatory. Informally, attendance at 75% of the mandatory days is expected. To join the mailing list email pallmedlondon@gmail.com. The dates and registration links can also be found on the NHS England/HEE Events webpage Palliative Medicine section (see 'IM courses' below). Note you must have registered online in order to receive an attendance certificate.
- **APM:** the Association for Palliative Medicine is a great resource and the trainee group puts on study days and courses throughout the year. Membership also includes subscription to the *European Association of Palliative Care* (EAPC) and the BMJ's *Supportive and Palliative Care Journal* and the *Palliative Care Formulary*. Courses are also accessible to non-members and can be found on their event calendar. Of note the APM run an ethics course and a research methods course which may help curriculum coverage.
- **RSM**: the Royal Society of Medicine has an active Palliative Care section in addition to a broad range of medical/surgical study days (see their events list). RSM has several Palliative Medicine educational days throughout the year and runs the six-part applied therapeutics course, which many trainees have found useful, including for preparation for the SCE exam.

IM courses

Dual trainees need 75 hours of IM study leave across their programme, including 20 hours in ST7. These 75 hours can consist of regional study days, deanery-approved study days and courses approved for CPD. It has been clarified with the London School of Medicine in 2024 that teaching such as grand round and x-ray meetings also **do contribute** to these hours, which is different to earlier guidance received.

- You can look for IM courses on NHS England/HEE Events webpage.
- The following filters are suggested:
  - Specialty: medicine and medical specialties
  - Sub-specialty: acute internal medicine
  - Suitable for: trainees
  - Date range: at least 12 months
  - Region: pan-London
- The London Medical Trainee Network hosts regular IM training afternoons on a range of topics, targeted for IMS1 trainees but still very useful. Please use the link to join the WhatsApp group to hear more about these sessions.

Advanced Life Support (ALS)

ALS needs to be valid throughout training (certificates are valid for four years). Qualification is via four formats as described by the Resuscitation Council UK:

- a one-day face-to-face recertification course (note this can't be taken if it's more than a year since your last ALS certificate expired, and it "is not recommended if you are not practicing the skills within your current job role" as per Resuscitation Council UK's description)
- a two-day face-to-face course (note a smaller amount of online learning and reading the ALS manual before the face-to-face course is still required)
- e-ALS: one day of e-learning plus one day of face-to-face training
- ALS modular course: this is a timetabled series of modules for special circumstances when a Course Centre cannot provide a full one or two-day face-to-face course. Candidates must attend every timetabled component to complete the course.

Find a spot on a course by selecting one of the four course types and scrolling to the bottom of the page for Course Availability. The course would also need to be factored into your study leave allocation. It has recently been agreed by the STC that ALS course completion can count towards four hours of your IM simulation hours requirement.

IM simulation

There are additional requirements in the IMS2 ARCP decision aid to have completed "at least 12 hours of simulation training to include recognition of human factor in interactions during IMS2, including at least 4 hours in the final year of IMS2 training". This will need to come out of your study leave allocation. There are corresponding course codes for reimbursement under All Programmes or Palliative Medicine in the Medicine Course List.

There are local variations regarding provision of IM simulation and human factors training. A Pan London Simulation Lead for IMT Stage 2 has been appointed, currently Dr Shreena Shah, acute medicine consultant at West Middlesex University Hospital. This role aims to increase the simulation provision for all London higher specialty medicine trainees and procedural courses are expected to be advertised soon. Other ideas to find simulation training opportunities include contacting your local NHS hospital about their sim training days, speaking to IM colleagues, and asking your TPD about links with IM TPDs to access this information.

Note that advanced communication skills training also counts four hours toward the human factors IM simulation requirement (but the public health in palliative care course

does not). Human factors may also be included in Palliative Medicine simulation days (below). ALS course completion can be counted as four hours of simulation training as well.

Palliative Medicine simulation

Palliative Medicine simulation days for trainees are organised by the Palliative Medicine Trainees Committee and information is emailed round to trainees (see above). A trainee can sign up for a maximum of two sessions per year. The sessions combine a mixture of procedural skills, situational sim and human factors training. You may also find opportunities from Pallisim Network or in local hospices/palliative care teams. Note there is no requirement on the Palliative Medicine ARCP decision aid for a certain number of simulation or human factor training hours.

Advanced communication skills

As per the Palliative Medicine ARCP decision aid, trainees are required to have "Evidence of completion of locally approved advanced communication skills training by the end of training". This training can contribute to the IM human factors requirement. There are several advanced communication skills course providers, in and outside of London (some examples below). Online or in-person courses are accepted.

- In London:
  - St Joseph's Hospice
  - Royal Marsden
  - St Rafael's Hospice – can also email Maura Flint (mauraflint@straphaels.org.uk)
  - Princess Alice Hospice
  - Pilgrim's Hospice
  - The Hospice of St Francis
- Outside London:
  - Arthur Rank Hospice, Cambridge
  - St Gemma's Hospice, Leeds
  - OxCERPC, Sobell House Hospice, Oxford
  - LOROS Hospice, Leicester

Formal training in teaching

Trainees need to be involved in "participation in and evaluation of teaching" in every year of training, covering a variety of topics and audiences, as per the Palliative Medicine ARCP decision aid, and to have "evidence of formal training in teaching and learning".

Teaching provision will often be part of trainees' normal clinical role and thus part of the normal working day. However, if you are teaching e.g. in a different trust or on a specific course, liaise locally to find out whether study leave needs to be taken.

There are lots of teaching courses from lots of providers, online and in-person, usually over two days. Courses include:

- Train the Trainer
- Teach the Teacher
- Training to Teach
- RCP effective teaching skills workshop (see the RCP Courses list).

Other courses

There are a host of educational opportunities which may be useful to your clinical practice and ePortfolio.

- **Management and leadership:** there are many courses on offer which help meet the Palliative Medicine speciality CiP 7: "Demonstrates the ability to lead a palliative care service in any setting, including the third sector". For example, St Christopher's has offered a leadership and management course aimed at Palliative Medicine trainees and covers non-NHS/charity management.
- **Therapeutics and symptom management:** there are many courses on offer. The following come recommended by the London Palliative Medicine Trainee Committee:
    - The Advanced Course in Pain and Symptom Management: colloquially known as "Oxford" or "The Oxford course". It covers current topics and attracts excellent speakers. It is highly sought after.
    - Applied Therapeutics for Palliative Medicine: this is run by Palliative Medicine consultants specifically for trainees and hosted by RSM. It runs one day a month for six months. It will give you a good broad grounding in pharmacology and the evidence for the drugs used in palliative care. Places are limited so book early. Note if you have to miss a day, RSM may let you attend that day the following year or watch a recorded version. Search the RSM website to find when next course dates are released. You can sign up for early-bird notification also.
    - General Medicine Update for Palliative Care Physicians, Oxford.
    - Guildford Advanced Symptom Management Course.

Specialty Certificate Examination

SCE overview

The Palliative Medicine Specialty Certificate Examination (SCE) is a multiple-choice exam (best of five answers) comprised of 200 questions split across two three-hour papers (both answered in one day). The exam is held at Pearson Vue centres around the UK every nine months. The result is released four weeks after the exam. The exam dates and application windows can be found on the MRCPUK website. This page also contains:

- a blueprint document listing the exam topics and number of questions per topic
- 99 sample questions.

The exam costs £700 to sit in the UK and the fee is eligible for tax relief.

The SCE can be taken in any year of Palliative Medicine training, but as per the Palliative Medicine ARCP decision aid, it must have been attempted by the end of ST6 and passed by the end of ST7 in order to CCT. Note there is no SCE for IM, just full MRCP required to pass IMS1.

SCE revision aids and resources

- **Course**: two-day annual interactive Zoom revision course by Pallmedpro (previously run from St Gemma's hospice in Leeds).

- **Flashcards**: SCE revision flashcards with over 500 interactive flashcards, interactive quizzes and a full mock paper. Can be viewed on PC, Mac, iPad or iPhone. Note not currently compatible with Android smartphones. Old editions can also be updated for a fee.
    - Note as of Aug 2022 the APM is offering a full discount on purchases of these revision flashcards for APM members who are taking the exam in that year, by reimbursing the £30 fee (members still have to pay the £2.99 for the required flashcard app. More details here).
- **Question bank**: Study PRN Palliative Medicine question bank of 556 practice questions. Varying subscription lengths for varying prices. There is also an option to sign up for ten free questions from the question bank.
- **Practice questions**: 99 practice questions from MRCP, scroll down to "sample questions".
- **Suggested reading**: this document has been produced by previous Palliative Medicine trainees suggesting preparatory reading materials and resources.

Human resources / Lead employer

Introduction to the London/KSS lead employer arrangement

During your time as a Palliative Medicine trainee in London/KSS, you will work across several settings, including the third sector, community and NHS acute trusts. You may also swap between departments within acute trusts, sometimes for single MC days. To make salary payments simpler in the context of all these changes, throughout all your training your salary will be paid by the lead employer: Mersey and West Lancashire Teaching Hospitals NHS Trust (abbreviated to "MWL"). Note the Trust underwent a merger and prior to 1 July 2023 the lead employer was known as St Helens and Knowsley Teaching Hospitals NHS Trust, abbreviated to StHK, which may appear in older documentation. Their website is: https://leademployer.sthk.nhs.uk/. They are lead employer for Palliative Medicine trainees in London/KSS, Northwest, West Midlands and East Midlands deaneries.

Note MWL act as lead employer for circa 13,000 doctors/dentists across eight NHS England regions so do not expect them to be Palliative Medicine specific. Note they are not education or training providers so do not contact them with e.g. ARCP questions.

MWL will pay you according to the information provided to them by your host organisation/placement (e.g. hospice/acute trust) via your work schedule document emailed to MWL. It is therefore vitally important that you have early sight of your work schedule and that it is accurate. If you are a BMA member, have a low threshold to use their contract or rota checking services in light of this complexity and room for error. Work schedules should be sent by your host organisation to the lead employer six weeks ahead of start date to ensure you are paid correctly.

Lead employer contact details

These can be found on the MWL website. MWL are contactable on the phone, Monday-Friday 9am-5pm:

Tel: 0151 478 7777

Then select from following five options:
1. Queries relating to Employment Services and Case Management
2. Queries relating the North West Collaborative Bank
3. Queries relating to Salary Sacrifice
4. Queries relating to Payroll
5. Queries relating to Pensions

You can also email lead employer. They ask you include your specialty, region and GMC number in the title of your email along with a brief description of your query.

Email: lead.employer@sthk.nhs.uk

For HR queries, the main contact is Matt Russell who can be contacted using the above details.

Pre-employment checks

When you are offered your training number via the Oriel application system, you will be sent pre-employment forms to complete by MWL. Throughout the course of your Palliative Medicine training you should **only** have employment checks done by MWL – if a host organisation is asking you to duplicate this information please direct them to MWL.

DBS

You are required to submit a DBS certificate to MWL as part of your pre-employment checks. This is repeated every three years (unless trainees are opted into the update service) and MWL will contact you when this is due again. DBS checks are now paid for by NHS England (prior to July 2023 the trainee had to fund this).

Moving expenses

These may be paid if you are moving NHS England area and if you apply prospectively. More details are on the MWL website.

Guardians of safe working / exception reporting

The provision of a Guardian of Safe Working (GOSW) and the exception reporting system were agreed in the 2016 junior doctor contract. For hospice placements your GOSW is organised by the lead employer. For hospital placements your GOSW is organised by the local trust. The local GOSW should be listed on your work schedule (this might not always be listed on hospice work schedules but will be Dr Peter Arthur). Exception reporting logins will correspondingly be provided by MWL (Allocate system) or the local trust, depending on your placement.

Please consider submitting an exception report within 7-14 days of the exception occurring if:

- You have stayed late (anything more than 30 mins)
- You felt inadequately supported during your work commitments
- You are always missing your breaks: Entitled to 30 mins if shift >5 hours plus further 30 mins if shift >9 hours plus further 30 mins if 12-hour night shift

- You have been unable to attend scheduled teaching/educational opportunities
- Your working pattern is different to that described on your work schedule i.e. the sequence of shifts or rest pattern is different or your normal days are not being scheduled in the same way as detailed on your work schedule.

Where exception reporting results in a payment as opposed to time off in-lieu, the information should be sent to MWL for payment. For hospice placements this will be done directly through the Allocate system used by MWL. For hospital placements, the hospital should notify MWL detailing what payments need to be made, and MWL will make the payment into your next paycheque (note this should be submitted to MWL by the last day of a month in order for it to be included in the following month's payroll). See here for more information from MWL on exception reporting.

Locum shifts

You should inform MWL if you plan to take locum shifts (see here for more information). You may be asked to complete opt-out forms if locums will take your working week to >48 hours. You will also need to discuss it with your indemnity provider.

Indemnity

As employees of MWL you will be covered by medical indemnity funded by NHS England as part of a national arrangement (see here for more details). This indemnity covers your hospice, community and hospital training placements. For London trainees this cover is provided by MDDUS. You will be sent an email by MDDUS at the start of your training. As instructed in this email you will need to register for access to the member portal and update your personal information. Note, if you plan to do locum IM or Palliative Medicine shifts, you will need to pay an extra amount for this - please discuss it with MDDUS (sales@mddus.com). Do not pay for your own additional indemnity as you cannot hold indemnity with two providers – duplicate cover may result in complications should a claim or complaint be made against you.

If you prefer a different provider, you can opt out of this MDDUS indemnity cover, organise and pay for your own indemnity and have it refunded by NHS England. Further information can be found here. Contact NHS England via the PGMDE Support Portal in the first instance.

Contract

Your contract will be issued by MWL once you have satisfied all pre-employment checks. This should be received before your start date and you should confirm acceptance of your contract prior to your start date. Your contract will cover the whole duration of your training programme.

Work schedule

This will be issued by your local host/organisation for each post; you will have a separate IM and Palliative Medicine work schedule as, for example, the on-call requirements will be very different. Your work schedule should be received at least eight weeks before you are due to start in the post. If there are delays, please contact your host organisation's HR department. Read your work schedule closely and make sure it matches your rota – your

work schedule provides the details of what MWL should pay you. Scrutinise your payslip also to make sure it reflects weekend and overnight working.

The work schedule should include a rolling rota template, from which you can easily check whether or not the rota complies with the various hours, limits and rest requirements in the 2016 junior doctor contract terms and conditions. A template work schedule is provided by the BMA.

The work schedule will include your salary. This will be calculated according to the national junior doctor pay scale (depending on whether you're on the 2016 or 2002 junior doctor contract). The salary scales can be found here. Note the increase in salary under the 2016 contract when trainees move from ST5 to ST6.

Rota

You should be issued your rota six weeks in advance of starting in post. This will be issued by the specific department you will work for in the host organisation (e.g. acute medicine or a hospice).

Electronic Staff Record / payslips

MWL will provide your Electronic Staff Record login details. Log in to the portal to download your payslip, p60 etc. You will be paid by MWL for IM and Palliative Medicine posts. There have been issues before with newer host organisations where trainees were paid by MWL *and* the host organisation. Contact your local HR department ASAP if the host organisation is trying to pay you.

Industrial action

If junior doctor industrial action occurs and you choose to be involved, you will need to log this with MWL after the event so that a deduction is reflected in your pay. You will usually receive an email from NWL containing a link to a form to complete for each set of industrial action. Further information from MWL is found here. Also follow any local instructions from the host organisation e.g. for logging your attendance if you choose to work during industrial action. The BMA has provided a guide to industrial action. This is especially worth reading if you are soon to be taking maternity leave as striking could impact your statutory maternity pay entitlement.

Annual leave

Your annual leave entitlement is as per the junior doctor contact you are on. The 2016 contract conditions allow for 27 days annual leave, increasing to 32 days after five years' NHS service. Your annual leave allocation is pro rata if you are LTFT. This will appear in your contract. If you've taken no breaks since F1 and thus ST4 is your sixth year working for the NHS, make sure with HR that your annual leave has been increased to 32 days.

Annual leave should be requested and recorded via your host organisation/placement's policies and requirements; NWL does not need informing of annual leave. Annual leave should be taken proportionally across any rotations in a training year.

Mandatory training

The lead employer requires a number of mandatory training modules to be completed every one to three years. Some material is provided by MWL, some material is provided by the local host organisation. The list of mandatory training is found in Section 11 of Appendix A of the Core skills mandatory training full document. It is also listed below.

Requirements set by the lead employer for all trainees (note these can be accessed through your Electronic Staff Record self-service account or e-LfH account if you have one):

1. NHS|CSTF|Equality, Diversity and Human Rights - 3 Years
2. NHS|CSTF|Fire Safety - 2 Years
3. NHS|CSTF|Health, Safety and Welfare - 3 Years
4. NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year
5. NHS|CSTF|Information Governance and Data Security - 1 Year
6. NHS|CSTF|NHS Conflict Resolution (England) - 3 Years
7. NHS|CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years
8. NHS|CSTF|Safeguarding Adults (Version 2) - Level 2 - 3 Years
9. NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years

Hosts are responsible for providing trainees with access to four specific requirements:

1. NHS|CSTF|Safeguarding Children - Level 3 - 3 Year
2. NHS|CSTF|Safeguarding Adults - Level 3 - 3 Years → *note these two safeguarding requirements need to be locally assessed as to whether it is required for a specific rotation (N.B. Should these be awarded by a trust the trainee will be awarded Level 2 for the same duration)*
3. NHS|CSTF|Moving and Handling - Level 2 – 2 Years → *needs local assessment due to specific equipment being used at the Trust before they can be awarded.*
4. NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year → *needs local assessment due to specific equipment being used at the Trust before they can be awarded. Note this doesn't need to be done in a year where you have re-certified in ALS.*

Note hosts are given access to certain elements of your Electronic Staff Record, including the mandatory training section, so will be able to see what you are compliant with to avoid duplication.

Instructions on how to find and complete the mandatory training e-learning on Electronic Staff Record or e-LfH can be found here.

OOP

Time out of programme (OOP) allows you to retain your National Training Number (NTN) whilst doing non-training activities including:

- research (OOPR) such as master's degrees
- experience (OOPE) such as medical education, leadership or voluntary work opportunities
- career break (OOPC) for things such as time in industry, but excluding maternity leave
- a pause (OOPP) of up to a year.

If you are considering an OOP you should discuss it with your TPD and ES as soon as possible. Note, if you are working on a Skilled Worker visa, an OOP could impact your sponsorship and right to live and work. You should thus seek specialist immigration advice before making an application. You must apply for the OOP via the PGMDE Support Portal at least six months in advance. The forms and deadlines can be found here.

OOP considerations:

- Indemnity: if you are doing clinical work whilst on an OOP you will not be covered by the medical indemnity provided by NHS England for Palliative Medicine trainees in London/KSS. Contact MDDUS to inform them of your plans and buy your own indemnity cover if needed for the OOP period.
- Continuity of NHS service: discuss with MWL and your host organisation's HR department about potential implications of your OOP on pension and continuity of service.
- GMC: you do not need approval from the GMC for an OOP but you will need to maintain your registration and license to practice if you intend on coming back into training or doing clinical work during the OOP.
- ePortfolio: change your post description to an OOP.
- ARCP: you will still be required to take part in an annual ARCP. You will need to submit an OOP update form and a Form R. The update form can be found here.
- Tax: if you are undertaking an OOP and will be paid by a different employer, MWL will continue to employ you but place you on a zero-hours contract. Therefore, you will need to inform HMRC that you are working on zero-hours contract for MWL and are still technically employed by them, but that your main employer is the OOP provider. You will need to ask HMRC to transfer the tax code from MWL to the new employer. This cannot be done within the first month after changing employer but should be done ASAP after this point.

Return to work after OOP

The lead employer will contact OOP trainees three months prior to the end of their OOP and ask for certain information in order to facilitate re-entry to the training programme (occupational health questionnaire, travel history, vaccination update, DBS check etc). Please note a delay in responding to this information request can cause a delay in the trainee's return to work.

London/KSS has a Supported Return to Training programme, "SuppoRRT", for trainees who have been out of training for three months or more, regardless of the reason. This programme provides a range of support services including coaching and workshops and will also enable you to apply for funding for return-to-work training. To apply a pre-absence form will need to be completed with your supervisor (ES, TPD or college tutor) to guide conversations around keeping in touch whilst out of training and resources that may be helpful. Prior to returning, a pre-return form is to be completed with your supervisor and this will enable supervised clinical sessions and shadowing to be arranged along with refresher courses and coaching. As soon as possible following return to work, trainees should meet with their ES to complete a follow-up form. Forms can be found here.

LTFT training

If considering working less than full-time (LTFT), London trainees should look at the information on the London Postgraduate Medical and Dental Education (LPMDE) website and PGMDE Support Portal.

LTFT trainees will only need to apply once to train LTFT and this is done via the PGMDE Support Portal. This should be done at least 16 weeks prior to intention to starting LTFT training (a notice period of less than 16 weeks may be considered in exceptional circumstances). Various evidence may be required. Timing of approval and start dates may be limited to application windows (however, applications on the basis of child care/health/disability/caring responsibilities can be made at any point throughout the training year), rotation dates or availability of the current year's placements. Once NHS England have confirmed LTFT eligibility it is helpful to inform the following: lead employer, TPD, Sector Lead(s) and LTFT Consultant Lead for the area. All LTFT trainees will be placed in slot-shares or reduced hours full-time posts. These posts are determined by the Specialty Training Committee.

LTFT trainees will only need to complete a new LTFT form via the PGMDE Support Portal on returning to full-time work or increasing/decreasing the number of sessions they work. This must also be done during specific windows related to the month of rotation. It is recommended that a trainee discusses their LTFT application with their ES and TPD. It is essential to complete the application form via the PGMDE Support Portal.

Please note, lead employer has a Champion of Flexible Training. More information can be found on their website.

New parent support

Entitlements for maternity leave, paternity leave, shared parental leave and adoption leave are all managed by the lead employer, under the provisions of your training contract (see section 15 of the NHS Terms and Conditions of Service Handbook).

If you plan to take new parent leave you will need to inform:

- the lead employer:
    - MWL have produced a the "Maternity handbook" outlining maternity leave.
    - There is no separate document for other kinds of new parent leave, but there are application forms on the same MWL webpage for:
        - paternity leave
        - shared parental leave
        - adoption leave
    - Note, to access new parent leave and pay, you must notify the lead employer at least **15 weeks** before the week you expect to become a new parent.
- your TPD
- the deanery via the PGMDE Support Portal by submitting an enquiry. The Changes in Circumstances FAQs may also be helpful.

The following resources may also be useful:

- BMA paternity leave guidance
- BMA maternity leave guidance

Designated body

You need to make sure your designated body is accurate on GMC online during the whole of your training. Log in to GMC online to update this. To find out who your designated body is click on 'Find your connection'.

Post-CCT: period of grace

Period of grace enables doctors who have completed training (been awarded a CCT) and not yet obtained a consultant post to continue their specialty registrar grade contract for a time-limited period whilst they find employment. The standard period of grace is six calendar months following the date of CCT and this is not pro rata for LTFT. The doctor is no longer considered to be in training, but in-post for the purposes of service. To apply for a period of grace, submit a query via the PGMDE Support Portal a minimum of six months prior to your CCT date (the period of grace is no longer automatically given). Note, the placement is subject to the availability of posts within the programme and service needs of the employing Trust. As such, specific locations or specific sub-specialty attachments may not be possible. More information can be found within the PGMDE support portal.

The APM has written a guide for new consultants to help with this transition.

Professional Support Unit

The Professional Support Unit (PSU) offers a range of free services and resources to London postgraduate trainees and other allied health professionals to support their progression and wellbeing. This includes coaching, careers advice, neurodiversity resources, dyslexia assessments and urgent psychological support.

Comments/ideas

Please get in touch if you think of information that you believe would be useful to other trainees to have included in this handbook, or if you notice any inaccuracies. Thank you.

Contact:
Dr Molly Stewart - molly.stewart6@nhs.net
Dr Hannah Petra - h.petra@nhs.net